Health Financial Sys		IU HEALTH JAY			u of Form CMS-25	552-10
	red by law (42 USC 1395g; the beginning of the cost				n FORM APPROVED OMB NO. 0938-0 EXPIRES 03-31-	
HOSPITAL AND HOSPITA AND SETTLEMENT SUMMA	NE HEALTH CARE COMPLEX COST RY	REPORT CERTIFICATIC	N Provider CCN: 15-1320	Period: From 01/01/2021 To 12/31/2021	Worksheet S Parts I-III Date/Time Prep 5/27/2022 8:00	
PART I - COST REPORT						
use only 2. []Electronically prepared]Manually prepared cost r]If this is an amended re]Medicare Utilization. Er	report	r of times the provider	Date: 5/27/20		00 am
Contractor use only 5. [1 (1) (2) (3) (4)	Cost Report Status6.As Submitted7.Settled without Audit8.	Date Received: Contractor No	10 11 for this Provider CCN12	.NPR Date: .Contractor's Vend .[0]If line 5, co	or Code:	4 nter 0-9.
PART II - CERTIFICAT	TION BY A CHIEF FINANCIAL (OFFICER OR ADMINISTRA	TOR OR PROVIDER(S)			
ADMINISTRATIVE ACTIO PROVIDED OR PROCURED	R FALSIFICATION OF ANY INFO NN, FINE AND/OR IMPRISONMEN D THROUGH THE PAYMENT DIREC NN, FINES AND/OR IMPRISONME	NT UNDER FEDERAL LAW. CTLY OR INDIRECTLY OF	FURTHERMORE, IF SERVI	CES IDENTIFIED IN 1	THIS REPORT WERE	E
CERTI FI CATI C	ON BY CHIEF FINANCIAL OFFIC	CER OR ADMINISTRATOR	Of PROVIDER(S)			
electronical Statement of beginning O1 are true, cc applicable i regarding th	RTIFY that I have read the ly filed or manually submi Revenue and Expenses prep 1/01/2021 and ending 12/31/ prrect, complete and prepar nstructions, except as not be provision of health care compliance with such laws	tted cost report and bared by IU HEALTH JA /2021 and to the best red from the books an ted. I further certif e services, and that	Isubmitted cost report Y HOSPITAL (15–1320) of my knowledge and be d records of the provid y that I am familiar wi	and the Balance Sho for the cost report lief, this report a er in accordance wi th the laws and rea	eet and ting period and statement ith gulations	
SI GNATURE OF CI	HIEF FINANCIAL OFFICER OR		CKBOX	ELECTRONIC		

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

		Title	XVIII			
Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospi tal	0	-534, 505	-441, 144	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing Bed - SNF	0	-374, 578	0		0	5.00
6.00 Swing Bed - NF	0				0	6.00
200. 00 Total	0	-909, 083	-441, 144	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.

	AL AND HOSPITAL HEALTH CARE COMPLEX		Provi d	er CCN:		Period: From 01/01/ To 12/31/	2021 2021	of For Workshe Part I Date/Ti 5/27/20	eet S-2 me Pre	pared:
	1.00	2.00		3.00		4	1.00			
00	Hospital and Hospital Health Care Co	PO Box:								1 00
. 00	Street: 500 W. VOTAW		Zin Code	. 17271	Count					1.00
. 00	City: PORTLAND	State: IN	Zip Code			y: JAY	Dourmon	nt Syst	om (D	2.00
		Component Name	CCN Number	CBSA Number	Provi der	Date Certified		0, or		
			Number	Number	Туре	Certifieu	V 1,	XVIII	1 '	-
		1.00	2.00	3.00	4.00	5.00	6. 00	7.00	XIX 8.00	-
	Hospital and Hospital-Based Componer		2.00	3.00	4.00	5.00	0.00	1.00	0.00	
. 00	Hospi tal	IU HEALTH JAY HOSPITAL	151320	99915	1	01/01/2004	N	0	Р	3.00
. 00	Subprovi der – IPF		131320	77715		0170172004	IN IN		'	4.00
. 00	Subprovider - IRF									5.00
. 00	Subprovider - (Other)									6.00
. 00		I UHP SWING BEDS	15Z320	99915		01/01/2004	N	0	N	7.00
. 00	Swing Beds - NF		152520	77715		0170172004	IN IN			8.00
. 00	Hospital-Based SNF									9.00
0.00	Hospi tal -Based NF									10.00
1.00	Hospi tal -Based OLTC									11.00
2.00	Hospi tal -Based HHA									12.00
2.00	Separately Certified ASC									12.00
	Hospi tal -Based Hospi ce									14.00
4.00 5.00	Hospital-Based Health Clinic - RHC									14.00
	Hospital-Based Health Clinic - FQHC									16.00
7.00	Hospital -Based (CMHC) I									17.00
8.00	Renal Dialysis									18.00
	Other									19.00
7.00	other					From:		То		17.00
						1.00		2.0		1
0. 00	Cost Reporting Period (mm/dd/yyyy)					01/01/20	021	12/31/		20.00
	Type of Control (see instructions)					2				21.00
					1.00	2.00		3.0	00	1
	Inpatient PPS Information						I			
2.00	Does this facility qualify and is it	currently receiving pa	yments for	r 🛛	N	N			-	22.00
	disproportionate share hospital adju	stment, in accordance w	ith 42 CFF	२						
	§412.106? In column 1, enter "Y" fc	or yes or "N" for no. Is	thi s							
	facility subject to 42 CFR Section §	412.106(c)(2)(Pickle am	endment							
	hospital?) In column 2, enter "Y" fo	r yes or "N" for no.								
2. 01	Did this hospital receive interim un				N	N				22.01
	cost reporting period? Enter in colu	ımn 1, "Y" for yes or "N	" for no f	for						
	the portion of the cost reporting pe									
	Enter in column 2, "Y" for yes or "N			cost						
	reporting period occurring on or aft									
2. 02	Is this a newly merged hospital that				N	N				22.02
	payments to be determined at cost re			ns)						
	Enter in column 1, "Y" for yes or "N									
	cost reporting period prior to Octob									
				tor						
	or "N" for no, for the portion of th	e cost reporting period	on or aft							
	October 1.				N	N.I.				
2. 03	October 1. Did this hospital receive a geograph	ic reclassification fro	m urban to	o	Ν	N		N		22.03
2. 03	October 1. Did this hospital receive a geograph rural as a result of the OMB standar	ic reclassification from ds for delineating stat	m urban to istical an	reas	Ν	N		Ν		22.03
2. 03	October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in c	ic reclassification from rds for delineating stat column 1, "Y" for yes or	m urban to istical an "N" for n	reas no	Ν	N		N		22. 03
2. 03	October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in c for the portion of the cost reportin	ic reclassification from ds for delineating stat column 1, "Y" for yes or ng period prior to Octob	m urban to istical an "N" for r er 1. Ente	reas no	Ν	N		N		22.03
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Health Financial Systems IU HEA HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ALTH JAY HOS ATA F	Provider CC	CN: 15-1320	Peri od:	In Lieu	Norkshe	et S-2	
				From 01/07 To 12/37	1/2021		me Pre 022 8:0	
	In-State Medicaid paid days	ln-State Medicaid eligible unpaid	Out-of State Medicaid paid days	Out-of State Medicaid eligible	Medicai HMO day	d 0 s Mec	ther li cai d lays	
		days	. ,	unpai d				
24.00 If this provider is an IPPS hospital, enter the	1.00	2.00	3.00	4.00	5.00	0	<u>. 00</u>	24.00
 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid 	0	0		0		0		25. 00
HMO paid and eligible but unpaid days in column 5.				Urban/Ru	ural S [)ate of	Geogr	
26.00 Enter your standard geographic classification (not wa	age) status	at the be	ginning of	1.0 the	0 2	2. (00	26.00
cost reporting period. Enter "1" for urban or "2" for 27.00 Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban of enter the effective date of the geographic reclassifi	r rural. age) status r "2" for r	at the en ural. If a	d of the co		2			27.00
35.00 If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			CH status i	n	0			35.00
errect in the cost reporting perrod.				Begi nn		Endi		
36.00 Enter applicable beginning and ending dates of SCH s		cript line	36 for num	1.0 ber	0	2. (00	36.00
of periods in excess of one and enter subsequent date 87.00 If this is a Medicare dependent hospital (MDH), enter		r of perio	ds MDH stat	us	о			37.00
is in effect in the cost reporting period. 87.01 Is this hospital a former MDH that is eligible for the accordance with FY 2016 OPPS final rule? Enter "Y" for instructions								37.0 ⁴
instructions) 38.00 If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.								38.00
				Y/N 1.0		Y/ 2. (-
39.00 Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions)), (ii), or the mileage	(iii)? En requireme	ter in colu nts in	ume N mn		N		39.00
40.00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octol no in column 2, for discharges on or after October 1.	ber 1. Ente	r "Y" for				N		40.00
					V 1.00	XVIII 2.00	XI X 3.00	
Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital paymen	nt for disp	roportiona	te share in	accordance	N	N	N	45.00
with 42 CFR Section §412.320? (see instructions)								46.00
46.00 Is this facility eligible for additional payment exce	eption for	extraordi n	ary circums		N	N	N	
 16.00 Is this facility eligible for additional payment exception pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III. 17.00 Is this a new hospital under 42 CFR §412.300(b) PPS of the second se	eption for t. L, Pt. I capital? E	extraordin II and Wks nter "Y fo	ary circums t. L-1, Pt. r yes or "N	l through " for no.	N	N N	N N	
 46.00 Is this facility eligible for additional payment exception pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III. 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS of 1s the facility electing full federal capital payment Teaching Hospitals 	eption for t. L, Pt. I capital? E t? Enter "	extraordin II and Wks nter "Y fo <u>Y" for yes</u>	ary circums t. L-1, Pt. r yes or "N or "N" for	l through " for no. no.	N N			48.00
 46.00 Is this facility eligible for additional payment excorpursuant to 42 CFR §412.348(f)? If yes, complete WksPt. III. 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS of Is the facility electing full federal capital payment Teaching Hospitals 56.00 Is this a hospital involved in training residents in "N" for no in column 1. For column 2, if the response was involved in training residents in approved GME private, and are you are impacted by CR 11642 (or applic Enter "Y" for yes; otherwise, enter "N" for no in column 2. 	eption for t. L, Pt. I capital? E t? Enter " approved G e to column rograms in cable CRS) lumn 2.	extraordin II and Wks nter "Y fo Y" for yes ME program 1 is "Y", the prior MA direct	ary circums t. L-1, Pt. r yes or "N or "N" for s? Enter "Y or if this year or pen GME payment	I through " for no. no. " for yes ou hospital ultimate reduction?	N N r N	N	N	48.00
 46.00 Is this facility eligible for additional payment excorpursuant to 42 CFR §412.348(f)? If yes, complete WksPt. III. 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS of Is the facility electing full federal capital payment Teaching Hospitals 56.00 Is this a hospital involved in training residents in "N" for no in column 1. For column 2, if the response was involved in training residents in approved GME pryear, and are you are impacted by CR 11642 (or applic Enter "Y" for yes; otherwise, enter "N" for no in col 57.00 If line 56 is yes, is this the first cost reporting programs trained at this facility? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y" add residents start training in the first momfor yes or "N" for no in column 2. If column 2 is "Y" "N", complete Wkst. D, Parts III & IV and D-2, Pt. II 	eption for t. L, Pt. I capital? E t? Enter " approved G e to column rograms in cable CRs) lumn 2. period duri r yes or "N th of this Y", complet I, if appli	extraordin II and Wks nter "Y fo Y" for yes ME program 1 is "Y", the prior MA direct ng which r " for no i cost repor e Workshee cable.	ary circums t. L-1, Pt. r yes or "N or "N" for s? Enter "Y or if this year or pen GME payment esidents in n column 1. ting period t E-4. If c	I through " for no. no. " for yes or hospital ultimate reduction? approved If column? ? Enter "Y" olumn 2 is	N N T N	N	N	47. 00 48. 00 56. 00 57. 00
 46.00 Is this facility eligible for additional payment excorpursuant to 42 CFR §412.348(f)? If yes, complete WksPt. III. 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS of Is the facility electing full federal capital payment Teaching Hospitals 56.00 Is this a hospital involved in training residents in "N" for no in column 1. For column 2, if the response was involved in training residents in approved GME pryear, and are you are impacted by CR 11642 (or applic Enter "Y" for yes; otherwise, enter "N" for no in col If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mom for yes or "N" for no in column 2. If column 2 is "N" 	eption for t. L, Pt. I capital? E t? Enter " approved G e to column rograms in cable CRs) lumn 2. period duri r yes or "N th of this Y", complet l, if appli bursement f	extraordin II and Wks nter "Y fo Y" for yes ME program 1 is "Y", the prior MA direct ng which r " for no i cost repor e Workshee cable. or physici	ary circums t. L-1, Pt. r yes or "N or "N" for s? Enter "Y or if this year or pen GME payment esidents in n column 1. ting period t E-4. If c	I through " for no. no. " for yes or hospital ultimate reduction? approved If column? ? Enter "Y" olumn 2 is	N N T N	N	N	48.00

Health Financial Systems IU HEA	LTH JAY	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider C	CN: 15-1320	Peri od: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Pre 5/27/2022 8:0	pared:
			NAHE 413.85 Y/N	5 Worksheet A Line #	Pass-Through Qualification Criterion Code	
			1.00	2.00	3.00	
60.00 Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent C adjustement? Enter "Y" for yes or "N" for no in col	85? (s umn 1. CR) NAHI	see If column 1	N			60.00
	Y/N	IME	Direct GME		Direct GME	
	1.00	2.00	3.00	4.00	5.00	
 61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 61.01 Enter the average number of unweighted primary care 	N			0.00	0.00	61.00
FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						(1.02
61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
	Pro	ogram Name	Program Cod	e Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	(1.10
61.10 Of the FTEs in line 61.05, specify each new program special ty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
 61.20 Of the FTEs in Line 61.05, specify each expanded 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. 				0.00	0.00	61.20
					1.00	-
ACA Provisions Affecting the Health Resources and Ser						
62.00 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruct	tions)					62.00
62.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC proc	gram. (s	see instructio		to your hospital	0.00	62.01
63.00 Has your facility trained residents in Nonprovider se "Y" for yes or "N" for no in column 1. If yes, completing	ettings	during this o			N	63.00

alth Financial Systems SPITAL AND HOSPITAL HEALTH CARE COMPLI		ALTH JAY HOSPITAL ATA Provider C		eriod: com 01/01/2021	u of Form CMS-2 Worksheet S-2 Part I	
			TC			pared:
			Unweighted	Unweighted	5/27/2022 8:0	00 am
			FTEs	FTEs in	Ratio (col. 1/ (col. 1 +	
			Nonprovi der	Hospi tal	col. 2))	
			Si te			
			1.00	2.00	3.00	
Section 5504 of the ACA Base Year			-This base year	is your cost	reporting	
period that begins on or after Ju Enter in column 1, if line 63 is in the base year period, the numb resident FTEs attributable to rot settings. Enter in column 2 the	yes, or your facili er of unweighted no ations occurring in	ty trained residents n-primary care all nonprovider	0.00	0.00	0. 000000	64.00
resident FTEs that trained in you						
of (column 1 divided by (column 1			Upweighted	Upwai abtad	Datio (aal	
	Program Name	Program Code	Unweighted FTEs	Unweighted FTEs in	Ratio (col. 3/ (col. 3 +	
			Nonprovi der	Hospi tal	col. 4))	
			Si te	noopritar		
	1.00	2.00	3.00	4.00	5.00	1
.00 Enter in column 1, if line 63			0.00	0.00	0. 000000	65.0
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			Unwei ghted	Unwei ghted	Ratio (col.	
			FTEs Nonprovider Site	FTEs in Hospital	1/ (col . 1 + col . 2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Current Y		n Nonprovider Setting	gsEffective f	or cost report	ing periods	
.00 Enter in column 1 the number of u	nweighted non-prima		0.00	0.00	0. 000000	66.0
Enter in column 2 the number of u						
FTEs that trained in your hospita						
(column 1 divided by (column 1 +	column 2)). (see in	structions)				
	Program Name	Program Code	Unweighted	Unweighted	Ratio (col.	
			FTES	FTEs in	3/ (col. 3 +	
			Nonprovider Site	Hospi tal	col. 4))	
	1.00	2.00	3.00	4.00	5.00	-
.00 Enter in column 1, the program	1.00	2.00	0.00	4.00		67 0
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				0.00		

Heal th	Financial Systems IU HEALTH JAY HOSPITAL	١n	Li eu	of Form	m CMS-2	2552-10
HOSPI T		eriod: rom 01/01/2 p 12/31/2	2021 I 2021 I	Workshe Part I Date/Ti	me Pre	pared:
		_		5/27/20 2.00		
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF sub		N			70.00
71.00	Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in	the most	N	N	0	71.00
	recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for 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 reportin (see instructions)	no. (see hi ng no.				
75.00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF		N			75.00
76.00	subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in	the most			0	76.00
	recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes o no. Column 2: Did this facility train residents in a new teaching program in accordance CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y indicate which program year began during this cost reporting period. (see instructions)	with 42				
			_	1.0	0	_
	Long Term Care Hospital PPS					
	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. Is this a LTCH co-located within another hospital for part or all of the cost reporting "Y" for yes and "N" for no.	period? Er	nter	N N		80.00 81.00
	TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Sectio		no.	N		85.00 86.00
87.00	<pre>\$413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.</pre>			Ν		87.00
		V 1.00		XI) 2. 0		
90.00	Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for	N		Y		90.00
91.00	yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost report either in	N		Ν		91.00
92.00	full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			Ν		92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	Ν		Ν		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		Ν		94.00
	If line 94 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	0. 00 N		0. 0 N		95.00 96.00
	IF line 96 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	0. 00 N		0. 0 Y		97.00 98.00
98. 01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y		98.01
98. 02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y		98.02
98. 03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1	N		N		98.03
98.04	for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX	N		N		98.04
98.05	in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in	N		Y		98.05
98.06	column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y		98.06
	column 2 for title XIX. Rural Providers	1				
	Does this hospital qualify as a CAH? If this facility qualifies as a CAH, has it elected the all-inclusive method of payment	Y N				105.00 106.00
107.00	for outpatient services? (see instructions) Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for L&R	N				107.00
	training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) 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 LRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)					

Health Financial Systems IU HEALTH JAY	HOSPI TAL		In Lieu	of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C		eriod: com 01/01/2021 o 12/31/2021	Worksheet S- Part I Date/Time Pr 5/27/2022 8:	epared:
			V	XI X	
108.00 Is this a rural hospital qualifying for an exception to the	CRNA fee sche	edul e? See 42	1.00 N	2.00	108.00
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			Crasse	Dessionstern	
-	Physi cal 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00	-
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
110 00 Did this breakted south single in the Dural Community Userit	- Demonstrasti		104	1.00	110.00
110.00 Did this hospital participate in the Rural Community Hospita Demonstration)for the current cost reporting period? Enter " complete Worksheet E, Part A, lines 200 through 218, and Wor applicable.	'Y" for yes or	"N" for no. I	f yes,	N	110.00
			1.00	2.00	_
111.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this courry "Y" for yes or "N" for no in column 1. If the response to contintegration prong of the FCHIP demo in which this CAH is part Enter all that apply: "A" for Ambulance services; "B" for action for tele-health services.	ost reporting olumn 1 is Y, rticipating ir	period? Enter enter the column 2.	N		111.00
		1.00	2.00	3.00	-
112.00 Did this hospital participate in the Pennsylvania Rural Heal demonstration for any portion of the current cost reporting Enter "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital cear participation in the demonstration, if applicable.	period? s "Y", enter ne	N	2.00	3.00	112.00
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or	r "N" for no	N			0115.00
in column 1. If column 1 is yes, enter the method used (A, E in column 2. If column 2 is "E", enter in column 3 either "9 for short term hospital or "98" percent for long term care (psychiatric, rehabilitation and long term hospitals provider the definition in CMS Pub.15-1, chapter 22, §2208.1.	3, or E only) 93" percent (includes				
116.00 Is this facility classified as a referral center? Enter "Y" "N" for no.	for yes or	N			116.00
117.00 Is this facility legally-required to carry malpractice insur	rance? Enter	N			117.00
"Y" for yes or "N" for no. 118.00 Is the malpractice insurance a claims-made or occurrence pol if the policy is claim-made. Enter 2 if the policy is occurr		2			118.00
		Premi ums	Losses	Insurance	
118.01 List amounts of malpractice premiums and paid losses:		1.00	2.00	3.00	0118.01
					_
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scheo and amounts contained therein.			1.00 N	2.00	118.02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendment Fortan in science 2. "Y"	ר column 1, "א ualifies for t	(" for yes or the Outpatient	Ν	Ν	119.00 120.00
Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no.	antable device	es charged to	Y		121.00
122.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.			Y	5.00	122.00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for	or yes and "N"	for no. If	N		125.00
yes, enter certification date(s) (mm/dd/yyyy) below.	-				
126.00 If this is a Medicare certified kidney transplant center, er in column 1 and termination date, if applicable, in column 2		nication date			126.00
127.00 If this is a Medicare certified heart transplant center, ent	ter the certif	ication date			127.00
in column 1 and termination date, if applicable, in column 2 128.00 If this is a Medicare certified liver transplant center, ent	ter the certif	fication date			128.00
in column 1 and termination date, if applicable, in column 2 129.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2.		cation date in			129.00

alth Financial Systems SPITAL AND HOSPITAL HEALTH CARE COMPL	IU HEALT EX IDENTIFICATION DATA	Provider CC	CN: 15-1320		i od:		u of Form CMS- Worksheet S-:	2
				Froi To		01/2021 31/2021	Part I Date/Time Pro 5/27/2022 8:0	epared 00 am
					1	00	2.00	_
0.00 f this is a Medicare certified p	pancreas transplant cer	iter, enter the cer	ti fi cati on	1	1.	00	2.00	130.0
date in column 1 and termination 1.00 If this is a Medicare certified i	ntestinal transplant c	enter, enter the c	erti fi cati	on				131. (
date in column 1 and termination 2.00 If this is a Medicare certified i in column 1 and termination date,	slet transplant center	, enter the certif	ïcation da	ite				132. (
3.00 Removed and reserved 4.00 If this is an organ procurement of and termination date, if applicab	organization (OPO), ent		in column	1				133. (134. (
All Providers 0.00 Are there any related organization chapter 10? Enter "Y" for yes or are claimed, enter in column 2 th	"N" for no in column 1	. If yes, and home imber. (see instruc	office co			Y	15H059	140. (
<u> </u>			ugh 143 th	ne name	e and	3.00 address	of the home	
1. 00 Name: I NDI ANA UNI VERSI TY HEALTH		e: WI SCONSI N PHYSI C SERVI CES	IAN Contra	actor's	s Numb	er: 0810	1	141. (
2.00 Street: 340 WEST TENTH STREET 3.00 City: INDIANAPOLIS	PO Box: State:	IN	Zip Co	ode:		4620	4	142.0
			1=. p 30					
4.00 Are provider based physicians' co	osts included in Worksh	neet A?					1.00 Y	144.
					1	00	2.00	-
5.00 f costs for renal services are of inpatient services only? Enter "Y no, does the dialysis facility in period? Enter "Y" for yes or "N"	Y" for yes or "N" for n nclude Medicare utiliza	no in column 1. If	column 1 i			00	2.00	145.
5.00 Has the cost allocation methodolo		eviously filed cos	t report?			N		146.
Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/				lf				
Enter "Y" for yes or "N" for no i				lf			1.00	-
Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/ 7.00Was there a change in the statist	/dd/yyyy) in column 2. tical basis? Enter "Y"	Pub. 15-2, chapter for yes or "N" for	40, §4020) no.	lf			1.00 N	
Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/ 7.00Was there a change in the statist 8.00Was there a change in the order of	/dd/yyyy) in column 2. tical basis? Enter "Y" of allocation? Enter "Y	Pub. 15-2, chapter for yes or "N" for " for yes or "N" f	40, §4020)).			148.
Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/ 7.00Was there a change in the statist 3.00Was there a change in the order of	/dd/yyyy) in column 2. tical basis? Enter "Y" of allocation? Enter "Y	Pub. 15-2, chapter for yes or "N" for "for yes or "N" f d? Enter "Y" for y Part A	40, \$4020) no. or no. es or "N" Part E	for no	Ti t	le V	N N Title XIX	148.
Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/ 7.00Was there a change in the statist 3.00Was there a change in the order o 9.00Was there a change to the simplif	/dd/yyyy) in column 2. tical basis? Enter "Y" of allocation? Enter "Y fied cost finding metho	Pub. 15-2, chapter for yes or "N" for "for yes or "N" f vd? Enter "Y" for y Part A 1.00	40, \$4020) r no. for no. res or "N" Part E 2.00	for no 3	Ti t 3.	I e V 00	N N Title XIX 4.00	148.
Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/ 7.00Was there a change in the statist 8.00Was there a change in the order of 0.00Was there a change to the simplif Does this facility contain a prov or charges? Enter "Y" for yes or	(dd/yyyy) in column 2. tical basis? Enter "Y" of allocation? Enter "Y fied cost finding metho vider that qualifies fo	Pub. 15-2, chapter for yes or "N" for "for yes or "N" f wd? Enter "Y" for y Part A 1.00 pr an exemption frc	40, \$4020) no. for no. res or "N" Part E 2.00 om the appl	for no 3 i cati c	Tit 3. on of ee 42	le V 00 the Iow CFR §41	N N Title XIX 4.00 er of costs 3.13)	148. 149.
Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/ 2.00 Was there a change in the statist 3.00 Was there a change in the order of 2.00 Was there a change to the simplif Does this facility contain a prov or charges? Enter "Y" for yes or 5.00 Hospital	(dd/yyyy) in column 2. tical basis? Enter "Y" of allocation? Enter "Y fied cost finding metho vider that qualifies fo	for yes or "N" for "for yes or "N" for yes or "N" for yes or "N" for yes or "N" for yes or "N" for Part A 1.00 or an exemption from ponent for Part A N	40, \$4020) in no. ior no. es or "N" Part E 2.00 m the appl and Part N	for no 3 i cati c	Tit 3. on of ee 42	le V 00 the Iow CFR §41 N	N N Title XIX 4.00 er of costs 3.13) N	148. 149. 155.
Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/ 0.00 Was there a change in the statist 0.00 Was there a change in the order of 0.00 Was there a change to the simplif Does this facility contain a prov or charges? Enter "Y" for yes or 5.00 Hospital 5.00 Subprovider - IPF	(dd/yyyy) in column 2. tical basis? Enter "Y" of allocation? Enter "Y fied cost finding metho vider that qualifies fo	Pub. 15-2, chapter for yes or "N" for '" for yes or "N" f bd? Enter "Y" for y Part A 1.00 or an exemption fro omponent for Part A	40, \$4020) no. or no. res or "N" Part E 2.00 om the appl A and Part N N	for no 3 i cati c	Tit 3. on of ee 42	le V 00 the low CFR §41 N	N N Title XIX 4.00 er of costs 3.13)	148. 149. 155. 155.
Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/ 7.00 Was there a change in the statist 3.00 Was there a change in the order of 2.00 Was there a change to the simplif Does this facility contain a prov or charges? Enter "Y" for yes or 5.00 Hospital 5.00 Subprovider - IPF 7.00 Subprovider - IRF 3.00 SUBPROVIDER	(dd/yyyy) in column 2. tical basis? Enter "Y" of allocation? Enter "Y fied cost finding metho vider that qualifies fo	for yes or "N" for "for yes or "N" for "for yes or "N" for part A 1.00 pr an exemption from ponent for Part A N	40, \$4020) or no. or no. res or "N" Part E 2.00 m the appl and Part N N N	for no 3 i cati c	Tit 3. on of ee 42	le V 00 the Iow CFR §41 N	N N Title XIX 4.00 er of costs 3.13) N N N	148. 149. 155. 155. 156. 157. 158.
Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/ 7.00Was there a change in the statist 3.00Was there a change in the order of 0.00Was there a change to the simplif Does this facility contain a prov or charges? Enter "Y" for yes or 5.00Hospital 6.00Subprovider - IPF 7.00Subprovider - IRF 8.00SUBPROVIDER 9.00SNF	(dd/yyyy) in column 2. tical basis? Enter "Y" of allocation? Enter "Y fied cost finding metho vider that qualifies fo	Pub. 15-2, chapter for yes or "N" for "for yes or "N" f d? Enter "Y" for y Part A 1.00 or an exemption fro pmponent for Part A N N N	40, \$4020) or no. es or "N" Part E 2.00 m the appl and Part N N N	for no 3 i cati c	Tit 3. on of ee 42	le V 00 the low CFR §41 N N N N	N N Title XIX 4.00 er of costs 3.13) N N N	148. 149. 155. 155. 156. 157. 158. 159.
Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/ 7.00Was there a change in the statist 3.00Was there a change in the order of 0.00Was there a change to the simplif Does this facility contain a prov or charges? Enter "Y" for yes or 5.00Hospital 6.00Subprovider - IPF 7.00Subprovider - IRF 8.00SUBPROVIDER 9.00SNF 0.00HOME HEALTH AGENCY	(dd/yyyy) in column 2. tical basis? Enter "Y" of allocation? Enter "Y fied cost finding metho vider that qualifies fo	for yes or "N" for "for yes or "N" for "for yes or "N" f d? Enter "Y" for y Part A 1.00 or an exemption fro omponent for Part A N N	40, \$4020) or no. or no. res or "N" Part E 2.00 m the appl and Part N N N	for no 3 i cati c	Tit 3. on of ee 42	le V 00 the low CFR §41 N N N	N N Title XIX 4.00 er of costs 3.13) N N N	148. 149. 155. 156. 157. 158. 159. 160.
Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/ 7.00Was there a change in the statist 3.00Was there a change in the order of 0.00Was there a change to the simplif Does this facility contain a prov or charges? Enter "Y" for yes or 5.00Hospital 6.00Subprovider - IPF 7.00Subprovider - IRF 8.00SUBPROVIDER 9.00SNF 0.00HOME HEALTH AGENCY	(dd/yyyy) in column 2. tical basis? Enter "Y" of allocation? Enter "Y fied cost finding metho vider that qualifies fo	Pub. 15-2, chapter for yes or "N" for "for yes or "N" f d? Enter "Y" for y Part A 1.00 or an exemption fro pmponent for Part A N N N	40, \$4020) or no. es or "N" Part E 2.00 om the appl and Part N N N N N	for no 3 i cati c	Tit 3. on of ee 42	le V 00 the low CFR §41 N N N N	N N Title XIX 4.00 er of costs 3.13) N N N N N N N	148. 149. 155. 156. 157. 158. 159. 160.
Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/ 7.00 Was there a change in the statist 8.00 Was there a change in the order of 9.00 Was there a change to the simplif Does this facility contain a prov or charges? Enter "Y" for yes or 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC	/dd/yyyy) in column 2. tical basis? Enter "Y" of allocation? Enter "Y fied cost finding metho vider that qualifies fo "N" for no for each co	Pub. 15-2, chapter for yes or "N" for "for yes or "N" f pd? Enter "Y" for y Part A 1.00 or an exemption fro pmponent for Part A N N N N	40, \$4020) no. for no. tes or "N" Part E 2.00 m the appl A and Part N N N N N N N	for no 3 i cati c B. (Se	Tit 3. on of ee 42	le V 00 the low CFR §41 N N N N N N N	N N Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N	147. 148. 149. 155. 156. 157. 158. 157. 160. 161. 161.
Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/ 7.00 Was there a change in the statist 8.00 Was there a change in the order of 9.00 Was there a change to the simplif Does this facility contain a prov or charges? Enter "Y" for yes or 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC	/dd/yyyy) in column 2. tical basis? Enter "Y" of allocation? Enter "Y fied cost finding metho vider that qualifies fo "N" for no for each co	Pub. 15-2, chapter for yes or "N" for "for yes or "N" f pd? Enter "Y" for y Part A 1.00 or an exemption fro pmponent for Part A N N N N	40, \$4020) no. for no. tes or "N" Part E 2.00 m the appl A and Part N N N N N N N	for no 3 i cati c B. (Se	Tit 3. on of ee 42	le V 00 the low CFR §41 N N N N N N N	N N Title XIX 4.00 er of costs 3.13) N N N N N N N	148. 149. 155. 156. 157. 158. 159. 160.
Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/ 7.00 Was there a change in the statist 3.00 Was there a change in the order of 2.00 Was there a change to the simplif Does this facility contain a prov or charges? Enter "Y" for yes or 5.00 Hospital 5.00 Subprovider - IPF 7.00 Subprovider - IPF 7.00 SUBPROVIDER 9.00 SUF 0.00 HOME HEALTH AGENCY 1.00 CMHC Multicampus 5.00 Is this hospital part of a Multic	<pre>/dd/yyyy) in column 2. tical basis? Enter "Y" of allocation? Enter "Y fied cost finding metho vider that qualifies fo "N" for no for each co campus hospital that ha Name</pre>	for yes or "N" for for yes or "N" for yes or "N" for yes or "N" for yes or "N" for yes or "N" for Part A 1.00 or an exemption fro ponent for Part A N N N N N N N N N N N N N	40, \$4020) ino. ior no. ies or "N" Part E 2.00 om the appl A and Part N N N N N N N N N N N N N	for no i cati c B. (Se fferen Zi p Cc	Tit 3. on of ee 42 it CBS ode	le V 00 the low CFR 541 N N N N N N As? CBSA	N N Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N T.00	148. 149. 155. 156. 157. 158. 159. 160. 161.
Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/ 7.00 Was there a change in the statist 8.00 Was there a change in the order of 9.00 Was there a change to the simplif 0.00 Was there a change to the simplif 0.00 Was there a change to the simplif 0.00 Subprovider - 1 PF 7.00 Subprovider - 1 PF 7.00 Subprovider - 1 RF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC Multicampus 5.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no.	/dd/yyyy) in column 2. tical basis? Enter "Y" of allocation? Enter "Y fied cost finding metho vider that qualifies for "N" for no for each co campus hospital that ha	for yes or "N" for for yes or "N" for yes or "N" for yes or "N" for yes or "N" for Part A 1.00 or an exemption from ponent for Part A N N N N N N N N N N N	40, \$4020) ino. ior no. ior no. ior sor "N" Part E 2.00 m the appl and Part N N N N N N N N N N N	for no 3 i cati c B. (Se fferen	Tit 3. on of ee 42 it CBS ode	le V 00 the low CFR §41 N N N N N N N As?	N N N Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N T.00 N FTE/Campus 5.00	148. 149. 155. 156. 157. 158. 159. 160. 161.
Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/ 7.00 Was there a change in the statist 3.00 Was there a change in the order of 9.00 Was there a change to the simplif Does this facility contain a provor or charges? Enter "Y" for yes or 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HME HEALTH AGENCY 1.00 CMHC Multicampus 5.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no. 5.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in	<pre>/dd/yyyy) in column 2. tical basis? Enter "Y" of allocation? Enter "Y fied cost finding metho vider that qualifies fo "N" for no for each co campus hospital that ha Name</pre>	for yes or "N" for for yes or "N" for yes or "N" for yes or "N" for yes or "N" for yes or "N" for Part A 1.00 or an exemption fro ponent for Part A N N N N N N N N N N N N N	40, \$4020) ino. ior no. ies or "N" Part E 2.00 om the appl A and Part N N N N N N N N N N N N N	for no i cati c B. (Se fferen Zi p Cc	Tit 3. on of ee 42 it CBS ode	le V 00 the low CFR 541 N N N N N N As? CBSA	N N N Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N N N N N N N	148. 149. 155. 156. 157. 158. 159. 160. 161. 165.
Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/ 7.00 Was there a change in the statist 8.00 Was there a change in the order of 9.00 Was there a change to the simplif Does this facility contain a prov or charges? Enter "Y" for yes or 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC Multicampus 5.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no. 6.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)	<pre>/dd/yyyy) in column 2. tical basis? Enter "Y" of allocation? Enter "Y Fied cost finding metho vider that qualifies for "N" for no for each co campus hospital that ha Name 0 1T) incentive in the America IT) incentive in the America It incentive It incentive It incentive It incentive It in the America It incentive It in the It incentive It in the It in the America It in the It in</pre>	for yes or "N" for for yes or "N" for yes or "N" for yes or "N" for yes or "N" for yes or "N" for Part A 1.00 or an exemption from moment for Part A N N N N N N N N N N N N N	40, \$4020) The image of the second se	for no i cati c B. (Se fferen Zip Cc 3.00	Ti t 3. on of ee 42 it CBS	le V 00 the low CFR 541 N N N N N N As? CBSA	N N N Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N N N N N N N	148. 149. 155. 156. 157. 158. 159. 160. 161. 165. 0 166.
Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/ 7.00 Was there a change in the statist 8.00 Was there a change in the order of 9.00 Was there a change to the simplif Does this facility contain a prov or charges? Enter "Y" for yes or 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC Multicampus 5.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no. 6.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)	<pre>/dd/yyyy) in column 2. tical basis? Enter "Y" of allocation? Enter "Y" fied cost finding metho vider that qualifies for "N" for no for each co "N" for no for each co campus hospital that ha Name 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0</pre>	for yes or "N" for "for yes or "N" for "for yes or "N" for <u>Part A</u> 1.00 or an exemption from ponent for Part A N N N N N N N N N N N N N	40, \$4020) Tono. for no. for n	for no i cati c B. (Se fferen Zi p Cc 3. 00 tment A	Ti t 3. on of ee 42 ot CBS ode	Le V 00 the low CFR 541 N N N N N As? CBSA 4.00	N N N Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N N N N N N N	148. 149. 155. 156. 157. 158. 159. 160. 161. 165.

Health Financial Systems	IU HEALTH JAY	HOSPI TAL	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DATA	Provider CCN: 15-1320	Period:	Worksheet S-2)
			From 01/01/2021	Part I	
			To 12/31/2021	Date/Time Pre	
				5/27/2022 8:0	<u>v am</u>
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR	beginning date and ending da	te for the reporting			170.00
period respectively (mm/dd/yyyy)					
			1.00	2.00	
171.00 If line 167 is "Y", does this pr	ovider have any days for indi	viduals enrolled in	Y	16	171.00
section 1876 Medicare cost plans	reported on Wkst. S-3, Pt. I	, line 2, col. 6? Enter			
"Y" for yes and "N" for no in co	lumn 1. lf column 1 is yes, e	enter the number of secti	on		
1876 Medicare days in column 2.	(see instructions)				

	Financial Systems IU HEALTH JA AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-1320	Peri od:	u of Form CMS- Worksheet S-2	
				From 01/01/2021 To 12/31/2021	Part II	epare
				Y/N	Date	
				1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter M mm/dd/yyyy format.	l for all NO re	esponses. Ent	er all dates in	the	
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation					-
00	Has the provider changed ownership immediately prior to the	e beainnina of	the cost	N		1.
	reporting period? If yes, enter the date of the change in a	column 2. (see	instructions			
			Y/N	Date	V/I	
00	Has the provider terminated participation in the Medicare F	Drogrom2 If	1.00 N	2.00	3.00	2.
00	yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.		N			2.
00	Is the provider involved in business transactions, includir contracts, with individuals or entities (e.g., chain home of an medical cumply companies) that are related to the provide	offices, drug	Y			3.
	or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members of of directors through ownership, control, or family and othe	of the board				
	relationships? (see instructions)			-		
			Y/N 1.00	Type 2.00	Date 3.00	
	Financial Data and Reports		1.00	2.00	3.00	
. 00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava	for Compiled,	Y	A	02/25/2022	4.
00	column 3. (see instructions) If no, see instructions.	aront from	N			5.
00	Are the cost report total expenses and total revenues different those on the filed financial statements? If yes, submit reconcisional statements of the statement of the stateme		N			5.
	,		I	Y/N 1.00	Legal Oper. 2.00	
	Approved Educational Activities			1.00	2.00	
00	Column 1: Are costs claimed for a nursing program? Column	2: If yes, i	s the provide	er N		6.
~~	is the legal operator of the program?					_
00 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions.		wed during th	ne N		7. 8.
00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		cal educatior	n N		9.
0. 00	Was an approved Intern and Resident GME program initiated of cost reporting period? If yes, see instructions.		the current	Ν		10.
1.00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	l & R in an Ap	proved	N	Y/N	11.
					1.00	
	Bad Debts Is the provider seeking reimbursement for bad debts? If yes	s, see instruc	ti ons.		Y	12.
	If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			cost reporting	Ň	13.
4.00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? I	fyes, see ir	istructions.	N	14.
5.00	Did total beds available change from the prior cost reporti	ng period?lf	yes, see ins	structions.	N	15.
			t A		t B	
		Y/N 1.00	Date 2.00	Y/N	Date 4.00	
	PS&R Data	1.00	2.00	3.00	4.00	
5. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see	Ν		N		16.
7.00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Υ	04/04/2022	Y	04/04/2022	17.
3. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed	Ν		N		18.
9. 00	but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19.

TH FINANCIAL SYSTEMS I U HEALTH JA PITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	F	Period: From 01/01/2021	Worksheet S Part II			
		T	o 12/31/2021	Date/Time F 5/27/2022 8			
	Descr	iption	Y/N	Y/N	<u>. 00 a</u>		
		0	1.00	3.00			
00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	Ν	20		
	Y/N 1.00	Date 2.00	Y/N 3.00	Date 4.00			
00 Was the cost report prepared only using the provider's records? If yes, see instructions.	N	2.00	N N	4.00	21		
	<u> </u>						
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE				1.00	_		
Completed by cost Reimborsed and TEFRA HOSPITALS UNLY (EACE	EPT CHILDRENS	HUSPITALS)					
00 Have assets been relifed for Medicare purposes? If yes, see 00 Have changes occurred in the Medicare depreciation expense			ng the cost	N Y	22 23		
reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases entered If yes, see instructions	ed into during	this cost rep	orting period?	Ν	2		
00 Have there been new capitalized leases entered into during instructions.		5 1	J .	Ν	2		
6.00 Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.							
7.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy. Interest Expense							
 Were new Loans, mortgage agreements or letters of credit en period? If yes, see instructions. 	ntered into du	ring the cost	reporting	Ν	2		
29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions							
Treated as a funded depreciation account? If yes, see instructions 0.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.							
00 Has debt been recalled before scheduled maturity without is instructions.	ssuance of new	debt? If yes,	see	N	3		
Purchased Services Have changes or new agreements occurred in patient care services		ed through con	tractual	N	3		
arrangements with suppliers of services? If yes, see instru 10 If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.		ng to competit	ive bidding? If	-	3		
Provi der-Based Physi ci ans				N N			
00 Are services furnished at the provider facility under an an If yes, see instructions.	0			Y	3		
00 If line 34 is yes, were there new agreements or amended exi physicians during the cost reporting period? If yes, see in		nts with the p	rovi der-based	Ν	3		
			Y/N	Date			
Home Office Costs			1.00	2.00			
00 Were home office costs claimed on the cost report?			Y		3		
00 If line 36 is yes, has a home office cost statement been p	repared by the	home office?	Ý		3		
If yes, see instructions. 00 If line 36 is yes , was the fiscal year end of the home of			N		3		
the provider? If yes, enter in column 2 the fiscal year end 00 If line 36 is yes, did the provider render services to othe	d of the home	offi ce.	Y		3		
see instructions. 00 If line 36 is yes, did the provider render services to the	home office?	lfyes, see	N		4		
instructions.		-					
	1.	00	2.	00			
Cost Report Preparer Contact Information DEnter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	RHONDA		UTTER		4		
respectively.	INDIANA UNIVEF	RSITY HEALTH			4		
preparer.							
	317-962-1093		RUTTER@I UHEALTI	H. ORG	4		

Health Fir	nancial Systems	IU HEALTH JA	Y HOSPI TAL		In Lieu	u of Form CMS-2	2552-10
HOSPI TAL	AND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE	Provi der	CCN: 15-1320	Period:	Worksheet S-2	
					From 01/01/2021 To 12/31/2021	Part II Date/Time Pre	nared
						5/27/2022 8:0	<u>0 am</u>
				3.00			
Cos	st Report Preparer Contact Information						
41.00 Ent	ter the first name, last name and the	title/position	DI RECTOR				41.00
hel	ld by the cost report preparer in colu	mns 1, 2, and 3,					
res	specti vel y.						
42.00 Ent	ter the employer/company name of the c	ost report					42.00
pre	eparer.						
43.00 Ent	ter the telephone number and email add	ress of the cost					43.00
re	port preparer in columns 1 and 2, resp	ecti vel y.					

iospi t	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C	CN: 15-1320	Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part I Date/Time Pre	
					To 12/31/2021	5/27/2022 8:0	
						I/P Days /	
						0/P Visits /	
						Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number 1.00	2.00	Available 3.00	4.00	5.00	
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30,00	2.00	3.00		5.00	1.0
. 00	8 exclude Swing Bed, Observation Bed and	30.00	21	7,0	41, 720.00	0	1.0
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
. 00	HMO and other (see instructions)						2.0
. 00	HMO IPF Subprovider						3.0
. 00	HMO IRF Subprovider						4.0
. 00	Hospital Adults & Peds. Swing Bed SNF					0	5.0
. 00	Hospital Adults & Peds. Swing Bed NF					0	6.
. 00	Total Adults and Peds. (exclude observation		21	7,6	65 41, 928. 00	0	7.0
. 00	beds) (see instructions) INTENSIVE CARE UNIT						8.
. 00	CORONARY CARE UNIT						9.
0.00	BURN I NTENSI VE CARE UNI T						10.
1.00	SURGI CAL I NTENSI VE CARE UNI T						11.
2.00	OTHER SPECIAL CARE (SPECIFY)						12.
3.00	NURSERY	43.00				0	13.
4.00	Total (see instructions)		21	7,6	65 41, 928. 00	0	14.
5.00	CAH visits					0	15.
6.00	SUBPROVIDER - IPF	40.00	0		0	0	16.
7.00	SUBPROVIDER - IRF						17.
8.00	SUBPROVI DER						18.
9.00	SKILLED NURSING FACILITY						19.
0.00 1.00	NURSING FACILITY OTHER LONG TERM CARE						20. 21.
2.00	HOME HEALTH AGENCY						21.
3.00	AMBULATORY SURGICAL CENTER (D. P.)						23.
4.00	HOSPI CE						24.
1.10	HOSPICE (non-distinct part)	30.00					24.
5.00	CMHC - CMHC						25.
5.00	RURAL HEALTH CLINIC						26.
6. 25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.
7.00	Total (sum of lines 14-26)		21				27.
3.00	Observation Bed Days					0	28.
9.00	Ambul ance Trips						29.
0.00	Employee discount days (see instruction)						30.
1.00	Employee discount days - IRF		0		0		31. 32.
2.00 2.01	Labor & delivery days (see instructions) Total ancillary labor & delivery room		0		U		32. 32.
∠. ∪⊺	outpatient days (see instructions)						JZ.
3.00	LTCH non-covered days						33.
	LTCH site neutral days and discharges						33.

HOSPITAL AND HOS	Systems PITAL HEALTH CARE COMPLEX STATISTIC	<u>IU HEALTH JAY</u> AL DATA	Provi der CC	CN: 15-1320	Period: From 01/01/2021 To 12/31/2021	u of Form CMS-: Worksheet S-3 Part I Date/Time Pre 5/27/2022 8:0	pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time E	qui val ents	
Comp	onent	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
8 exclude Hospice d for the p	Adults & Peds. (columns 5, 6, 7 and Swing Bed, Observation Bed and ays)(see instructions for col. 2 ortion of LDP room available beds) ther (see instructions)	652 479	40 231	1, 80	08		1.0
3.00 HMO IPF S	ubprovi der ubprovi der	479 0 0	0				2.0 3.0 4.0
	Adults & Peds. Swing Bed SNF	640	0	64	40		5.0
	Adults & Peds. Swing Bed NF		0		53		6.0
beds) (se	lts and Peds. (exclude observation e instructions) CARE UNIT	1, 292	40	3, 0	11		7.0 8.0
Ø. 00 CORONARY 10. 00 BURN I NTE 11. 00 SURGI CAL	CARE UNIT NSIVE CARE UNIT INTENSIVE CARE UNIT						9.0 10.0 11.0
2.00 OTHER SPE 3.00 NURSERY	CLAL CARE (SPECLEY)		0		0		12.0
	e instructions)	1, 292	40	3, 0'	0.00	200. 52	
5.00 CAH visit		1, 2, 2	0	0,0	0	200.02	15.0
6.00 SUBPROVI D		0	0		0 0.00	0.00	16. (
7.00 SUBPROVI D							17.0
8.00 SUBPROVI D							18.
	URSING FACILITY						19.
0.00 NURSING F 1.00 OTHER LON	G TERM CARE						20.
2.00 HOME HEAL							21.
	Y SURGICAL CENTER (D. P.)						23.
4. 00 HOSPI CE							24.
	non-distinct part)			(52		24.
5.00 CMHC - CM							25.
		0	0		0 0.00	0.00	26. 26.
	QUALIFIED HEALTH CENTER m of lines 14-26)	0	0		0.00		
	on Bed Days		6	5	78	200. 32	28.
9.00 Ambul ance	3	0			-		29.
0.00 Employee	discount days (see instruction)				0		30.
	discount days - IRF				0		31.
2.01 Total anc	elivery days (see instructions) illary labor & delivery room t days (see instructions)	0	0		0		32. 32.
	covered days	0					33.
	neutral days and discharges	0					33.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C	CN: 15-1320	Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part I Date/Time Pre 5/27/2022 8:0	pared:
	Full Time Equivalents		Di s	charges		
Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
	11.00	12.00	13.00	14.00	15.00	
 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) MM and other (see instructions) HMO and other (see instructions) HMO IPF Subprovider HMO HOSPItal Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) O INTENSIVE CARE UNIT O CORONARY CARE UNIT O SURGICAL INTENSIVE CARE UNIT O OTHER SPECIAL CARE (SPECIFY) O NURSERY O Total (see instructions) O SUBPROVIDER - IPF O SUBPROVIDER - IPF O SUBPROVIDER - IRF O SUBPROVIDER - IRF O SUBPROVIDER - IRF O SUBPROVIDER - IRF O SUBPROVIDER - IPF O SUBPROVIDER - IPF O SUBPROVIDER - IRF O OTHER LONG TERM CARE O HOME HEALTH AGENCY O AMBULATORY SURGICAL CENTER (D. P.) AMBULATORY SURGICAL CENTER (D. P.) O CMHC - CMHC O RURAL HEALTH CLINIC O SE FEDERALLY QUALIFIED HEALTH CENTER O Total (sum of lines 14-26) O Observation Bed Days O Ambul ance Trips O DEMIONE discount days (see instruction) O Employee discount days (see instruction) O Employee discount days (see instructions) <	0. 00 0. 00 0. 00 0. 00	0	1	84 7 14 58 0 0 84 7 0 0	617 0	$\begin{array}{c} 1.\ 00\\ \\ 2.\ 00\\ 3.\ 00\\ \\ 4.\ 00\\ \\ 5.\ 00\\ \\ 6.\ 00\\ \\ 7.\ 00\\ \\ 8.\ 00\\ \\ 9.\ 00\\ \\ 10.\ 00\\ \\ 11.\ 00\\ \\ 13.\ 00\\ \\ 13.\ 00\\ \\ 13.\ 00\\ \\ 13.\ 00\\ \\ 14.\ 00\\ \\ 15.\ 00\\ \\ 16.\ 00\\ \\ 17.\ 00\\ \\ 18.\ 00\\ \\ 22.\ 00\\ \\ 23.\ 00\\ \\ 24.\ 10\\ \\ 25.\ 00\\ \\ 26.\ 00\\ \\ 26.\ 00\\ \\ 26.\ 00\\ \\ 26.\ 00\\ \\ 27.\ 00\\ \\ 28.\ 00\\ \\ 29.\ 00\\ \\ 30.\ 00\\ \\ 31.\ 00\\ \\ 32.\ 01\\ \\ 32.\$
outpatient days (see instructions)33.00LTCH non-covered days33.01LTCH site neutral days and discharges				0 0		33. 00 33. 01

Heal th	Financial Systems IU HEALTH JAY H	OSPI TAL		In Lie	u of Form CMS-2	2552-10		
	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CO	CN: 15-1320	Peri od:	Worksheet S-1			
				From 01/01/2021				
				To 12/31/2021	Date/Time Pre 5/27/2022 8:0			
					0,21,2022 0.0			
					1.00			
	Uncompensated and indigent care cost computation							
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 di	vided by li	ne 202 colum	n 8)	0. 403021	1.00		
	Medicaid (see instructions for each line)				1			
2.00	Net revenue from Medicaid				6, 285, 485			
3.00	Did you receive DSH or supplemental payments from Medicaid?				Y	3.00		
4.00	If line 3 is yes, does line 2 include all DSH and/or supplement			ai d?	Y	4.00		
5.00	If line 4 is no, then enter DSH and/or supplemental payments f	rom medical	a		0	5.00 6.00		
6.00 7.00	Medicaid charges Medicaid cost (line 1 times line 6)				17, 795, 434			
7.00 8.00	Difference between net revenue and costs for Medicaid program	(line 7 mir	auc cum of Li	noc 2 and E. if	7, 171, 934 886, 449			
0.00	<pre>contended and costs for medical d program </pre>			nes z anu o, m	000, 449	0.00		
	Children's Health Insurance Program (CHIP) (see instructions f	or each lir	ne)					
9.00	Net revenue from stand-al one CHIP		,		0	9.00		
10.00					0			
11.00	0				0	11.00		
12.00	12.00 Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero ther							
	enter zero)							
	Other state or local government indigent care program (see ins	tructions f	for each line)				
	Net revenue from state or local indigent care program (Not inc				23, 372 109, 502			
14.00	14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)							
15.00	44, 132	15.00						
16.00	no 15 minus lin							
10.00	Difference between net revenue and costs for state or local ir 13; if < zero then enter zero)	langent care			20,700	10.00		
	Grants, donations and total unreimbursed cost for Medicaid, CH	IP and stat	te/local indi	gent care progra	ams (see			
	instructions for each line)			5 1 5	•			
17.00					0	17.00		
	Government grants, appropriations or transfers for support of				0			
19.00	Total unreimbursed cost for Medicaid , CHIP and state and loca	I indigent	care program	s (sum of lines	907, 209	19.00		
	8, 12 and 16)		Uni nsured	Insured	Total (col. 1			
			patients	patients	+ col. 2)			
			1.00	2.00	3.00			
	Uncompensated Care (see instructions for each line)							
20.00	Charity care charges and uninsured discounts for the entire fa	ncility	1, 565, 7	18 300, 801	1, 866, 519	20.00		
	(see instructions)							
21.00	Cost of patients approved for charity care and uninsured disco instructions)	ounts (see	631, 0 ⁻	300, 801	931, 818	21.00		
22.00	Payments received from patients for amounts previously writter	off as		0 0	0	22.00		
	chari ty care							
23.00	Cost of charity care (line 21 minus line 22)		631, 0	300, 801	931, 818	23.00		
					1.00			
24.00	Does the amount on line 20 column 2, include charges for patie	ont days bey	vond a length	of stay limit	N 1.00	24.00		
21.00	imposed on patients covered by Medicaid or other indigent care		yona a rengti	or stuy rimit		21.00		
25.00	If line 24 is yes, enter the charges for patient days beyond t		t care progra	m's length of	0	25.00		
	stay limit	5	1 3	5				
26.00	Total bad debt expense for the entire hospital complex (see in	structions))		2, 310, 576	26.00		
27.00	Medicare reimbursable bad debts for the entire hospital comple	ex (see inst	tructions)		329, 027	27.00		
27.01	Medicare allowable bad debts for the entire hospital complex (see instruc	ctions)		506, 195			
28.00	Non-Medicare bad debt expense (see instructions)				1, 804, 381			
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt ex	pense (see	instructions)	904, 371			
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)				1, 836, 189			
31.00	Total unreimbursed and uncompensated care cost (line 19 plus l	ine 30)			2, 743, 398	31.00		

Cost Center Description Sal aries Other Total (col. 1) Reclassification (col. 2) Reclassification (col. 2) 0100 2.00 3.00 4.00 5.00 (col. 2)	ance +-) , 030 1.00 , 227 1.01 , 030 1.02 , 433 1.03 0 1.04 , 820 2.00 0 2.03 0 2.03 , 992 4.00 , 819 5.00 , 782 7.00 , 772 7.01 , 488 7.02 0 7.03 0, 976 8.00 , 392 9.00
Cost Center Description Salaries Other Total (col. 1) (col. 2) Reclassificat (col. 3) Reclassificat (col. 3) 6ENERAL SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 1.00 00100 (CAP REL COST-BLIDG & FIXT-MOB 0 0 1.185,030 1.185,030 1.00 00102 (CAP REL COST-BLIDG & FIXT-MOB 0 0 35,030 3 1.00 00102 (CAP REL COST-BLIDG & FIXT-MOB 0 0 9,433 1.01 00101 (CAP REL COST-SHUGE & FIXT-INTERST 0 0 0 9,433 2.01 00200 (CAP REL COST-SHUBLE & FIXT-INTERST 0 0 0 1,42,80 2.01 00200 (CAP REL COST-SHUBLE EQUIP - M0B 0 0 0 0 0 2.01 00201 (CAP REL COST-SHUBLE EQUIP - M0B 0	i ed ance +- 030 1.00 ,227 1.01 ,030 ,433 0 ,433 0.30 ,820 2.01 0 0 ,830 2.01 0 0 2.03 ,992 4.00 ,782 7.01 ,488 7.02 0 ,976 8.00 ,922 9.000
ENERAL SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 1.00 COTOD CAP REL COSTS -BLDG & FIXT 0 0 1.185.030 1.1 1.00 COTOD CAP REL COSTS -BLDG & FIXT-MOB 0 0 35.030 1.5 1.02 COTOZ CAP REL COSTS -BLDG & FIXT-WD 0 0 9.433 0 1.04 OOTOG CAP REL COSTS -MUBLE EOULP 0 0 1.427.820 1.427 2.00 OCZOC CAP REL COSTS -MUBLE EOULP NOB 0 0 0 0 2.01 OCZOC CAP REL COSTS -MUBLE EOULP P.WJ 0 0 0 0 0 2.03 OCZOS CAP REL COSTS -MUBLE EOULP P.WJ 0 <td>, 030 1. 00 , 227 1. 01 , 030 1. 02 , 433 1. 03 0 1. 04 , 820 2. 00 , 830 2. 01 0 2. 02 0 2. 03 , 992 4. 00 , 782 7. 00 , 782 7. 00 , 772 7. 01 , 488 7. 02 0 7. 03 , 976 8. 00 , 392 9. 00</td>	, 030 1. 00 , 227 1. 01 , 030 1. 02 , 433 1. 03 0 1. 04 , 820 2. 00 , 830 2. 01 0 2. 02 0 2. 03 , 992 4. 00 , 782 7. 00 , 782 7. 00 , 772 7. 01 , 488 7. 02 0 7. 03 , 976 8. 00 , 392 9. 00
1.00 00100 CAP REL COSTS-BLDG & FIXT 0 0 1, 185, 030 1, 185 1.01 00101 CAP REL COSTS-BLDG & FIXT-NOB 0 0 35, 030 2 1.02 00102 CAP REL COSTS-BLDG & FIXT-NDB 0 0 9, 433 2 1.04 00104 CAP REL COSTS-MUBLE EQUIP 0 0 9, 433 2 2.00 00200 CAP REL COSTS-MUBLE EQUIP 0 0 1, 427, 820 1, 427, 820 2.01 00202 CAP REL COSTS-MUBLE EQUIP P - WDB 0 0 32, 830 2 2.03 00203 CAP REL COSTS-MUBLE EQUIP P - WD 9, 578 14, 939 24, 517 2, 869, 475 2, 86 2.00 00200 CAP REL COSTS-MUBLE EQUIP P - WJ 9, 578 14, 939 24, 517 2, 850, 71 2, 850, 71 2, 850, 71 2, 850, 71 2, 850, 71 2, 850, 71 2, 850, 71 2, 850, 71 3, 71, 866 9, 627, 024 9, 998, 890 -250, 071 9, 77 70 0, 00 00 0 0 0 0 0 0 0 0 0 <td>, 227 1.01 , 030 1.02 , 433 1.03 0 1.04 , 820 2.00 , 830 2.01 0 2.02 0 2.03 , 992 4.00 , 819 5.00 , 782 7.02 0 7.03 , 976 8.00 , 976 8.00 , 392 9.00</td>	, 227 1.01 , 030 1.02 , 433 1.03 0 1.04 , 820 2.00 , 830 2.01 0 2.02 0 2.03 , 992 4.00 , 819 5.00 , 782 7.02 0 7.03 , 976 8.00 , 976 8.00 , 392 9.00
1.02 00102 CAP REL COSTS-BLDG & FIXT-WD 0 0 35,030 35 1.03 00103 CAP REL COSTS-BLDG & FIXT-WD 0 0 9,9433 2.00 00200 CAP REL COSTS-MUBLE EQUIP 0 0 0 1,427,820 2.01 00200 CAP REL COSTS-MUBLE EQUIP NOB 0 0 1,427,820 2.02 00202 CAP REL COSTS-MUBLE EQUIP NUB 0 0 0 2.03 00202 CAP REL COSTS-MUBLE EQUIP NUB 0 0 0 0 4.00 00400 ENPLOYEE BENEFITS DEPARTMENT 9,578 14,933 24,517 2,869,475 2,869 1.01 00701 OPERATION OF PLANT MOB 0 122,523 122,523 127,535 14,033 24,517 74,105 13 1.03 00703 OPERATION OF PLANT MOB 0 0 0 0 0 0 0 0 0 0 0 0 0 <td< td=""><td>,030 1.02 ,433 1.03 0 1.04 ,820 2.00 ,830 2.01 0 2.02 0 2.03 ,992 4.00 ,819 5.00 ,782 7.02 ,772 7.01 ,488 7.02 0 7.03 ,976 8.00 ,392 9.00</td></td<>	,030 1.02 ,433 1.03 0 1.04 ,820 2.00 ,830 2.01 0 2.02 0 2.03 ,992 4.00 ,819 5.00 ,782 7.02 ,772 7.01 ,488 7.02 0 7.03 ,976 8.00 ,392 9.00
1.03 00103 CAP FEL COSTS-BLDG & FLYT-INTEREST 0 0 9,433 1.04 00104 CAP FEL COSTS-HUGB & FLYT-INTEREST 0 0 0 0 2.00 00200 CAP FEL COSTS-HUBLE EOUIP - NOB 0 0 32,830 32,02 2.02 00202 CAP FEL COSTS-HUBLE EOUIP - NUJ 0 0 0 0 2.03 00203 CAP REL COSTS-HUBLE EOUIP - NUJ 0 0 0 0 2.03 00203 CAP REL COSTS-HUBLE EOUIP - NUJ 0 0 0 0 0.0030 CAP REL COSTS-HUBLE EOUIP - NUJ 0 0 0 0 0 0.0030 OPERATION OF PLANT - NOB 0 122,523 122,523 -77,751 4 0.00 00000 OUENTRY 334,679 673,729 -127,337 55 0.00 00000 OUEXTERPL NO 122,523 58,871 74,105 13 0.00 00000 OUEXTERPL NO 32,912 25,959 58,871 <td>, 433 1.03 0 1.04 , 820 2.00 , 830 2.01 0 2.02 0 2.03 , 992 4.00 , 819 5.00 , 782 7.00 , 772 7.01 , 488 7.02 0 7.03 , 976 8.00 , 392 9.00</td>	, 433 1.03 0 1.04 , 820 2.00 , 830 2.01 0 2.02 0 2.03 , 992 4.00 , 819 5.00 , 782 7.00 , 772 7.01 , 488 7.02 0 7.03 , 976 8.00 , 392 9.00
2.00 00200 CAP REL COSTS-WHDLE EQUIP 0 1, 427, 820 1, 427, 820 2.01 00201 CAP REL COSTS-WHDLE EQUIP - P08 0 <	, 820 2.00 , 830 2.01 0 2.02 0 2.03 , 992 4.00 , 819 5.00 , 782 7.00 , 772 7.01 , 488 7.02 0 7.03 , 976 8.00 , 392 9.00
2. 01 00201 CAP REL COSTSMVBLE EQUIP P - MOB 0 0 32, 830 32 2. 02 00203 CAP REL COSTSMVBLE EQUIP P - WJ 0 0 0 0 4. 00 00400 EMPLOYCE BENEFITS DEPARTMENT 9, 578 14, 939 24, 517 2, 869, 475 2, 86 5. 00 00500 ADMI NI STRATI VE & CENERAL 371, 866 9, 627, 024 9, 98, 80 -250, 071 9, 77 7. 00 00700 OPERATION OF PLANT MOB 0 99, 873 99, 873 -36, 385 6 7. 02 00703 OPERATION OF PLANT WDB 0 9, 973 99, 873 -36, 385 6 7. 03 00703 OPERATION OF PLANT WDB 333, 659 565, 238 880, 220 -475, 108 44 10. 00 1000 DICARPY 314, 982 565, 238 880, 220 -475, 108 44 10. 00 01000 ILTARY 314, 982 565, 238 880, 220 -20, 420 734, 508 7 10. 00 01000 ILTARY 0 -20 20, 420	, 830 2.01 0 2.02 0 2.03 , 992 4.00 , 819 5.00 , 772 7.01 , 488 7.02 0 7.03 , 976 8.00 , 392 9.00
2.02 00222 CAP REL COSTS-MWBLE EQUIP - POB 0 0 0 0.03 0023 CAP REL COSTS-WBLE EQUIP - VJ 0 0 0 4.00 00400 EMPLOYEE BENEFITS DEPARTIMENT 9, 578 14, 939 24, 517 2, 869, 475 2, 85 5.00 00500 OPERATION OF PLANT 860, 44, 131, 845 4, 682, 083 -1, 501, 301 3, 18 7.01 00701 OPERATION OF PLANT - M0B 0 99, 873 -56, 385 66 7.02 00702 OPERATION OF PLANT - WJ 0 <td< td=""><td>0 2.02 0 2.03 992 4.00 ,819 5.00 ,72 7.01 ,488 7.02 0 7.03 ,976 8.00 ,392 9.00</td></td<>	0 2.02 0 2.03 992 4.00 ,819 5.00 ,72 7.01 ,488 7.02 0 7.03 ,976 8.00 ,392 9.00
4.00 004001 EMPLOYEE BEMEFITS DEPARTMENT 9, 578 14, 939 24, 517 2, 869, 475 2, 879, 475 5.00 00500 ADM INI STRATIVE & GENERAL 371, 866 9, 627, 024 9, 98, 890 -250, 071 9, 78 7.00 00701 0PERATI ON OF PLANT M0B 0 122, 523 1-77, 751 -47 7.01 00701 0PERATI ON OF PLANT PUBB 0 9, 873 -36, 385 -60 7.03 00730 0PERATI ON OF PLANT WJ 0 0 0 0 -60 0 8.00 00800 LAUNDRY & LINEN SERVICE 32, 912 25, 959 58, 871 74, 105 13 9.00 00500 HAUNDRY & LINEN SERVICE 32, 912 0 0 0 -20, 420 -20, 420 -23, 868 1, 64 11.00 01100 CAFETERI A 0 0 -20, 420 -20, 420 -20, 420 -20, 420 -20, 420 -20, 420 -20, 420 -20, 420 -20, 420 -20, 420 -20, 420 -20, 420 -20, 420 -20, 420 -20, 420 -20, 420 -20, 420 -20, 420 -	, 992 4.00 , 819 5.00 , 782 7.00 , 772 7.01 , 488 7.02 0 7.03 , 976 8.00 , 392 9.00
5. 00 00500 ADMI NI STRATI VE & GENERAL 371, 866 9, 627, 024 9, 998, 890 -250, 071 9, 77 7. 00 00700 OPERATI ON OF PLANT MOB 0 122, 523 122, 523 -77, 751 62 7. 01 00701 OPERATI ON OF PLANT - MOB 0 122, 523 122, 523 -77, 751 62 7. 02 00702 OPERATI ON OF PLANT - WJ 0 <td< td=""><td>, 819 5.00 , 782 7.00 , 772 7.01 , 488 7.02 0 7.03 , 976 8.00 , 392 9.00</td></td<>	, 819 5.00 , 782 7.00 , 772 7.01 , 488 7.02 0 7.03 , 976 8.00 , 392 9.00
7. 01 0PERATI ON OF PLANT - MOB 122, 523 122, 523 -77, 751 4 7. 02 00703 0PERATI ON OF PLANT - POB 0 99, 873 99, 873 -36, 385 6 7. 03 00703 0PERATI ON OF PLANT - WJ 0	772 7.01 488 7.02 0 7.03 ,976 8.00 ,392 9.00
7. 02 00702 0PERATI 0N OF PLANT - POB 0 99, 873 99, 873 -36, 385 66 7. 03 00703 0PERATI 0N OF PLANT - WJ 0	, 488 7. 02 0 7. 03 , 976 8. 00 , 392 9. 00
7.03 OOT03 OPERATION OF PLANT - WJ 0 0 0 0 8.00 OOROO LAUNDRY & LINEN SERVICE 32, 912 25, 959 58, 871 74, 105 11 9.00 OO900 HOUSEKEEPING 337, 050 336, 679 673, 729 -127, 337 56 10.00 OIT00 DETARY 314, 982 565, 238 880, 220 -475, 108 44 11.00 OIT00 CAFETERIA 0 0 0 296, 795 225 11.00 OIT00 CAFETERIA 0 -20, 420 -20, 420 734, 508 77 15.00 OI500 PHARMACY 525, 491 1, 939, 302 2, 464, 793 -1, 467, 221 99 16.00 OISOO NURSI NG ADMINI STRATI CS 1, 786, 997 1, 486, 549 3, 273, 546 -530, 893 2, 74 0.00 OISOO ADULTS & PEDIATRICS 1, 786, 997 1, 486, 549 3, 273, 546 -530, 893 2, 74 0.00 OUSOO ODUBERATI NG ROOM 767, 852 1, 379, 150 2, 147, 002 -784, 697 1, 32 0.00 OSOO ODOROPERATI NG ROOM 767, 852 1, 379, 150 2, 147, 002<	0 7.03 ,976 8.00 ,392 9.00
9.00 00900 HOUSEKEEPING 337,050 336,679 673,729 -127,337 55 10.00 01000 DETARY 314,982 565,238 880,220 -475,108 40 11.00 01100 CAFETERIA 0 0 0296,795 22 13.00 01300 NURSING ADMINISTRATION 1,258,054 741,996 2,000,050 -399,868 1,66 14.00 01400 CENTRAL SERVICES & SUPPLY 0 -20,420 -20,420 734,508 77 15.00 01500 PHARMACY 525,491 1,939,302 2,464,793 -1,467,221 95 16.00 01500 FARTINE SERVICE 0	, 392 9. 00
10.00 01000 DETARY 314,982 565,238 880,220 -475,108 44 11.00 01100 CAFETERIA 0 0 0 296,795 23 31.00 01300 NURSI NG ADMINI STRATI ON 1,258,054 741,996 2,000,050 -399,868 1,66 10.00 DI400 CENTRAL SERVI CES & SUPPLY 0 -20,420 -20,420 734,508 77 15.00 01500 PHARMACY 0	
11.00 01100 CAFETERIA 0 0 296,795 296 13.00 01300 NURSI NG ADMI NI STRATI ON 1,258,054 741,996 2,000,050 -399,868 1,66 14.00 01400 CENTRAL SERVI CES & SUPPLY 0 -20,420	, 112 10. 00
14.00 01400 CENTRAL SERVICES & SUPPLY 0 -20,420 -20,420 734,508 77 15.00 01500 PHARMACY 525,491 1,939,302 2,464,793 -1,467,221 99 16.00 01600 MEDI CAL RECORDS & LIBRARY 0 0 0 0 0 0 17.00 01700 SOCI AL SERVICE 0 </td <td>, 795 11.00</td>	, 795 11.00
15.00 01500 PHARMACY 525, 491 1, 939, 302 2, 464, 793 -1, 467, 221 94 16.00 01600 MEDI CAL SECVICE 0 0 0 0 0 17.00 DOCIAL SERVICE 0 0 0 0 0 0 0 18.00 03000 ADULTS & PEDIATRICS 1, 786, 997 1, 486, 549 3, 273, 546 -530, 893 2, 74 40.00 04000 SUBPROVIDER - IPF 0 0 0 0 0 40.00 OBJOD OPERATING ROOM 767, 852 1, 379, 150 2, 147, 002 -784, 697 1, 36 50.00 05000 OPERATING ROOM 767, 852 1, 379, 150 2, 147, 002 -784, 697 1, 36 51.00 05000 OPERATING ROOM 0	, 182 13. 00
16.00 01600 MEDI CAL RECORDS & LIBRARY 0	, 088 14. 00 , 572 15. 00
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 03000 ADULTS & PEDI ATRI CS 1, 786, 997 1, 486, 549 3, 273, 546 -530, 893 2, 74 40.00 04000 SUBPROVI DER - I PF 0 0 0 0 0 43.00 04300 NURSERY 0 0 0 0 0 0 ANCI LLARY SERVI CE COST CENTERS 50.00 05000 OPERATI NG ROOM 0	0 16.00
30.00 O3000 ADULTS & PEDIATRICS 1,786,997 1,486,549 3,273,546 -530,893 2,74 40.00 O4000 SUBRROVIDER - IPF 0 0 0 0 0 43.00 O4000 SUBRROVIDER - IPF 0 0 0 0 0 0 43.00 OVADO SUBRROVIDER - IPF 0	0 17.00
40.00 04000 SUBPROVI DER - 1 PF 0 0 0 0 43.00 04300 NURSERY 0 0 0 0 0 ANCI LLARY SERVI CE COST CENTERS	, 653 30. 00
ANCI LLARY SERVI CE COST CENTERS 50.00 05000 OPERATI NG ROOM 767, 852 1, 379, 150 2, 147, 002 -784, 697 1, 36 52.00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 0 0 53.00 05300 ANESTHESI OLOGY 0 0 0 0 0 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 888, 451 1, 166, 468 2, 054, 919 -923, 982 1, 136 60.00 06000 LABORATORY 8, 405 1, 939, 862 1, 948, 267 -16, 824 1, 92 65.00 06500 RESPI RATORY THERAPY 399, 367 202, 820 602, 187 -124, 237 47 66.00 06600 PHYSI CAL THERAPY 504, 725 28, 456 533, 181 -3, 341 52 67.00 06700 OCCUPATI ONAL THERAPY 92, 328 126 92, 454 -126 92 68.00 06800 SPEECH PATHOLOGY 0 1, 907 -998 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 93, 761	0 40.00
50.00 05000 0PERATING ROOM 767,852 1,379,150 2,147,002 -784,697 1,36 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 0 53.00 05300 ANESTHESI OLOGY 0 0 0 0 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 888,451 1,166,468 2,054,919 -923,982 1,12 60.00 06000 LABORATORY 8,405 1,939,862 1,948,267 -16,824 1,92 65.00 06500 RESPI RATORY THERAPY 399,367 202,820 602,187 -124,237 47 66.00 06600 PHYSI CAL THERAPY 504,725 28,456 533,181 -3,341 52 67.00 06700 OCCUPATI ONAL THERAPY 92,328 126 92,454 -126 92 68.00 06800 SPEECH PATHOLOGY 18,466 0 18,466 0 17,907 -998 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 21,599 2 <td>0 43.00</td>	0 43.00
53.00 05300 ANESTHESI OLOGY 0 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 888, 451 1, 166, 468 2, 054, 919 -923, 982 1, 13 60.00 06000 LABORATORY 8, 405 1, 939, 862 1, 948, 267 -16, 824 1, 95 65.00 06500 RESPI RATORY THERAPY 399, 367 202, 820 602, 187 -124, 237 47 66.00 06600 PHYSI CAL THERAPY 504, 725 28, 456 533, 181 -3, 341 52 67.00 06700 OCUPATI ONAL THERAPY 92, 328 126 92, 454 -126 92 68.00 06800 SPEECH PATHOLOGY 18, 466 0 18, 466 0 1 69.00 06900 ELECTROCARDI OLOGY 18, 466 0 1, 907 -998 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 21, 599 22 73.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 1, 868, 075 1, 86 75.00 03160 <td< td=""><td>, 305 50. 00</td></td<>	, 305 50. 00
54.00 05400 RADI OLOGY-DI AGNOSTI C 888, 451 1, 166, 468 2, 054, 919 -923, 982 1, 13 60.00 06000 LABORATORY 8, 405 1, 939, 862 1, 948, 267 -16, 824 1, 93 65.00 06500 RESPI RATORY THERAPY 399, 367 202, 820 602, 187 -124, 237 47 66.00 06600 PHYSI CAL THERAPY 504, 725 28, 456 533, 181 -3, 341 52 67.00 06700 OCCUPATI ONAL THERAPY 92, 328 126 92, 454 -126 53 68.00 06800 SPEECH PATHOLOGY 18, 466 0 18, 466 0 1 90 69.00 18, 907 1, 907 -998 2 2 2 2 3	0 52.00
60.00 06000 LABORATORY 8,405 1,939,862 1,948,267 -16,824 1,935 65.00 06500 RESPIRATORY THERAPY 399,367 202,820 602,187 -124,237 475 66.00 06600 PHYSI CAL THERAPY 504,725 28,456 533,181 -3,341 555 67.00 06700 OCCUPATI ONAL THERAPY 92,328 126 92,454 -126 92 68.00 06800 SPEECH PATHOLOGY 18,466 0 1,907 1,907 -998 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 93,761 92 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 21,599 22 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 1,868,075 1,86 76.00 03160 CARDI OPULMONARY 150,728 145,169 295,897 -72,460 22 77.00 09000 CLINIC 0 0 0 0 0 22 76.00 <t< td=""><td>0 53.00 937 54.00</td></t<>	0 53.00 937 54.00
66.00 06600 PHYSI CAL THERAPY 504, 725 28, 456 533, 181 -3, 341 52 67.00 06700 0CCUPATI ONAL THERAPY 92, 328 126 92, 454 -126 92 68.00 06800 SPEECH PATHOLOGY 18, 466 0 18, 466 0 1 69.00 06900 ELECTROCARDI OLOGY 0 1, 907 1, 907 -998 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 93, 761 92 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 21, 599 22 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 1, 868, 075 1, 866 76.00 03160 CARDI OPULMONARY 150, 728 145, 169 295, 897 -72, 460 22 90.00 09000 CLI NI C 0 0 0 0 0 90.00 09000 CLI NI C 0 0 0 -470, 173 85 <td>, 443 60. 00</td>	, 443 60. 00
67.00 06700 0CCUPATI ONAL THERAPY 92, 328 126 92, 454 -126 92 68.00 06800 SPEECH PATHOLOGY 18, 466 0 18, 466 0 18 69.00 06900 ELECTROCARDI OLOGY 0 1, 907 1, 907 -998 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 93, 761 92 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 21, 599 22 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 1, 868, 075 1, 866 76.00 03160 CARDI OPULMONARY 150, 728 145, 169 295, 897 -72, 460 22 90.00 09000 CLI NI C 0 0 0 0 0 90.01 09001 FAMI LY PRACTICE OF JAY COUNTY 672, 637 650, 032 1, 322, 669 -470, 173 85	, 950 65. 00
68.00 06800 SPEECH PATHOLOGY 18,466 0 18,466 0 16 69.00 06900 ELECTROCARDI OLOGY 0 1,907 1,907 -998 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 93,761 92 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 21,599 22 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 1,868,075 1,866 76.00 03160 CARDI OPULMONARY 150,728 145,169 295,897 -72,460 22 0UTPATI ENT SERVI CE COST CENTERS 0 0 0 0 0 0 90.00 09000 CLI NI C 0 0 0 0 0 90.01 09001 FAMI LY PRACTICE OF JAY COUNTY 672,637 650,032 1,322,669 -470,173 85	, 840 66. 00 , 328 67. 00
69.00 06900 ELECTROCARDIOLOGY 0 1,907 1,907 -998 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 93,761 57 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 21,599 22 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 1,868,075 1,866 76.00 03160 CARDIOPULMONARY 150,728 145,169 295,897 -72,460 22 0.00 09000 CLINIC 0 0 0 0 90.00 09000 CLINIC 0 0 0 0 90.01 09000 FAMILY PRACTICE OF JAY COUNTY 672,637 650,032 1,322,669 -470,173 85	, 466 68. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0 0 21,599 22 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 1,868,075 1,86 76. 00 03160 CARDI OPULMONARY 150,728 145,169 295,897 -72,460 22 OUTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 0 </td <td>909 69.00</td>	909 69.00
73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 1,868,075 1,86 76.00 03160 CARDI OPULMONARY 150,728 145,169 295,897 -72,460 225 0UTPATIENT SERVICE COST CENTERS 0 0 0 0 0 0 90.00 09000 CLINIC 0 0 0 0 0 90.01 09001 FAMILY PRACTICE OF JAY COUNTY 672,637 650,032 1,322,669 -470,173 85	, 761 71.00 , 599 72.00
76.00 03160 CARDI OPULMONARY 150, 728 145, 169 295, 897 -72, 460 22 OUTPATI ENT SERVICE COST CENTERS 0<	, 075 73. 00
90.00 09000 CLINIC 0	, 437 76. 00
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY 672, 637 650, 032 1, 322, 669 -470, 173 85	0 90.00
	, 496 90. 01
	, 147 90. 02
90. 03 09003 WOUND CLINIC 0 1, 322 -1, 322 90. 04 09 004 0P ORTHO CLINIC 0 0 0 0	0 90.03
	, 908 90. 05
	, 927 90. 06
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	, 166 90. 07
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 11, 449, 690 28, 053, 665 39, 503, 355 57, 352 39, 56	, 166 90. 07 , 607 91. 00
NONREIMBURSABLE COST CENTERS	, 166 90. 07 , 607 91. 00 92. 00
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 327 327 0 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 104, 313 93, 938 198, 251 -57, 369 14	, 166 90. 07 , 607 91. 00 92. 00 , 413 93. 00 , 707 118. 00
193. 00 19300 NONPAID WORKERS 0 0 0 0	, 166 90. 07 , 607 91. 00 92. 00 , 413 93. 00 1, 707 118. 00 327 190. 00
194. 00 07950 VACANT 0 0 0 0	, 166 90. 07 , 607 91. 00 92. 00 , 413 93. 00 , 707 118. 00
194. 02 07952 WEST JAY CLINIC 0	, 166 90. 07 , 607 91. 00 92. 00 , 413 93. 00 , 707 118. 00 , 882 192. 00 0 193. 00 0 194. 00
174:0507953 241 MILT DI AN ORGENT CARE 0 -17 -17 17 200.00 TOTAL (SUM OF LINES 118 through 199) 11, 554, 003 28, 147, 913 39, 701, 916 0 39, 70	, 166 90. 07 , 607 91. 00 92. 00 93. 00 1, 707 118. 00 327 190. 00 0, 882 192. 00 0 193. 00

CLASS	IFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CCN: 15-13		Worksheet A
				From 01/01/2021 To 12/31/2021	Date/Time Prepare
	Cost Center Description	Adjustments	Net Expenses	,	5/27/2022 8:00 an
		(See A-8)	For		
			Allocation		
0		6.00	7.00		
	GENERAL SERVICE COST CENTERS	-347, 981	837, 049		1
	00101 CAP REL COSTS-BLDG & FIXT-MOB	-75, 227	037,049		1
	00102 CAP REL COSTS-BLDG & FIXT-POB	-69, 804	-34, 774		1
	00103 CAP REL COSTS-BLDG & FIXT-WJ	-9, 433	0		1
04 C	00104 CAP REL COSTS-BLDG & FIXT-INTEREST	0	0		1
	00200 CAP REL COSTS-MVBLE EQUIP	445,067	1, 872, 887		2
	00201 CAP REL COSTS-MVBLE EQUIP - MOB 00202 CAP REL COSTS-MVBLE EQUIP - POB	-1, 056 0	31, 774 0		2
	00203 CAP REL COSTS-MVBLE EQUIP - VJ	0	0		2
	00400 EMPLOYEE BENEFITS DEPARTMENT	-709, 014	2, 184, 978		4
	00500 ADMI NI STRATI VE & GENERAL	-1, 781, 751	7, 967, 068		5
00 0	00700 OPERATION OF PLANT	75, 766	3, 256, 548		7
	00701 OPERATION OF PLANT - MOB	0	44, 772		7
1	00702 OPERATION OF PLANT - POB	0	63, 488		7
1	00703 OPERATION OF PLANT - WJ 00800 LAUNDRY & LINEN SERVICE	0	0 132, 976		7
	00900 HOUSEKEEPING	0	546, 392		9
	D1000 DI ETARY	11, 798	416, 910		10
. 00 0	01100 CAFETERI A	-62, 507	234, 288		11
	01300 NURSING ADMINISTRATION	85, 431	1, 685, 613		13
	01400 CENTRAL SERVICES & SUPPLY	0	714,088		14
	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	75, 367 0	1, 072, 939 0		15
	01700 SOCIAL SERVICE	0	0		17
	NPATIENT ROUTINE SERVICE COST CENTERS		0		
	03000 ADULTS & PEDIATRICS	-763, 852	1, 978, 801		30
	04000 SUBPROVIDER - IPF	0	0		40
	04300 NURSERY	0	0		43
	NCILLARY SERVICE COST CENTERS	-466, 621	895, 684		50
	05200 DELIVERY ROOM & LABOR ROOM	00, 021	0		52
	05300 ANESTHESI OLOGY	0	0		53
	05400 RADI OLOGY-DI AGNOSTI C	-13, 730	1, 117, 207		54
	06000 LABORATORY	-1, 510	1, 929, 933		60
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	4, 813 74, 126	482, 763 603, 966		65
	06700 OCCUPATI ONAL THERAPY	,4,120	92, 328		67
	06800 SPEECH PATHOLOGY	0	18, 466		68
0. 00 C	06900 ELECTROCARDI OLOGY	0	909		69
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	93, 761		71
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	21, 599		72
	07300 DRUGS CHARGED TO PATIENTS 03160 CARDI OPULMONARY	0 22, 351	1, 868, 075 245, 788		73
	DUTPATIENT SERVICE COST CENTERS	22, 331	243, 700		///
	09000 CLINIC	0	0		90
	09001 FAMILY PRACTICE OF JAY COUNTY	-116, 580	735, 916		90
	09002 JAY FAMILY MEDICINE	-315, 629	777, 518		90
		0	0		90
	09004 OP ORTHO CLINIC 09005 JAY FAMILY FIRST HEALTH CARE	0 -57, 653	369, 255		90 90
	09006 INFUSION CLINIC	-57,055	118, 927		90
	09007 HEALTH BEGINNINGS PROGRAM	Ő	264, 166		90
	09100 EMERGENCY	-1, 262, 129	1, 625, 478		91
	09200 OBSERVATION BEDS (NON-DISTINCT PART				92
	04950 OUTPATIENT PSYCH	-2, 131	31, 282		93
8.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	-5, 261, 889	34, 298, 818		118
	IONREI MBURSABLE COST CENTERS	-3, 201, 009	54, 270, 010		
0.001	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	327		190
2.001	19200 PHYSI CLANS' PRI VATE OFFI CES	0	140, 882		192
	9300 NONPAID WORKERS	0	0		193
	07950 VACANT	0	0		194
	07952 WEST JAY CLINIC	0	0		194 194
	07953 JAY MERIDIAN URGENT CARE	0	U		1194

	Financial Systems SIFICATIONS		IU HEALTH J			<u>rm CMS-2552-10</u> neet A-6
						Time Prepared:
	Cost Contor	Increases	Colory	Othor	5/2//2	2022 8:00 am
	Cost Center 2.00	Li ne # 3.00	Sal ary 4. 00	0ther 5.00		
1.00	A – CAFETERIA CAFETERIA	11.00	132, 622	164 172		1.00
1.00	0		132, 622	<u>164, 173</u> 164, 173		1.00
1.00	B - DRUGS RECLASS PHARMACY	15.00	0	77, 380		1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	1, 868, 075		2.00
3.00 4.00		0.00 0.00	0 0	0		3.00
4.00 5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00 8.00		0. 00 0. 00	0 0	0		7.00 8.00
9.00		0.00	0	0		9.00
10. 00 11. 00		0. 00 0. 00	0 0	0		10.00
12.00		0.00	0	0		12.00
13.00 14.00		0. 00 0. 00	0 0	0		13.00 14.00
15.00		0.00	0	0		15.00
16.00 17.00		0. 00 0. 00	0 0	0		16.00 17.00
17.00	o		— — — 0	1, 945, 455		
1.00	C - SUPPLIES/IMPLANTS CENTRAL SERVICES & SUPPLY	14.00	0	734, 511		1.00
2.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	93, 761		2.00
3.00	PATIENTS IMPL. DEV. CHARGED TO	72.00	0	21, 599		3.00
	PATI ENTS					
4.00 5.00	ADMINISTRATIVE & GENERAL JAY MERIDIAN URGENT CARE	5. 00 194. 03	0 0	3, 541 17		4.00 5.00
6.00	JAT MERIDIAN URGENT CARE	0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00 9.00		0. 00 0. 00	0 0	0		8.00 9.00
10.00		0.00	0	0		10.00
11. 00 12. 00		0. 00 0. 00	0 0	0		11.00
13.00		0.00	0	0		13.00
14.00 15.00		0. 00 0. 00	0 0	0		14.00 15.00
16.00		0.00	0	0		16.00
17.00 18.00		0.00 0.00	0 0	0		17.00 18.00
19.00		0.00	0	0		19.00
20.00		0.00	0 0	0		20.00
21.00 22.00		0. 00 0. 00	0	0 0		21.00 22.00
23.00		0.00	0	0		23.00
24.00 25.00		0. 00 0. 00	0 0	0		24.00 25.00
26.00	<u> </u>	0.00	0	0		26.00
	0 D - LAUNDRY		0	853, 429		
1.00	LAUNDRY & LI NEN SERVI CE	8.00	0	106, 478		1.00
2.00 3.00		0. 00 0. 00	0 0	0		2.00 3.00
4.00		0.00	0	0		4.00
5.00 6.00		0. 00 0. 00	0 0	0		5.00 6.00
7.00		0.00	0	0		7.00
8.00 9.00		0. 00 0. 00	0	0		8.00 9.00
10.00		0.00	0	0		10.00
11. 00 12. 00		0.00 0.00	0	0		11.00 12.00
12.00		0.00	0	0		13.00
	O		0	106, 478		
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1, 155, 069		1.00
2.00	CAP REL COSTS-BLDG &	1. 01	0	75, 227		2.00
3.00	FIXT-MOB CAP REL COSTS-BLDG &	1. 02	0	35, 030		3.00
4 00	FIXT-POB CAP REL COSTS-BLDG & FIXT-WJ	1.03	~	9, 433		1 00
4.00	INI NEL USIS-DEDU & FIAI-WJ	1.03	0	9, 433	1	4.00

Health Financial Systems RECLASSIFICATIONS

IU HEALTH JAY HOSPITAL Provider CCN: 15-1320 Period:

In Lieu of Form CMS-2552-10 Worksheet A-6

RECLASS	STFICATIONS			Provider C	CN: 15-1320	Period: From 01/01/202 To 12/31/202	Worksheet 21 21 Date/Time	
		Increases					5/27/2022	8:00 am
	Cost Center 2.00	Li ne # 3.00	Sal ary 4.00	0ther 5.00				
5.00 6.00	CAP REL COSTS-MVBLE EQUIP CAP REL COSTS-MVBLE EQUIP - MOB	2. 00 2. 01	0	1, 399, 498 32, 830				5.00 6.00
$\begin{array}{c} 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ \end{array}$	0	0.00 0.00		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00
1.00	F - PROPERTY TAXES CAP REL COSTS-BLDG & FIXT	1.00	0	25, 856				1.00
	O G - PROPERTY INSURANCE		0	25, 856				_
1.00 2.00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP 0	1.00 2.00	0 0	4, 105 2 <u>8, 3</u> 22 32, 427				1.00 2.00
$\begin{array}{c} 1. \ 00\\ 2. \ 00\\ 3. \ 00\\ 4. \ 00\\ 5. \ 00\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 12. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 16. \ 00\\ 17. \ 00\\ \end{array}$	H - HOUSEKEEPI NG SUPPLI ES HOUSEKEEPI NG OPERATI ON OF PLANT NURSI NG ADMI NI STRATI ON	9.00 7.00 13.00 0.00 0.00 0.00 0.00 0.00 0.00		668 3, 262 10 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$
$\begin{array}{c} 1. \ 00\\ 2. \ 00\\ 3. \ 00\\ 4. \ 00\\ 5. \ 00\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 10. \ 00\\ 11. \ 00\\ 12. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 16. \ 00\\ 17. \ 00\\ 18. \ 00\\ 19. \ 00\\ 20. \ 00\\ 21. \ 00\\ 21. \ 00\\ \end{array}$	J - EMPLOYEE BENEFITS EMPLOYEE BENEFITS DEPARTMENT	4. 00 0.		2, 861, 176 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 10.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ \end{array}$
1.00 2.00 3.00 4.00 5.00 6.00	N - ACCRUED PTO EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL OPERATION OF PLANT LAUNDRY & LINEN SERVICE NURSING ADMINISTRATION OPERATING ROOM	4.00 5.00 7.00 8.00 13.00 50.00	18, 341 13, 144 4, 645 270 6, 599 13, 865					1.00 2.00 3.00 4.00 5.00 6.00

Heal th	Financial Systems		IU HEALTH JA	Y HOSPI TAL		In Lieu	u of Form CMS.	-2552-10
RECLAS	SIFICATIONS			Provider (CCN: 15-1320	Period:	Worksheet A-	6
						From 01/01/2021 To 12/31/2021	Date/Time Pr 5/27/2022 8:	epared: 00 am
		Increases						
	Cost Center	Line #	Sal ary	Other				
	2.00	3.00	4.00	5.00				
7.00	RADI OLOGY-DI AGNOSTI C	54.00	6, 355	0				7.00
8.00	LABORATORY	60.00	205	0				8.00
9.00	CARDI OPULMONARY	76.00	1, 278	0				9.00
10.00	FAMILY PRACTICE OF JAY COUNTY	90. 01	4, 810	0				10.00
11.00	HEALTH BEGINNINGS PROGRAM	90. 07	7, 323	0				11.00
	0 — — — — — — —		76, 835	0				
	0 - PREMIUM WAGES							1
1.00	ADULTS & PEDIATRICS	30.00	24, 401	3, 451				1.00
2.00	RESPI RATORY THERAPY	65.00	33, 861	4, 788				2.00
	TOTALS		58, 262	8, 239]			1
500.00	Grand Total: Increases		267, 719	8, 708, 260]			500.00

ECLAS	Financial Systems SIFICATIONS		IU HEALTH JA		CCN: 15-1320	Peri od:	u of Form CMS-2552- Worksheet A-6
						From 01/01/2021 To 12/31/2021	Date/Time Prepared
		Decreases					5/27/2022 8:00 am
	Cost Center	Line #	Salary	0ther	Wkst. A-7 Re	f.	
		7.00	8.00	9.00	10.00		
. 00	A – CAFETERIA DI ETARY	10.00	132, 622	164, 17	3	0	1.0
	0		132, 622	164, 17			
	B – DRUGS RECLASS				1		
. 00		15.00	0	1, 382, 39		0	1.0
. 00 . 00	EMPLOYEE BENEFITS DEPARTMENT	4.00 7.00	0	9, 87 42, 25		0	2.0
. 00	NURSI NG ADMI NI STRATI ON	13.00	0	42, 23		0	4.0
. 00	ADULTS & PEDIATRICS	30.00	0	20, 38		0	5.0
. 00	OPERATING ROOM	50.00	О	10, 48		0	6.0
. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	76, 39		0	7.0
. 00 . 00	RESPI RATORY THERAPY ELECTROCARDI OLOGY	65.00 69.00	0	1, 94 2		0	8.0
0.00	CARDI OPULMONARY	76.00	0	2 99		0	10.0
1.00	FAMILY PRACTICE OF JAY	90.01	0	146, 53	-	0	11.0
	COUNTY						
2.00	JAY FAMILY MEDICINE	90.02	0	150, 76		0	12.0
3.00 4.00	JAY FAMILY FIRST HEALTH CARE	90. 05 90. 06	0	43, 34 7, 44		0	13.0
4.00 5.00	HEALTH BEGINNINGS PROGRAM	90.00	0	, 44		0	14.0
6.00	EMERGENCY	91.00	0	52, 17		0	16.0
7.00	OUTPATIENT PSYCH	93.00	0	<u> </u>		o	17.0
			0	1, 945, 45	5		
. 00	C - SUPPLIES/IMPLANTS EMPLOYEE BENEFITS DEPARTMENT	4.00	0	16	5	0	1.0
. 00	OPERATION OF PLANT	7.00	0	147, 83		0	2.0
. 00	OPERATION OF PLANT - MOB	7.01	0	1, 46		0	3. (
. 00	OPERATION OF PLANT - POB	7.02	0	1, 21		0	4.0
. 00	LAUNDRY & LINEN SERVICE	8.00	0	23, 09		0	5.0
. 00 . 00	HOUSEKEEPI NG DI ETARY	9.00 10.00	0	29, 65 5, 68		0	6.0
. 00	NURSI NG ADMI NI STRATI ON	13.00	0	100, 10		0	8.0
. 00	PHARMACY	15.00	0	8, 73		0	9. (
0. 00	ADULTS & PEDIATRICS	30.00	0	152, 93		0	10. (
1.00	OPERATING ROOM	50.00	0	150, 78		0	11.0
2.00 3.00	RADI OLOGY-DI AGNOSTI C LABORATORY	54.00 60.00	0	11, 89 11, 58		0	12.0
4.00	RESPI RATORY THERAPY	65.00	0	24, 61		0	14.0
5.00	PHYSI CAL THERAPY	66.00	0	3, 33		0	15.0
6.00	OCCUPATI ONAL THERAPY	67.00	0	12		0	16.0
7.00	ELECTROCARDI OLOGY	69.00	0	97		0	17.0
8.00 9.00	CARDIOPULMONARY	76.00 90.01	0	2, 00 27, 66		0	18.0
9.00	COUNTY	90.01	0	27,00	1	0	19.0
0. 00	JAY FAMILY MEDICINE	90.02	0	23, 80	6	0	20.
1. 00	JAY FAMILY FIRST HEALTH CARE	90.05	0	9, 01		0	21.0
2.00	INFUSION CLINIC	90.06	0	3, 39		0	22.0
3.00 4.00	HEALTH BEGINNINGS PROGRAM EMERGENCY	90. 07 91. 00	0	42 111, 20		0	23.0
5.00	OUTPATIENT PSYCH	93.00	0	22		0	24.0
6.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	1, 48		0	26.
	0		0	853, 42	9		
. 00	D – LAUNDRY ADMI NI STRATI VE & GENERAL	5.00	0	2	6	0	1.0
. 00 . 00	OPERATION OF PLANT - POB	5.00	0	2 14		0	2.0
. 00	HOUSEKEEPING	9.00	0	14, 55		0	3.0
. 00	DI ETARY	10.00	0	24	2	0	4. (
. 00	ADULTS & PEDIATRICS	30.00	0	34, 63		0	5.0
. 00	OPERATING ROOM	50.00	0	18, 92		0	6.0
. 00 . 00	RADIOLOGY-DIAGNOSTIC FAMILY PRACTICE OF JAY	54.00 90.01	0	12, 98 2, 13		0	7.0
	COUNTY	70.01	J	2,13	·	~	0.1
. 00	JAY FAMILY MEDICINE	90. 02	О	25	1	0	9. (
0.00	JAY FAMILY FIRST HEALTH CARE	90.05	0	32		0	10. (
1.00	HEALTH BEGINNINGS PROGRAM	90.07	0	3		0	11.0
2.00 3.00	EMERGENCY PHYSICIANS' PRIVATE OFFICES	91.00 192.00	0 0	21, 93 29		0	12.0
5.00		172.00	— — — <u>0</u>	<u></u>		5	13.1
	E - DEPRECIATION	I			-1		
. 00	ADMI NI STRATI VE & GENERAL	5.00	0	110, 01		9	1.0
. 00	OPERATION OF PLANT	7.00	0	1, 179, 27		9	2.0
. 00 . 00	OPERATION OF PLANT - MOB OPERATION OF PLANT - POB	7.01 7.02	0	76, 28 35, 03		9 9	3.0
	DI ETARY	10.00	0	14, 83		9	5.0

IU HEALTH JAY HOSPITAL

Provider CCN: 15-1320

Peri od:

From 01/01/2021

In Lieu of Form CMS-2552-10 Worksheet A-6

То 12/31/2021 Date/Time Prepared: 5/27/2022 8:00 am Decreases Wkst. A-7 Ref. Cost Center Sal ary 0ther Line # 6.00 7.00 8.00 9.00 10.00 PHARMACY 6.00 15.00 0 39,601 6.00 9 7.00 ADULTS & PEDIATRICS 30.00 0 65, 570 0 7.00 0 8.00 OPERATI NG ROOM 50.00 0 382, 359 8.00 RADI OLOGY-DI AGNOSTI C 54.00 0 614.711 0 9 00 9.00 0 10.00 LABORATORY 60.00 0 5,094 10.00 RESPI RATORY THERAPY 0 0 11.00 65.00 24, 411 11.00 0 12.00 CARDI OPULMONARY 76.00 25,500 0 12.00 0 FAMILY PRACTICE OF JAY 0 13.00 90.01 6, 275 13.00 COUNTY 14.00 WOUND CLINIC 90.03 0 1, 322 0 14.00 15.00 JAY FAMILY FIRST HEALTH CARE 90.05 0 1,052 0 15.00 0 INFUSION CLINIC 90.06 0 16.00 16.00 445 17.00 HEALTH BEGINNINGS PROGRAM 90.07 0 35, 383 0 17.00 18.00 EMERGENCY 91.00 0 67,336 0 18.00 OUTPATIENT PSYCH 0 19.00 19.00 93.00 13.158 0 20.00 PHYSICIANS' PRIVATE OFFICES 192.00 0 9, 435 0 20.00 ō 2,707,087 PROPERTY TAXES ADMINISTRATIVE & GENERAL 1.00 5.00 25,856 1.00 0 13 25,856 - PROPERTY INSURANCE 0 1.00 ADMINISTRATIVE & GENERAL 5.00 32, 427 12 1.00 2.00 0.00 0 0 12 2.00 32, 427 H - HOUSEKEEPING SUPPLIES 1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 0 1.00 2 2.00 ADMINISTRATIVE & GENERAL 5.00 0 694 0 2.00 3.00 DI ETARY 10.00 0 40 0 3.00 0 0 4.00 CENTRAL SERVICES & SUPPLY 14.00 4.00 3 0 15.00 0 5.00 PHARMACY 457 5.00 ADULTS & PEDIATRICS 0 6.00 30.00 0 1,064 6.00 0 7.00 OPERATI NG ROOM 50.00 0 246 7.00 8.00 RADI OLOGY-DI AGNOSTI C 54.00 0 8.00 245 0 I ABORATORY 60.00 0 9.00 9.00 10.00 PHYSICAL THERAPY 66.00 0 10 10.00 CARDI OPULMONARY 0 0 11.00 76.00 3 11.00 0 FAMILY PRACTICE OF JAY 90.01 0 69 12.00 12.00 COUNTY 13.00 JAY FAMILY MEDICINE 90.02 0 105 0 13.00 JAY FAMILY FIRST HEALTH CARE 90.05 0 0 14.00 43 14.00 15.00 INFUSION CLINIC 90.06 0 7 0 15.00 EMERGENCY 91.00 0 510 0 16.00 16.00 17.00 PHYSICIANS' PRIVATE OFFICES 1<u>92.</u>00 0 435 0 17.00 ō 3,940 - EMPLOYEE BENEFITS 1.00 ADMINISTRATIVE & GENERAL 5.00 0 97.742 0 1.00 2.00 OPERATION OF PLANT 7.00 0 139, 841 0 2.00 3.00 LAUNDRY & LINEN SERVICE 8.00 0 9,549 0 3.00 0 0 4.00 HOUSEKEEPING 9.00 78.006 4.00 0 5.00 **DI ETARY** 10.00 0 155.736 5 00 6.00 NURSING ADMINISTRATION 13.00 0 239, 744 0 6.00 0 0 7.00 PHARMACY 15.00 111,001 7.00 0 ADULTS & PEDIATRICS 0 8.00 30.00 272.139 8.00 9.00 OPERATI NG ROOM 50.00 0 235, 757 9.00 10.00 RADI OLOGY-DI AGNOSTI C 54.00 0 214, 112 0 10.00 0 0 LABORATORY 0 11.00 60.00 344 11.00 12.00 RESPI RATORY THERAPY 65.00 0 101,944 12.00 CARDI OPULMONARY 76.00 0 45, 241 0 13.00 13.00 0 FAMILY PRACTICE OF JAY 90.01 0 292, 311 14.00 14.00 COUNTY 15.00 JAY FAMILY MEDICINE 0 309,950 0 90.02 15.00 16.00 JAY FAMILY FIRST HEALTH CARE 90.05 0 111, 362 0 16.00 0 0 17.00 INFUSION CLINIC 90.06 17,995 17.00 0 18 00 HEALTH BEGINNINGS PROGRAM 90 07 93 684 0 18 00 0 0 19.00 EMERGENCY 91.00 267, 555 19.00 20.00 OUTPATIENT PSYCH 93.00 0 21,602 0 20.00 21.00 PHYSICIANS' PRIVATE OFFICES 192.00 0 45, 561 0 21.00 ō 2,861,176 ACCRUED PTO Ν 1.00 HOUSEKEEPI NG 9.00 5, 789 0 0 1.00 2.00 **DI ETARY** 10.00 1,773 0 0 2.00 PHARMACY 0 0 3 00 15.00 2,414 3.00 4.00 ADULTS & PEDIATRICS 30.00 12,014 0 0 4.00 5.00 RESPI RATORY THERAPY 65.00 9,967 0 0 5.00

Heal th	Financial Systems		IU HEALTH JA	Y HOSPI TAL		In Lieu of Form CMS-2552-10		
RECLAS	SI FI CATI ONS			Provider (CCN: 15-1320	Period:	Worksheet A-	6
						From 01/01/2021 To 12/31/2021	Date/Time Pr	epared:
							5/27/2022 8:	<u> 00 am</u>
		Decreases						
	Cost Center	Line #	Sal ary	Other	Wkst. A-7 Ref	· .		
	6. 00	7.00	8.00	9.00	10.00			
6.00	JAY FAMILY MEDICINE	90. 02	13, 286	0		0		6.00
7.00	JAY FAMILY FIRST HEALTH CARE	90.05	3, 560	0		0		7.00
8.00	INFUSION CLINIC	90.06	11, 930	0		0		8.00
9.00	EMERGENCY	91.00	15, 500	0		0		9.00
10.00	OUTPATI ENT PSYCH	93.00	440	0		0		10.00
11.00	PHYSICIANS' PRIVATE OFFICES	192.00	162	0		0		11.00
	0		76, 835	0				
	O - PREMIUM WAGES							
1.00	NURSING ADMINISTRATION	13.00	58, 262	8, 239		0		1.00
2.00		0.00	0	0		0		2.00
	TOTALS		58, 262	8, 239				
500.00	Grand Total: Decreases		267, 719	8, 708, 260				500.00

ealth Financial Systems	IU HEALTH JA	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CC	CN: 15-1320	Period: From 01/01/2021 To 12/31/2021		pared:
			Acquisition	S		
	Begi nni ng	Purchases	Donati on	Total	Disposals and	
	Bal ances				Retirements	
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
I. 00 Land	989, 148	0		0 0	0	1.00
2.00 Land Improvements	0	0		0 0	0	2.00
3.00 Buildings and Fixtures	18, 977, 852	0		0 0	0	3.00
1.00 Building Improvements	0	0		0 0	0	4.00
5.00 Fixed Equipment	9, 370, 115	505, 030		0 505, 030	3, 400	5.00
5.00 Movable Equipment	0	0		0 0	0	6.00
7.00 HIT designated Assets	0	0		0 0	0	7.00
3.00 Subtotal (sum of lines 1-7)	29, 337, 115	505, 030		0 505, 030	3, 400	8.00
9.00 Reconciling Items	0	0		0 0	0	1
10.00 Total (line 8 minus line 9)	29, 337, 115	505, 030		0 505,030	3, 400	10.00
	Endi ng	Fully				
	Bal ance	Depreciated				
		Assets				
	6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
I. 00 Land	989, 148	0				1.00
2.00 Land Improvements	0	0				2.00
3.00 Buildings and Fixtures	18, 977, 852	0				3.00
1.00 Building Improvements	0	0				4.00
5.00 Fixed Equipment	9, 871, 745	1,677,694				5.00
5.00 Movable Equipment	0	0				6.00
7.00 HIT designated Assets	0	0				7.00
3.00 Subtotal (sum of lines 1-7)	29, 838, 745	1, 677, 694				8.00
9.00 Reconciling Items	0	0				9.00
10.00 Total (line 8 minus line 9)	29, 838, 745	1, 677, 694				10.00

Heal th	Financial Systems	IU HEALTH JA	Y HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 01/01/2021 To 12/31/2021		pared:
			SL	JMMARY OF CAF	PITAL		
	Cost Center Description	Depreciation	Lease	Interest	I nsurance (see i nstructi ons)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WO	RKSHEET A, COLUN	NN 2, LINES 1 a	and 2			
1.00 1.01 1.02 1.03 1.04	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-BLDG & FIXT-MOB CAP REL COSTS-BLDG & FIXT-POB CAP REL COSTS-BLDG & FIXT-WJ CAP REL COSTS-BLDG & FIXT-INTEREST		0 0 0 0				1.00 1.01 1.02 1.03 1.04
2.00 2.01 2.02 2.03	CAP REL COSTS-MVBLE EQUIP CAP REL COSTS-MVBLE EQUIP - MOB CAP REL COSTS-MVBLE EQUIP - POB CAP REL COSTS-MVBLE EQUIP - WJ	0 0 0 0					2.00 2.01 2.02 2.03
3.00	Total (sum of lines 1-2)	O SUMMARY O	0 F CAPI TAL		0 0	0	3.00
	Cost Center Description	Other Capital-Relat ed Costs (see instructions) 14.00		-			
	PART II - RECONCILIATION OF AMOUNTS FROM WO	RKSHEET A, COLUN	IN 2, LINES 1 a	and 2			
1.00 1.01 1.02 1.03 1.04	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-BLDG & FIXT-MOB CAP REL COSTS-BLDG & FIXT-POB CAP REL COSTS-BLDG & FIXT-WJ CAP REL COSTS-BLDG & FIXT-INTEREST		0 0 0 0 0				1.00 1.01 1.02 1.03 1.04
2.00 2.01 2.02 2.03 3.00	CAP REL COSTS-MVBLE EQUIP CAP REL COSTS-MVBLE EQUIP - MOB CAP REL COSTS-MVBLE EQUIP - POB CAP REL COSTS-MVBLE EQUIP - WJ Total (sum of lines 1-2)	0 0 0 0	0 0 0 0 0 0				2.00 2.01 2.02 2.03 3.00

Heal th	Financial Systems	IU HEALTH JA	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 01/01/2021 To 12/31/2021	Worksheet A-7 Part III Date/Time Prep 5/27/2022 8:00	pared: D am
		COMF	PUTATION OF RAT	TIOS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C			00.000.74			
1.00 1.01 1.02 1.03 1.04	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-BLDG & FIXT-MOB CAP REL COSTS-BLDG & FIXT-POB CAP REL COSTS-BLDG & FIXT-WJ CAP REL COSTS-BLDG & FIXT-INTEREST	29, 838, 745 0 0 0	0 0 0 0			0 0 0 0	1.00 1.01 1.02 1.03 1.04
2. 00 2. 01 2. 02 2. 03	CAP REL COSTS-MVBLE EQUIP CAP REL COSTS-MVBLE EQUIP - MOB CAP REL COSTS-MVBLE EQUIP - POB CAP REL COSTS-MVBLE EQUIP - WJ	0			0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000	0 0 0	2.00 2.01 2.02 2.03
3.00	Total (sum of lines 1-2)	29, 838, 745	0	29, 838, 74	5 1.000000	0	3.00
		ALLOCAT	FION OF OTHER (CAPI TAL	SUMMARY C	F CAPI TAL	
	Cost Center Description	Taxes	Other Capital-Relat ed Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6. 00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C		0	1	007.000		
1.00 1.01 1.02 1.03 1.04	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-BLDG & FIXT-MOB CAP REL COSTS-BLDG & FIXT-POB CAP REL COSTS-BLDG & FIXT-WJ CAP REL COSTS-BLDG & FIXT-INTEREST	0 0 0 0	0 0 0 0		807,088 0 0 0 -34,774 0 0 0 0	0 0 0	1.00 1.01 1.02 1.03 1.04
2.00 2.01 2.02 2.03 3.00	CAP REL COSTS-MVBLE EQUIP CAP REL COSTS-MVBLE EQUIP - MOB CAP REL COSTS-MVBLE EQUIP - POB CAP REL COSTS-MVBLE EQUIP - WJ Total (sum of lines 1-2)	0 0 0 0	0		1,844,565 31,774 0 <	0 0 0 0	2.00 2.01 2.02 2.03 3.00
			SL	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Relat ed Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
1.00	PART III - RECONCILIATION OF CAPITAL COSTS C CAP REL COSTS-BLDG & FIXT	ENTERS 0	4, 105	25, 85	6 0	837, 049	1.00
1. 01 1. 02 1. 03 1. 04	CAP REL COSTS-BLDG & FIXT-MOB CAP REL COSTS-BLDG & FIXT-POB CAP REL COSTS-BLDG & FIXT-WJ CAP REL COSTS-BLDG & FIXT-INTEREST	0 0 0 0	0 0 0 0		0 0 0 0 0 0 0 0	0 -34, 774 0 0	1.01 1.02 1.03 1.04
2.00 2.01 2.02 2.03 3.00	CAP REL COSTS-MVBLE EQUIP CAP REL COSTS-MVBLE EQUIP - MOB CAP REL COSTS-MVBLE EQUIP - POB CAP REL COSTS-MVBLE EQUIP - WJ Total (sum of lines 1-2)	0 0 0 0	28, 322 0 0 0 32, 427		D O D O D O D O D O D O D O D O	1, 872, 887 31, 774 0 2, 706, 936	2.00 2.01 2.02 2.03 3.00

	Financial Systems		IU HEALTH JA		eriod:	u of Form CMS-2 Worksheet A-8	
					rom 01/01/2021		pared:
				Expense Classification on To/From Which the Amount is			
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
. 00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	В	-14, 643	CAP REL COSTS-BLDG & FIXT	1.00	9	1.0
01	Investment income - CAP REL COSTS-BLDG & FIXT-MOB (chapter 2)			CAP_REL_COSTS-BLDG_& FLXT-MOB	1. 01	0	1. C
. 02	Investment income - CAP REL COSTS-BLDG & FIXT-POB (chapter 2)			CAP_REL_COSTS-BLDG_& FLXT-POB	1. 02	0	1. C
. 03	Investment income - CAP REL COSTS-BLDG & FIXT-WJ (chapter 2)		0	CAP REL COSTS-BLDG & FIXT-WJ	1.03	0	1.C
. 04	Investment income - CAP REL COSTS-BLDG & FIXT-INTEREST (chapter 2)			CAP REL COSTS-BLDG & FIXT-INTEREST	1.04	0	1. C
. 00	Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.0
. 01	COSTS-MVBLE EQUIP (chapter 2) Investment income - CAP REL COSTS-MVBLE EQUIP - MOB			CAP REL COSTS-MVBLE EQUIP - MOB	2.01	0	2. C
. 02	(chapter 2) Investment income - CAP REL COSTS-MVBLE EQUIP - POB			CAP REL COSTS-MVBLE EQUIP - POB	2.02	0	2.0
03	(chapter 2) Investment income - CAP REL COSTS-MVBLE EQUIP - WJ			CAP REL COSTS-MVBLE EQUIP - WJ	2.03	0	2. (
. 00	(chapter 2) Investment income - other		0		0.00	0	3.0
00	(chapter 2) Trade, quantity, and time		0		0. 00	0	4. (
. 00	discounts (chapter 8) Refunds and rebates of		0		0.00	0	5.0
00	expenses (chapter 8) Rental of provider space by	В	-34, 093	CAP REL COSTS-BLDG & FIXT	1.00	9	6.0
00	suppliers (chapter 8) Telephone services (pay stations excluded) (chapter		0		0.00	0	7.
00	21) Television and radio service (chapter 21)		0		0. 00	0	8. (
. 00 0. 00	Parking lot (chapter 21) Provider-based physician adjustment	A-8-2	0 -1, 965, 195		0.00	0 0	
. 00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.
2.00	Related organization transactions (chapter 10)	A-8-1	3, 339, 882			0	12.
3.00	Laundry and linen service		0		0.00	0	
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o. 00	and others Sale of medical and surgical supplies to other than		0		0. 00	0	16. (
7.00	patients Sale of drugs to other than		0		0. 00	0	17.0
	patients Sale of medical records and		0		0. 00		18.
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31. 00 Adjustment for speech A-8-3 0 SPEECH PATHOLOGY 68. 00 31. 00 32. 00 CAH HIT Adjustment for pepteriation and Interest 0 </td <td>30.99</td> <td>Hospice (non-distinct) (see</td> <td></td> <td>0</td> <td>ADULTS & PEDIATRICS</td> <td>30.00</td> <td></td> <td>30.99</td>	30.99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30.99
pathol ogy costs in excess of limitation (chapter 14) 0 0.00 <		instructions)						
I initiation (chapter 14) 0 <td>31.00</td> <td>Adjustment for speech</td> <td>A-8-3</td> <td>0</td> <td>SPEECH PATHOLOGY</td> <td>68.00</td> <td></td> <td>31.00</td>	31.00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for 0 0.00 0 32.00 33.00 EMPLOYEE BENFFITS A -2,861,176 EMPLOYEE BENFFITS DEPARTMENT 4.00 0 33.00 33.01 HOSPITAL ASSESSMENT FEES A -2,157,432 ADMIN ISTRATIVE & GENERAL 5.00 0 33.00 33.02 MI SCELLANEOUS INCOME B -479 PHARMACY 15.00 0 33.03 33.04 CONTRACTED HOSPITALIST A -763,852 ADULTS & PEDIATRICS 30.00 0 33.06 33.06 CONTRACTED CRNA A -275,945 OPERATINC ROM 50.00 0 33.06 33.07 MEDI CARE DEPRECIATION EXPENSE A -470,972 CAP REL COSTS-BLDG & FLXT 1.00 9 33.06 33.08 MEDI CARE DEPRECIATION EXPENSE A -9,433 CAP REL COSTS-BLDG & FLXT-WJ 1.03 9 33.07 33.10 MEDI CARE DEPRECIATION EXPENSE A -9,433 CAP REL COSTS-MUBLE EQUIP 2.01 9 33.10 33.11 MEDI CARE DEPRECIATION EXPENSE A -9,433 CAP REL COSTS-MUBLE EQUIP <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>								
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33. 00 EMPLOYEE BENEFITS A -2, 861, 17, 6 [PUPLOYEE BENEFITS DEPARTMENT 4, 00 0 33. 01 33. 01 HOSPITAL ASSESSMENT FEES A -2, 157, 432 [ADMI NI STRATI VE & GENERAL 5, 00 0 33. 01 33. 01 HOSPITAL ASSESSMENT FEES A -2, 157, 432 [ADMI NI STRATI VE & GENERAL 5, 00 0 33. 03 33. 02 MI SCELLANEOUS I NCOME B 23, 438 [ADMI NI STRATI VE & GENERAL 5, 00 0 33. 03 33. 03 MI SCELLANEOUS I NCOME B -479 [PHARMACY 15, 00 0 33. 02 33. 04 CONTRACTED CRNA A -257, 945 [OPERATI NG ROOM 50, 00 0 33. 06 33. 05 CONTRACTED CRNA A -257, 242 [CAP REL COSTS-BLDG & FI XT 1, 00 9 33. 07 33. 04 MEDI CARE DEPRECI ATI ON EXPENSE A -75, 227 [CAP REL COSTS-BLDG & FI XT-WJ 1, 03 9 33. 05 33. 00 MEDI CARE DEPRECI ATI ON EXPENSE A -9, 433 [CAP REL COSTS-MUBLE EQUI P 2, 00 9 33. 07 33. 10 MEDI CARE DEPRECI ATI ON EXPENSE A -9, 433 [CAP REL COSTS-MUBLE EQUI P 2, 00 <td>32.00</td> <td></td> <td></td> <td>0</td> <td></td> <td>0.00</td> <td>0</td> <td>32.00</td>	32.00			0		0.00	0	32.00
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Bit SC NON-ALLOWABLE A -973 DI ETARY 10.00 0 33.15 33.15 MI SC NON-ALLOWABLE A -973 DI ETARY 10.00 0 33.15 33.16 MI SC NON-ALLOWABLE A -1,026 NURSI NG ADMI NI STRATI ON 13.00 0 33.16 33.17 MI SC NON-ALLOWABLE A -67 CARDI OPULMONARY 76.00 0 33.17 33.18 MI SC NON-ALLOWABLE A -67 CARDI OPULMONARY 76.00 0 33.17 33.19 MI SC NON-ALLOWABLE A -631 OUTPATI ENT PSYCH 93.00 0 33.17 33.19 MI SCELLANEOUS I NCOME B -1,500 OUTPATI ENT PSYCH 93.00 0 33.19 33.20 MI SCELLANEOUS I NCOME B 80 EMPLOYEE BENEFI TS DEPARTMENT 4.00 0 33.20 33.21 MI SCELLANEOUS I NCOME B -30 JAY FAMI LY MEDI CI NE 90.02 0 33.21 33.22 MI SC NON-ALLOWABLE A -11, 870 ADMI NI STRATI VE & GENERAL 5.00 0 33.22								
33.15 MI SC NON-ALLOWABLE A -973 DI ETARY 10.00 0 33.15 33.15 MI SC NON-ALLOWABLE A -1,026 NURSI NG ADMI NI STRATI ON 13.00 0 33.16 33.16 MI SC NON-ALLOWABLE A -1,026 NURSI NG ADMI NI STRATI ON 13.00 0 33.16 33.17 MI SC NON-ALLOWABLE A 67 (CARDI OPULMONARY 76.00 0 33.17 33.18 MI SC NON-ALLOWABLE A -631 OUTPATI ENT PSYCH 93.00 0 33.17 33.19 MI SCELLANEOUS I NCOME B -1,500 OUTPATI ENT PSYCH 93.00 0 33.19 33.20 MI SCELLANEOUS I NCOME B -1,500 OUTPATI ENT PSYCH 93.00 0 33.20 33.21 MI SCELLANEOUS I NCOME B -30 JAY FAMI LY MEDI CI NE 90.02 0 33.20 33.22 MI SC NON-ALLOWABLE A -11,870 ADMI NI STRATI VE & GENERAL 5.00 0 33.22	33. 14	MISCELLANEOUS INCOME	В			1. 02	9	33. 14
33.16 MI SC NON-ALLOWABLE A -1,026 NURSI NG ADMI NI STRATI ON 13.00 0 33.16 33.17 MI SC NON-ALLOWABLE A 67 CARDI OPULMONARY 76.00 0 33.17 33.18 MI SC NON-ALLOWABLE A -631 OUTPATI ENT PSYCH 93.00 0 33.17 33.19 MI SCELLANEOUS I NCOME B -1,500 OUTPATI ENT PSYCH 93.00 0 33.19 33.20 MI SCELLANEOUS I NCOME B -1,500 OUTPATI ENT PSYCH 93.00 0 33.20 33.21 MI SCELLANEOUS I NCOME B -80 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 33.20 33.22 MI SCELLANEOUS I NCOME B -30 JAY FAMI LY MEDI CI NE 90.02 0 33.21 33.22 MI SC NON-ALLOWABLE A -11,870 ADMI NI STRATI VE & GENERAL 5.00 0 33.22	22.45					40.00	_	22.45
33.17 MI SC NON-ALLOWABLE A 67 CARDI OPULMONARY 76.00 0 33.17 33.18 MI SC NON-ALLOWABLE A -631 OUTPATI ENT PSYCH 93.00 0 33.18 33.19 MI SCELLANEOUS I NCOME B -1,500 OUTPATI ENT PSYCH 93.00 0 33.19 33.20 MI SCELLANEOUS I NCOME B -1,500 OUTPATI ENT PSYCH 93.00 0 33.20 33.21 MI SCELLANEOUS I NCOME B -0.1,500 OUTPATI ENT PSYCH 90.02 0 33.20 33.21 MI SCELLANEOUS I NCOME B -30 JAY FAMI LY MEDI CI NE 90.02 0 33.21 33.22 MI SC NON-ALLOWABLE A -11, 870 ADMI NI STRATI VE & GENERAL 5.00 0 33.22								
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33.19 MI SCELLANEOUS I NCOME B -1,500 OUTPATI ENT PSYCH 93.00 0 33.19 33.20 MI SCELLANEOUS I NCOME B 80 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 33.20 33.21 MI SCELLANEOUS I NCOME B -30 JAY FAMI LY MEDI CI NE 90.02 0 33.21 33.22 MI SC NON-ALLOWABLE A -11,870 ADMI NI STRATI VE & GENERAL 5.00 0 33.22								
33. 20 MI SCELLANEOUS I NCOME B 80 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 33.20 33. 21 MI SCELLANEOUS I NCOME B -30 JAY FAMILY MEDICINE 90.02 0 33.21 33. 22 MI SC NON-ALLOWABLE A -11, 870 ADMI NI STRATI VE & GENERAL 5.00 0 33.22								
33. 21 MI SCELLANEOUS I NCOME B -30 JAY FAMILY MEDICINE 90. 02 0 33. 21 33. 22 MI SC NON-ALLOWABLE A -11, 870 ADMI NI STRATI VE & GENERAL 5. 00 0 33. 22								
33. 22 MI SC NON-ALLOWABLE A -11, 870 ADMI NI STRATI VE & GENERAL 5. 00 0 33. 22								
33.23 PRESIDENT EXPENSE A -//, UTUJADMINISTRATIVE & GENERAL 5.00 0 33.23								
	33.23	PRESIDENT EXPENSE	I A	- / / , 010	ADMINISIKATIVE & GENERAL	5.00	0	33.23

Health Financial Systems	IU HEALTH JA	Y HOSPI TAL	In Lieu of Form CMS-2552-10			
ADJUSTMENTS TO EXPENSES			Provider CCN: 15-1320	Period:	Worksheet A-8	3
				From 01/01/2021 To 12/31/2021	Date/Time Pre 5/27/2022 8:0	epared: 00 am
			Expense Classification of			
			To/From Which the Amount i	s to be Adjusted		
Cast Captor Decarintian	Dani o (Cada	Amount	Cost Center	Line #	Wkst. A-7	
Cost Center Description	Basi s/Code (2)	Amount	Cost center	Line #	Ref.	
	1.00	2.00	3.00	4.00	5.00	
50.00 TOTAL (sum of lines 1 thru 49)		-5, 261, 889				50.00
(Transfer to Worksheet A,						
column 6, line 200.)						

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

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

	Financial Systems	IU HEALTH J		In Lie	u of Form CMS-2	2552-10
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO	ME Provider CCN: 15-1320	Period:	Worksheet A-8	-1
OFFICE	COSTS			From 01/01/2021		
				To 12/31/2021		
	Line No.	Cost Center	Expense Items	Amount of	5/27/2022 8:0 Amount	U alli
	Liffie NO.	COST Center	Expense i tems	Allowable Cost		
					Wks. A, column	
					5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUST	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED	ORGANI ZATI ONS OR	CLAIMED HOME	
	OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	171, 727	0	1.00
2.00		CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	191,059	0	2.00
3.00		EMPLOYEE BENEFITS DEPARTMENT		2, 081, 779	0	3.00
3.01		ADMI NI STRATI VE & GENERAL	HOME OFFICE	6, 390, 874	6, 151, 816	3.01
4.00		EMPLOYEE BENEFITS DEPARTMENT		70, 303	0,101,010	4.00
4.00		ADMI NI STRATI VE & GENERAL	RELATED PARTY	753, 298	551, 233	4.00
4.01			RELATED PARTY	204, 971	129, 205	4.02
4.02			RELATED PARTY	12, 771	127, 205	4.02
4.03			RELATED PARTY	325, 389	238, 932	4.03
4.04 4.05			RELATED PARTY			4.04
				294,069	218, 223	
4.06			RELATED PARTY	15, 314	10, 756	4.06
4.07			RELATED PARTY	132, 559	105, 289	4.07
4.08			RELATED PARTY	24, 270	19, 457	4.08
4.09			RELATED PARTY	97, 851	23, 725	4.09
4.10			RELATED PARTY	36, 804	14, 520	4.10
4.11		EMPLOYEE BENEFITS DEPARTMENT		13, 510	13, 510	4.11
4.12			SHARED EMPLOYEES	205, 895	205, 895	4.12
4.13			SHARED EMPLOYEES	-4, 138	-4, 138	4.13
4.14			SHARED EMPLOYEES	38, 353	38, 353	4.14
4.15			SHARED EMPLOYEES	113, 272	113, 272	4.15
4.16	30.00	ADULTS & PEDIATRICS	SHARED EMPLOYEES	776, 049	776, 049	4.16
4.17	50.00	OPERATING ROOM	SHARED EMPLOYEES	227, 289	227, 289	4.17
4.18	60.00	LABORATORY	SHARED EMPLOYEES	1, 803, 268	1, 803, 268	4.18
4.19	66.00	PHYSI CAL THERAPY	SHARED EMPLOYEES	504, 725	504, 725	4.19
4.20	67.00	OCCUPATI ONAL THERAPY	SHARED EMPLOYEES	92, 328	92, 328	4.20
4.21	68.00	SPEECH PATHOLOGY	SHARED EMPLOYEES	18, 466	18, 466	4.21
4.22	76.00	CARDI OPULMONARY	SHARED EMPLOYEES	45, 612	45, 612	4.22
4.23	90.01	FAMILY PRACTICE OF JAY COUNT	SHARED EMPLOYEES	116, 580	116, 580	4.23
4.24			SHARED EMPLOYEES	315, 599	315, 599	4.24
4.25		JAY FAMILY FIRST HEALTH CARE	SHARED EMPLOYEES	57, 653	57, 653	4.25
4.26			SHARED EMPLOYEES	1, 514, 318	1, 514, 318	4.26
4.27			SHARED EMPLOYEES	12, 351	12, 351	4.27
4.28	0.00			12, 331	12, 331	4.28
4.20 5.00	TOTALS (sum of lines 1-4).			16, 654, 168	13, 314, 286	5.00
0.00	Transfer column 6, line 5 to			10,004,100	13, 314, 200	5.00
	Worksheet A-8, column 2,					
	line 12.					
	amounts on Lines 1-4 (and sub					

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

nas not	Deen posted to worksheet A,	corumns ranu/or z, the amou	int arrowable si	iouru be murcateu micorullim	4 OF LIES PALE.					
				Related Organization(s) and/	'or Home Office					
	Symbol (1)	Name	Percentage of	Name	Percentage of					
			Ownership		Ownershi p					
	1.00	2.00	3.00	4.00	5.00					
	B 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 I U HEALTH BALL 100.00	6.00
7.00	В	0.00 I U HEALTH 100.00	7.00
8.00		0.00 0.00	8.00
9.00		0.00 0.00	9.00
10.00		0.00 0.00	10.00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

Heal th	Financial Systems	IU HEALTH .	JAY HOSPI TAL		In Lie	eu of Form CMS-	2552-10
		RELATED ORGANIZATIONS AND HO	ME Provider	CCN: 15-1320	Period:	Worksheet A-8	3-1
OFFICE	COSTS				From 01/01/2021 To 12/31/2021	Date/Time Pre	
						5/27/2022 8:0	<u>,0 am</u>
				Related Orga	nization(s) and/	or Home Office	
	Symbol (1)	Name	Percentage of	1	lame	Percentage of	
			Ownership			Ownership	
	1.00	2.00	3.00	4	1. 00	5.00	

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

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

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

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

Heal th	Financial Syste	ems	IU HEALTH JAY	HOSPI TAL	In Lieu	J of Form CMS-2552-10
STATEN	MENT OF COSTS OF	SERVICES FROM	RELATED ORGANIZATIONS AND HOME	Provider CCN: 15-1320	Period:	Worksheet A-8-1
OFFICE	COSTS				From 01/01/2021	
					To 12/31/2021	Date/Time Prepared: 5/27/2022 8:00 am
	Net	Wkst. A-7 Ref.				372772022 0.00 am
	Adjustments					
	(col. 4 minus					
	col. 5)*					
	6.00	7.00				
	A. COSTS INCUR	RED AND ADJUSTN	MENTS REQUIRED AS A RESULT OF T	RANSACTIONS WITH RELATED	ORGANI ZATI ONS OR	CLAIMED HOME
	OFFICE COSTS:					
1.00	171, 727					1.00
2.00	191, 059					2.00
3.00	2, 081, 779					3.00
3.01	239, 058					3.01
4.00	70, 303					4.00
4.01	202, 065					4.01
4.02	75, 766	0				4.02
4.03	12, 771	0				4.03
4.04	86, 457	0				4.04
4.05	75, 846					4.05
4.06	4, 558					4.06
4.07	27, 270					4.07
4.08	4, 813					4.08
4.09	74, 126					4.09
4.10	22, 284					4.10
4.11	0					4.11
4.12	0	0				4.12
4.13	0	0				4.13
4.14	0	0				4.14
4.15	0					4.15
4.16	0					4.16
4.17	0	0				4.17
4.18	0	-				4.18
4.19	0	-				4.19
4.20 4.21	0	-				4.20
4.21 4.22	0	0				4.21
4.22 4.23	0	0				4.22
4.23 4.24	0	0				4.23
4.24	0	0				4.24

 5.00
 3,339,882
 5.00

 * The amounts on Lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, Lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which

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has no	t been posted to Worksheet A,	columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.	
	Related Organization(s)		
	and/or Home Office		
		_	
	Type of Business		
	6.00		

B. INTERRELATIONSHIP TO 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.

reriibui			
6.00	HOSPI TAL		6.00
7.00	HOME OFFICE		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00		1	00.00

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

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

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

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

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

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

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

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PROVIDER BASED PHYSICIAN ADJUSTMENT Provider Cost: 15:1320 Period: scient/Physician Identifier Provider Component Period: scient/Physician Identifier Wreksheat A-8-2 Image: Scient Cost: 15:1320 Provider Cost: 15:1320 Provider Component Rec Amount Physician Propriet Provider Component Provider Component </th <th>Heal th</th> <th>Financial Syste</th> <th>ems</th> <th>IU HEALTH J</th> <th>AY HOSPI TAL</th> <th></th> <th>In Lie</th> <th>eu of Form CMS-</th> <th>2552-10</th>	Heal th	Financial Syste	ems	IU HEALTH J	AY HOSPI TAL		In Lie	eu of Form CMS-	2552-10
To 12/31/2021 Dato/Time Prepared: Component To 12/31/2021 Dato/Time Prepared: Previder 1 00 2.00 3.00 4.00 5.00 6.00 Previder Marine Prepared: Component RCE Anount Previder Marine Prepared: Previder Previder RCE Anount Previder Marine Prepared: Previder Previder RCE Anount Previder	PROVI DE	ER BASED PHYSIC	I AN ADJUSTMENT		Provider (3-2
Image: Instrument of the									epared.
Identifier Renumeration Component Component Ider Component Hours 1.00 2.00 3.00 4.00 5.00 6.00 7.00 2.00 90.01 FAMILY PRATICE OF JAY 213.234 213.234 0.0 0.0							10 12/01/2021	5/27/2022 8:0	00 am
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1.00 50.00/OPERATINE ROOM 213.234 213.234 213.234 0 0 0 1 0 2.00 90.01 FAULLY PRACTICE OF JAY COUNTY 116.580 116.580 0									
2.00 90.01 FAMILY PRACTICE OF JAY COUNTY 116,580 116,580 0 0 0 2.00 3.00 90.05 JAY FAMILY T MEDICINE 5.00 315,599 315,599 0 0 0 0.00									
COUNTY COUNTY<									
3.00 90.02 JAY FAILLY MEDICINE 315.599 0	2.00	90. 01		116, 580	116, 580	(0 0	0	2.00
4.00 90.05JAY FAMILY FIRST HEALTH CARE 91.00EHREGENCY 57.653 1,388,786 1,388,786 0 57.653 1,262,129 0	2.00	00.00		215 500	215 500				2 00
5.00 91.00EMERGENCY 1.388.766 1.262.129 126.657 0 0 5.00 0.00 0.00 0.00 0							-	-	
6.00 0.00 0<							- -	0	
1.00 0.00 0 </td <td></td> <td></td> <td>EMERGENCY</td> <td>1, 388, 780</td> <td>1, 202, 129</td> <td></td> <td></td> <td>0</td> <td></td>			EMERGENCY	1, 388, 780	1, 202, 129			0	
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200.00				0	0		-	0	
Wkst. A Line # Cost Center/Physician Identifier Unadjusted RCE Limit 5 Percent of Unadjusted RCE Limit Cost of Unadjusted RCE Limit Provider Component Share of col. Physician Cost of Malpractice Insurance 1.00 2.00 8.00 9.00 12.00 13.00 14.00 1.00 50.00/0PERATING ROM 0 0 0 0 0 0 1.00 14.00 14.00 1.00 90.01/AM FAMILY MEDICINE COUNTY 0		0.00		2 001 952	1 045 105		°	0	
Identifier Limit Unadjusted RCE Memberships & Component Share of col. Of Mal practice Insurance 1.00 2.00 8.00 9.00 12.00 13.00 14.00 2.00 90.01 FAMILY PRACTICE OF JAY COUNTY 0		Wkst Alipo #	Cost Contor/Physician					Dhysician Cost	
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1.00 50.00 00 0 0 0 0 0 0 0 0 0 1.00 2.00 90.01 FAMILY PRACTICE OF JAY COUNTY 0		1.00	2.00	8, 00	9,00			14.00	
COUNTY COUNTY<	1.00		OPERATING ROOM	0	0				1.00
3.00 90.02 JAY FAMILY MEDICINE 0 0 0 0 0 3.00 4.00 90.05 JAY FAMILY FIRST HEALTH CARE 0<	2.00	90.01	FAMILY PRACTICE OF JAY	0	0	(o o	0	2.00
4.00 90.05 JAY FAMILY FIRST HEALTH CARE 0 0			COUNTY						
5.00 91.00 EMERGENCY 0	3.00	90. 02	JAY FAMILY MEDICINE	0	0	(0 0	0	3.00
6.00 0.00 0 </td <td>4.00</td> <td>90.05</td> <td>JAY FAMILY FIRST HEALTH CARE</td> <td>0</td> <td>0</td> <td>(</td> <td>0 0</td> <td>0</td> <td>4.00</td>	4.00	90.05	JAY FAMILY FIRST HEALTH CARE	0	0	(0 0	0	4.00
7.00 0.00 <th< td=""><td>5.00</td><td>91.00</td><td>EMERGENCY</td><td>0</td><td>0</td><td>(</td><td>0 0</td><td>0</td><td>5.00</td></th<>	5.00	91.00	EMERGENCY	0	0	(0 0	0	5.00
8.00 0.00 <th< td=""><td>6.00</td><td></td><td></td><td>0</td><td>0</td><td>(</td><td>0 0</td><td>0</td><td>6.00</td></th<>	6.00			0	0	(0 0	0	6.00
9.00 0.00 <th< td=""><td>7.00</td><td>0.00</td><td></td><td>0</td><td>0</td><td>(</td><td>0 0</td><td>0</td><td>7.00</td></th<>	7.00	0.00		0	0	(0 0	0	7.00
10.00 0.00 0<								0	
200.00 Cost Center/Physician Identifier Provider Component Share of col. Adj usted RCE Li mi t RCE Di sal I owance Adj ustment Adj ustment 1.00 2.00 15.00 16.00 17.00 18.00 1.00 213,234 1.00 2.00 90.01 FAMI LY PRACTI CE OF JAY COUNTY 0 0 0 0 1.00 2.00 16.00 116,580 2.00 3.00 90.01 FAMI LY PRACTI CE OF JAY COUNTY 0 0 0 116,580 2.00 3.00 90.05 JAY FAMI LY MEDICINE 0 0 0 315,599 3.00 4.00 90.05 JAY FAMI LY FIRST HEALTH CARE 0 0 0 57,653 4.00 5.00 91.00 EMERGENCY 0 0 0 0 6.00 7.00 6.00 7.00 6.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00				0	0	(0 0	0	
Wkst. A Line # Cost Center/Physician Identifier Provider Component Share of col. 14 Adjusted RCE Limit RCE Disal Iowance Adjustment Adjustment 1.00 2.00 15.00 16.00 17.00 18.00 1.00 50.00 OPERATI NG ROOM COUNTY 0 0 0 11.00 2.00 15.00 16.00 17.00 18.00 1.00 50.00 OPERATI NG ROOM COUNTY 0 0 0 0 2.00 213,234 1.00 3.00 90.02 JAY FAMI LY PRACTI CE OF JAY COUNTY 0 0 0 0 116,580 2.00 5.00 91.00 EMERGENCY 0 0 0 0 315,599 3.00 6.00 0.00 0 0 0 0 0 5.00 6.00 0		0.00		0	0	(0 0	0	
Identifier Component Share of col. 14 Limit Disal Iowance Image: Component Share of col. 14 1.00 2.00 15.00 16.00 17.00 18.00 1.00 50.00 OPERATI NG ROOM 0 0 0 213,234 1.00 2.00 90.01 FAMI LY PRACTI CE OF JAY COUNTY 0 0 0 116,580 2.00 3.00 90.02 JAY FAMI LY MEDI CI NE COUNTY 0 0 0 315,599 3.00 4.00 90.05 JAY FAMI LY FIRST HEALTH CARE 0 0 0 57,653 4.00 5.00 91.00 EMERGENCY 0 0 0 0 6.00 0 0 6.00 7.00 6.00 7.00 0 7.00 0 7.00 0 7.00 0 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00				-	-			0	200.00
Image: Note of col . Share of col . 14 Image: Note of col . 14 1.00 2.00 15.00 16.00 17.00 18.00 1.00 50.00 OPERATI NG ROOM 0 0 0 213,234 1.00 2.00 90.01 FAMI LY PRACTI CE OF JAY 0 0 0 116,580 2.00 3.00 90.02 JAY FAMI LY MEDI CI NE 0 0 0 315,599 3.00 4.00 90.05 JAY FAMI LY MEDI CI NE 0 0 0 57,653 4.00 5.00 91.00 EMERGENCY 0 0 0 0 6.00 7.00 6.00 0 6.00 7.00 6.00 7.00 9		Wkst. A Line #					Adjustment		
Image: Note of the image in the image. the image in the			Identifier		Limit	Di sal l owance			
1.00 2.00 15.00 16.00 17.00 18.00 1.00 50.00 OPERATI NG ROOM 0 0 0 213,234 1.00 2.00 90.01 FAMI LY PRACTI CE OF JAY COUNTY 0 0 0 0 116,580 2.00 3.00 90.02 JAY FAMI LY MEDI CI NE COUNTY 0 0 0 0 315,599 3.00 4.00 90.05 JAY FAMI LY FIRST HEALTH CARE 0 0 0 57,653 4.00 5.00 91.00 EMERGENCY 0 0 0 0 6.00 0 6.00 0 6.00 0 6.00 0 6.00 91,262,129 5.00 5.00 6.00 0 0 0 0 6.00 7.00 8.00 9.00 0									
1.00 50.00 OPERATING ROOM 0 0 0 213,234 1.00 2.00 90.01 FAMILY PRACTICE OF JAY COUNTY 0 0 0 0 116,580 2.00 3.00 90.02 JAY FAMILY MEDICINE 0 0 0 315,599 3.00 4.00 90.05 JAY FAMILY FIRST HEALTH CARE 0 0 0 57,653 4.00 5.00 91.00 EMERGENCY 0 0 0 1,262,129 5.00 6.00 0.00 0 0 0 0 7.00 0.00 7.00 0 7.00 0 7.00 9.00 9.00 9.00 9.00 10.00 9.00 9.00 0 9.00 9.00 9.00 10.00 9.0		1 00	3.00		16.00	17.00	19.00		
2.00 90.01 FAMILY PRACTICE OF JAY COUNTY 0 0 116,580 2.00 3.00 90.02 JAY FAMILY MEDICINE 0 0 0 315,599 3.00 4.00 90.05 JAY FAMILY FIRST HEALTH CARE 0 0 0 57,653 4.00 5.00 91.00 EMERGENCY 0 0 0 1,262,129 5.00 6.00 0.00 0 0 0 0 6.00 7.00 0.00 7.00 0.00 7.00 0.00 7.00 9.00	1 00								1 00
COUNTY COUNTY 3.00 90.02 JAY FAMILY MEDICINE 0 0 315,599 3.00 4.00 90.05 JAY FAMILY FIRST HEALTH CARE 0 0 0 57,653 4.00 5.00 91.00 EMERGENCY 0 0 0 1,262,129 5.00 6.00 0.00 0 0 0 0 6.00 7.00 0.00 0 0 0 0 7.00 8.00 0.00 0 0 0 7.00 7.00 9.00 0 9.00 0 9.00 10.00 9.00 10.00 9.00 10.00 9.00 10.00 10.00 9.00 10.00 9.00 10.00				-	-				
3.00 90.02 JAY FAMILY MEDICINE 0 0 315,599 3.00 4.00 90.05 JAY FAMILY FIRST HEALTH CARE 0 0 0 57,653 4.00 5.00 91.00 EMERGENCY 0 0 0 1,262,129 5.00 6.00 0.00 0 0 0 0 6.00 6.00 7.00 0.00 0 0 0 0 7.00 8.00 8.00 8.00 8.00 9.00 0 9.00 9.00 10.00 9.00 10.00 9.00 10.00 9.00 10.00 9.00 10.00 9.00 10.00 9.00 <td< td=""><td>2.00</td><td>90.01</td><td></td><td>0</td><td>0</td><td></td><td>110, 580</td><td></td><td>2.00</td></td<>	2.00	90.01		0	0		110, 580		2.00
4.00 90.05 JAY FAMILY FIRST HEALTH CARE 0 0 57,653 4.00 5.00 91.00 EMERGENCY 0 0 0 1,262,129 5.00 6.00 0.00 0 0 0 0 6.00 6.00 7.00 0.00 0 0 0 0 7.00 0 7.00 9.00 0 0 7.00 0 7.00 9.00 0 9.00 9.00 9.00 9.00 9.00 0 9.00 9.00 10.00 9.00 10.00 9.00 9.00 0 0 10.00 <	3 00	cn no		Λ	n	(315 500		3 00
5.00 91.00 EMERGENCY 0 0 1,262,129 5.00 6.00 0.00 0 0 0 0 6.00 7.00 0.00 0 0 0 0 7.00 8.00 0.00 0 0 0 0 8.00 9.00 0.00 0 0 0 9.00 9.00 0 9.00 10.				-	-				
6.00 0.00 0 0 6.00 6.00 7.00 0.00 0 0 0 0 7.00 8.00 0.00 0 0 0 0 7.00 8.00 9.00 0 0 0 9.00 0 9.00 0 9.00 10.00									
7.00 0.00 0 0 0 7.00 8.00 0.00 0 0 0 0 8.00 9.00 0.00 0 0 0 0 9.00 10.00 0.00 0 0 0 10.00 10.00				, s	-		.,		
8.00 0.00 0 0 0 8.00 9.00 0 0 0 9.00 0 9.00 0 0 0 9.00 9.00 10.00 0 0 0 0 9.00 10.00				-			-		
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10.00 0.00 0 0 0 10.00									
		3.00							
			1	-	-	1			

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	IU HEALTH JA	Provi der CC	N: 15-1320		od: 01/01/2021	u of Form CMS Worksheet B Part I		
					То	12/31/2021	Date/Time Pr 5/27/2022 8:		
				CAPI TAL	RELAT	ED COSTS			
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	BLDG & FIXT-MOB		BLDG & FI XT-POB	BLDG & FI XT-WJ		
		0	1.00	1.01		1. 02	1.03		
	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	837, 049	837, 049						1.00
1.01 1.02 1.03 1.04 2.00 2.01	00101 CAP REL COSTS-BLDG & FIXT-MOB 00102 CAP REL COSTS-BLDG & FIXT-POB 00103 CAP REL COSTS-BLDG & FIXT-WJ 00104 CAP REL COSTS-BLDG & FIXT-INTEREST 00200 CAP REL COSTS-MVBLE EQUIP 00201 CAP REL COSTS-MVBLE EQUIP - MOB	0 - 34, 774 0 0 1, 872, 887 31, 774	0 0 0 0 0		0 0 0	-34, 774 0 0		0	1. 01 1. 02 1. 03 1. 04 2. 00 2. 01
2.03 4.00 5.00 7.00 7.01 7.02	00202 CAP REL COSTS-MVBLE EQUIP - POB 00203 CAP REL COSTS-MVBLE EQUIP - WJ 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00701 OPERATION OF PLANT - MOB 00702 OPERATION OF PLANT - POB 00703 OPERATION OF PLANT - WJ	0 2, 184, 978 7, 967, 068 3, 256, 548 44, 772 63, 488	1, 153 109, 751 189, 759 0 0 0		0 0 0 0 0	0 0 0 0 0		000000000000000000000000000000000000000	2. 02 2. 03 4. 00 5. 00 7. 00 7. 01 7. 02 7. 03
B. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	132, 976 546, 392 416, 910 234, 288 1, 685, 613 714, 088 1, 072, 939 0	6, 063 6, 124 25, 139 18, 464 11, 319 0 10, 207 0			0 0 0 0 0 0 0		0 0 0 0	8.00 9.00 10.00 11.00 13.00 14.00 15.00
17.00	01700 SOCIAL SERVICE	0	0		0	0		0	17.OC
40.00	03000 ADULTS & PEDI ATRI CS 04000 SUBPROVI DER - I PF 04300 NURSERY	1, 978, 801 0 0	100, 586 0 0		0 0 0	0 0 0		0	30. 00 40. 00 43. 00
50.00	ANCI LLARY SERVI CE COST CENTERS	895, 684	40, 745		0	0		0	50. OC
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0		0	52.00
	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0	0 50, 971		0 0	0			53.00
	06000 LABORATORY	1, 117, 207 1, 929, 933	26, 690		0	0			54.00 60.00
	06500 RESPIRATORY THERAPY	482, 763	7,461		0	0			65.0
6.00	06600 PHYSI CAL THERAPY	603, 966	33, 018		0	0		0	66.0
	06700 OCCUPATI ONAL THERAPY	92, 328	5, 991		0	0			67.C
	06800 SPEECH PATHOLOGY	18, 466	194		0	0			68. C
	06900 ELECTROCARDI OLOGY	909	0		0	0			69.0
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	93, 761 21, 599	0		0	0			71.0 72.0
	07300 DRUGS CHARGED TO PATIENTS	1, 868, 075	0		0	0			73.0
	03160 CARDI OPULMONARY	245, 788	0		0	0			76. C
	OUTPATIENT SERVICE COST CENTERS				_				
		725 014	0		0	0			90.0
	09001 FAMILY PRACTICE OF JAY COUNTY 09002 JAY FAMILY MEDICINE	735, 916 777, 518	0		0 0	0			90.0 90.0
	09002 WOUND CLINIC	0	0		0	0			90. C
	09004 OP ORTHO CLINIC	0	0		0	0			90.0
	09005 JAY FAMILY FIRST HEALTH CARE	369, 255	39, 479		0	0			90.0
0.06	09006 INFUSION CLINIC	118, 927	6, 308		0	0		0	90.0
	09007 HEALTH BEGINNINGS PROGRAM	264, 166	32, 069		0	0			90.0
	09100 EMERGENCY	1, 625, 478	48, 685		0	0			91.0
	09200 OBSERVATION BEDS (NON-DISTINCT PART 04950 OUTPATIENT PSYCH	21 202	1/ 00/		0	~			92.0
3.00	SPECIAL PURPOSE COST CENTERS	31, 282	16, 034		0	0		0	93.0
	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	34, 298, 818	786, 210		0	0			18.0
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	327	7, 869		0	0			90.0
	19200 PHYSI CLANS' PRI VATE OFFI CES 19300 NONPALD WORKERS	140, 882	0		0 0	0			92. 0 93. 0
	07950 VACANT	0	26, 588		0	0			93. U 94. C
	07952 WEST JAY CLINIC	0	20, 500		õ	0			94.0
	07953 JAY MERI DI AN URGENT CARE	o	16, 382		0	0			94.0
200.00	Cross Foot Adjustments	Ŭ	-,			Ũ		2	200.0
200.00						04 774		0	201.0
200.00 201.00 202.00		34, 440, 027	0 837, 049		0 0	-34, 774 -34, 774			201. 0 202. 0

Heal th Financia COST ALLOCATIO	al Systems N - GENERAL SERVICE COSTS	IU HEALTH JAY	Provider C	Fr	eriod: com 01/01/2021	u of Form CMS-: Worksheet B Part I	
				То		Date/Time Pre 5/27/2022 8:0	epared: 0 am
			CAP	ITAL RELATED CC	ISTS		
Co	st Center Description	BLDG &	MVBLE EQUIP	MVBLE EQUIP -			
		FIXT-INTEREST 1.04	2.00	MOB 2.01	POB 2.02		
	SERVICE COST CENTERS		2100	2.01	2.02	2100	
	P REL COSTS-BLDG & FIXT P REL COSTS-BLDG & FIXT-MOB						1.00
	P REL COSTS-BLDG & FIXT-POB						1.02
	P REL COSTS-BLDG & FIXT-WJ						1.03
	P REL COSTS-BLDG & FIXT-INTEREST P REL COSTS-MVBLE EQUIP	0	1, 872, 887				1.04
2. 01 00201 CA	P REL COSTS-MVBLE EQUIP - MOB		0	31, 774			2.01
	P REL COSTS-MVBLE EQUIP - POB P REL COSTS-MVBLE EQUIP - WJ		0	0	0	0	2.02
	PLOYEE BENEFITS DEPARTMENT	О	2, 581	0	0	0	
	MINISTRATIVE & GENERAL	0	245, 566		0	0	
	ERATION OF PLANT ERATION OF PLANT - MOB	0	424, 587 0	0	0	0	
	ERATION OF PLANT - MOB	0	0	724 0	0	0	
	ERATION OF PLANT - WJ	0	0	0	0	0	
	UNDRY & LINEN SERVICE USEKEEPING	0	13, 565 13, 702	0	0	0	
0.00 01000 DI		0	56, 248	-	0	0	
1.00 01100 CA		0	41, 312		0	0	
	RSING ADMINISTRATION NTRAL SERVICES & SUPPLY	0	25, 326 0	0	0	0	
5.00 01500 PH		0	22, 837	0	0	0	
	DICAL RECORDS & LIBRARY	0	0	0	0	0	
	CIAL SERVICE IT ROUTINE SERVICE COST CENTERS	0	0	0	0	0	17.00
	ULTS & PEDIATRICS	0	225, 059	0	0	0	30.00
	BPROVIDER - IPF	0	0		0	0	
3.00 04300 NU ANCLUAR	RSERY RY SERVICE COST CENTERS	0	0	0	0	0	43.00
	ERATING ROOM	0	91, 165	1, 336	0	0	50.00
	LIVERY ROOM & LABOR ROOM	0	0	0	0	0	
	IESTHESI OLOGY DI OLOGY-DI AGNOSTI C	0	0 114, 048	0	0	0	
D. 00 06000 LA	BORATORY	0	59, 719	0	0	0	60.00
1 1	SPI RATORY THERAPY	0	16, 694	0	0	0	
	YSI CAL THERAPY CUPATI ONAL THERAPY	0	73, 878 13, 405		0	0	
3. 00 06800 SP	EECH PATHOLOGY	0	434	0	0	0	68.00
	ECTROCARDI OLOGY DI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0	0	0	0	
	IPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	
3.00 07300 DR	UGS CHARGED TO PATIENTS	0	0		0	0	73.00
6.00 03160 CA	RDI OPULMONARY ENT SERVI CE COST CENTERS	0	0	2, 214	0	0	76.00
D. 00 09000 CL		0	0	0	0	0	90.00
	MILY PRACTICE OF JAY COUNTY	0	0		0	0	
D. 02 09002 JA D. 03 09003 W0	Y FAMILY MEDICINE	0	0	12, 467 0	0	0	
	ORTHO CLINIC	0	0	0	0	0	
	Y FAMILY FIRST HEALTH CARE	0	88, 334		0	0	
	IFUSION CLINIC ALTH BEGINNINGS PROGRAM	0	14, 113 71, 754		0	0	
1.00 09100 EM		0	108, 933		0	0	
	SERVATION BEDS (NON-DISTINCT PART		05 077				92.00
	TPATIENT PSYCH PURPOSE COST CENTERS	0	35, 877	0	0	0	93.00
18.00 SU	BTOTALS (SUM OF LINES 1 through 117)	0	1, 759, 137	31, 774	0	0	118.00
	SURSABLE COST CENTERS		17 (07		a		100.00
	FT, FLOWER, COFFEE SHOP & CANTEEN YSICIANS' PRIVATE OFFICES	0	17, 607 0	0	0		190.00 192.00
93. 00 19300 NO	NPAID WORKERS	0	0	0	0	0	193.00
94.0007950 VA		0	59, 490	0	0		194.00
	ST JAY CLINIC Y MERIDIAN URGENT CARE	0	0 36, 653	0	0		194.02 194.03
00.00 Cr	oss Foot Adjustments		-0,000	Ŭ	5		200.00
	gative Cost Centers	0	1 070 007	0	0		201.00
	TAL (sum lines 118 through 201)	0	1, 872, 887	31, 774	O	0	202.00

Health Financial Systems	IU HEALTH JAY	HOSPI TAL		In Lieu	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-1320 P	eriod: rom 01/01/2021 o 12/31/2021	Worksheet B Part I Date/Time Pre	narod
Cost Contar Decorintian	EMPLOYEE	Subtatal	ADMI NI STRATI V	OPERATION OF	07111111111111111111111111111111111111	
Cost Center Description	BENEFI TS DEPARTMENT	Subtotal	E & GENERAL	PLANT	PLANT - MOB	
	4.00	4A	5.00	7.00	7.01	
GENERAL SERVI CE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
1.00 00100 CAP REL COSTS-BLDG & FIXT 1.01 00101 CAP REL COSTS-BLDG & FIXT-MOB 1.02 00102 CAP REL COSTS-BLDG & FIXT-POB 1.03 00103 CAP REL COSTS-BLDG & FIXT-WJ 1.04 00104 CAP REL COSTS-BLDG & FIXT-INTEREST 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.01 00201 CAP REL COSTS-MVBLE EQUIP - MOB 2.02 00202 CAP REL COSTS-MVBLE EQUIP - POB 2.03 00203 CAP REL COSTS-MVBLE EQUIP - VJ 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT 7.01 00701 OPERATION OF PLANT - MOB 7.02 00702 OPERATION OF PLANT - MOB 7.03 00703 OPERATION OF PLANT - WJ 8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPING 10.00 01100 CAFETERIA 13.00 01300 NURSING ADMINISTRATION 14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 01500 PHARMACY 16.00 01600 MEDICAL RECORDS & LIBRARY 17.00 01700 SOCIAL SERVICE	2, 188, 712 73, 110 105, 368 0 0 6, 301 62, 904 34, 292 25, 184 229, 084 0 99, 328 0 0	8, 397, 568 3, 976, 262 45, 496 63, 488 0 158, 905 629, 122 532, 589 319, 248 1, 951, 342 714, 088 1, 205, 311 0 0	1, 280, 458 14, 651 20, 445 0 51, 172 202, 594 171, 508 102, 806 628, 385	5, 256, 720 30, 263 37, 524 0 36, 243 36, 609 150, 279 110, 376 67, 665 0 61, 015 0 0	90, 410 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 1. \ 01 \\ 1. \ 02 \\ 1. \ 03 \\ 1. \ 04 \\ 2. \ 00 \\ 2. \ 01 \\ 2. \ 02 \\ 2. \ 03 \\ 4. \ 00 \\ 5. \ 00 \\ 7. \ 00 \end{array}$
INPATIENT ROUTINE SERVICE COST CENTERS		0	-		0	17.00
30. 00 03000 ADULTS & PEDI ATRI CS 40. 00 04000 SUBPROVI DER – I PF	341, 690 0	2, 646, 136 0		601, 300 0	0	30.00 40.00
43. 00 04000 SUBPROVIDER - TPP 43. 00 04300 NURSERY	0	0	0	0	0	40.00
ANCI LLARY SERVICE COST CENTERS					=-	
50.00 05000 OPERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	148, 442	1, 177, 372	379, 146	690, 016 0	4, 170 0	50.00 52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	169, 917	1, 452, 143	467, 629	304, 707	0	54.00
60. 00 06000 LABORATORY	1, 635	2, 017, 977	649, 843	159, 553	0	60.00
65. 00 06500 RESPIRATORY THERAPY	80, 374	587, 292		44, 602	0	65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY	95, 843	806, 705		197, 382	0	66.00 67.00
68. 00 06800 SPEECH PATHOLOGY	17, 532 3, 507	129, 256 22, 601	41, 624 7, 278	35, 816 1, 159	0	67.00
69. 00 06900 ELECTROCARDI OLOGY	0	909	293	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	93, 761	30, 194	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	21, 599		0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	1, 868, 075		0	0	
76.00 03160 CARDI OPULMONARY OUTPATI ENT SERVI CE COST CENTERS	28, 865	276, 867	89, 159	92, 498	6, 908	76.00
90. 00 09000 CLINIC	0	0	0	0	0	90.00
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	128, 642	877, 314		532, 841	39, 796	
90. 02 09002 JAY FAMILY MEDICINE	136, 373	926, 358	298, 312	520, 821	38, 898	
90. 03 09003 WOUND CLINIC	0	0	0	0	0	90.03
90. 04 09004 OP ORTHO CLINIC		0 E (1 017	100 020	0 244 E47	0	90.04
90. 05 09005 JAY FAMILY FIRST HEALTH CARE 90. 06 09006 INFUSION CLINIC	64, 545 20, 869	561, 817 160, 217	180, 920 51, 594	244, 547 37, 707	638 0	90.05 90.06
90. 07 09007 HEALTH BEGI NNI NGS PROGRAM	49,800	417, 789		191, 708	0	90.07
91.00 09100 EMERGENCY	238, 564	2, 021, 660		291, 040	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0				92.00
93.00 04950 OUTPATIENT PSYCH	6, 766	89, 959	28, 969	95, 854	0	93.00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 11 NONREIMBURSABLE COST CENTERS	7) 2, 168, 935	34, 149, 226	8, 292, 724	4, 571, 525	90, 410	118.00
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	0	25, 803	8, 309	47, 042	0	190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	19, 777	160, 659		381, 281	0	192.00
193. 00 19300 NONPALD WORKERS	0	0	0	0		193.00
194. 00 07950 VACANT	0	86, 078	27, 719	158, 943		194.00
194. 02 07952 WEST JAY CLINIC 194. 03 07953 JAY MERIDIAN URGENT CARE	0	0 53, 035	17,079	0 97, 929		194.02 194.03
200.00 Cross Foot Adjustments		03, 035 N	17,079	71,729		200.00
201.00 Negative Cost Centers	0	-34, 774		0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	2, 188, 712	34, 440, 027	8, 397, 568	5, 256, 720	90, 410	202.00

Health Financial Systems COST ALLOCATION - GENERAL SERVICE COSTS	IU HEALTH JA	Y HOSPITAL Provider C	CN: 15-1320 P	In Lieu eriod:	ı of Form CMS-2 Worksheet B	2552-10
				rom 01/01/2021	Part I Date/Time Pre	
Cost Center Description	OPERATION OF	OPERATI ON OF	LAUNDRY &	HOUSEKEEPI NG	5/27/2022 8: 0 DI ETARY	o am
	PLANT - POB 7.02	<u>PLANT - WJ</u> 7.03	LINEN SERVICE 8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.01 00101 CAP REL COSTS-BLDG & FIXT 1.02 00102 CAP REL COSTS-BLDG & FIXT-MOB 1.03 00103 CAP REL COSTS-BLDG & FIXT-POB 1.03 00104 CAP REL COSTS-BLDG & FIXT-WJ 1.04 00104 CAP REL COSTS-BLDG & FIXT-INTEREST 2.00 00200 CAP REL COSTS-MVBLE EQUIP P 2.01 00201 CAP REL COSTS-MVBLE EQUIP P 2.03 00203 CAP	121, 457 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		246, 320 0 0 0 0 0 0 0 0 0 0 0 0	868, 325 25, 506 18, 733 11, 484 0 10, 356	879, 882 0 0 0 0 0	1.00 1.01 1.02 1.03 1.04 2.00 2.01 2.02 2.03 4.00 5.00 7.00 7.00 7.01 7.02 7.03 8.00 9.00 10.00 11.00 13.00 14.00 14.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE	0 0	0		0 0	0 0	16.00 17.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	0	0	246, 320	102, 055	879, 882	30.00
40. 00 04000 SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00 04300 NURSERY ANCLULARY SERVICE COST CENTERS	0	0	0	0	0	43.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM 52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY - DI AGNOSTI C 60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY 65. 00 06600 PHYSI CAL THERAPY 66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 73. 00 07300 DRUGS CHARGED TO PATI ENTS 76. 00 03160 CARDI OPULMONARY 0UTPATI ENT SERVI CE COST CENTERS 00 90. 00 090000 CLI NI C	87, 142 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			117, 112 0 0 51, 716 27, 080 7, 570 33, 501 6, 079 197 0 0 0 0 0 15, 699		76.00
90. 01 09001 FAMI LY PRACTI CE OF JAY COUNTY 90. 02 09002 JAY FAMI LY MEDI CI NE 90. 03 09003 WOUND CLI NI C 90. 04 09004 OP ORTHO CLI NI C 90. 05 09005 JAY FAMI LY FI RST HEALTH CARE 90. 06 09006 INFUSI ON CLI NI C 0 09007 90. 07 09007 HEALTH BEGI NNI NGS PROGRAM 91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 93. 00 04950 OUTPATI ENT PSYCH SPECI AL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LI NES 1 through 117)	0 0 0 0 0 0 0 0 0 0 87, 142			90, 436 88, 396 0 41, 506 6, 400 32, 538 49, 397 16, 269 752, 030	0 0 0 0 0 0 0 0 0 0 0 0 0 0	
NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		7, 984		190.00
192.00 19200 PHYSICLANS' PRIVATE OFFICES 193.00 19300 NONPALD WORKERS 194.00 07950 VACANT 194.02 07952 WEST JAY CLINIC 194.03 07953 JAY MERIDIAN URGENT CARE 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118 through 201)	34, 315 0 0 0 0 121, 457			64, 713 0 26, 977 0 16, 621 0 868, 325	0 0 0 0	192.00 193.00 194.00 194.02 194.03 200.00 201.00 202.00

Health Financial Systems	IU HEALTH JA	Y HOSPI TAL		In Lieu	u of Form CMS-:	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	F	veriod: from 01/01/2021 fo 12/31/2021	Worksheet B Part I Date/Time Pre 5/27/2022 8:0	
Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI O N	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	
	11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS				1		1 00
1. 00 00100 CAP REL COSTS-BLDG & FIXT 1. 01 00101 CAP REL COSTS-BLDG & FIXT-MOB 1. 02 00102 CAP REL COSTS-BLDG & FIXT-POB 1. 03 00103 CAP REL COSTS-BLDG & FIXT-POB 1. 04 00104 CAP REL COSTS-BLDG & FIXT-INTEREST 2. 00 00200 CAP REL COSTS-MVBLE EQUIP 2. 01 00201 CAP REL COSTS-MVBLE EQUIP - MOB 2. 02 00202 CAP REL COSTS-MVBLE EQUIP - MOB 2. 03 00203 CAP REL COSTS-MVBLE EQUIP - POB 2. 03 00203 CAP REL COSTS-MVBLE EQUIP - WJ 4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL 7. 00 00700 OPERATION OF PLANT MOB 7. 01 00701 OPERATION OF PLANT MOB 7. 02 00702 OPERATION OF PLANT MOB 7. 03 00703 OPERATION OF PLANT MOB 7. 03 00703 OPERATION OF PLANT WJ 8. 00 00800 LAUNDRY & LINEN SERVICE 9. 00 9. 00 009000 HOUSEKEEPING	551, 163 47, 715 0 20, 871		944, 044 8, 195			$\begin{array}{c} 1.\ 00\\ 1.\ 01\\ 1.\ 02\\ 1.\ 03\\ 1.\ 04\\ 2.\ 00\\ 2.\ 01\\ 2.\ 02\\ 2.\ 03\\ 4.\ 00\\ 5.\ 00\\ 7.\ 00\\ 7.\ 01\\ 7.\ 02\\ 7.\ 03\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ \end{array}$
16.00 01600 MEDI CAL RECORDS & LI BRARY	0	0	C	0	0	16.00
17.00 01700 SOCI AL SERVI CE	0	0	0	0	0	17.00
30.00 03000 ADULTS & PEDI ATRI CS	80, 159	865, 914	213, 126	13, 214	0	30.00
40. 00 04000 SUBPROVI DER - 1 PF	00, 139		213, 120		0	40.00
43. 00 04300 NURSERY	0		C		0	43.00
ANCILLARY SERVICE COST CENTERS	1					
50.00 05000 OPERATING ROOM	41, 301	455, 543	150, 399		0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0 42, 522	0	30, 227	0 5, 074	0	53.00 54.00
60. 00 06000 LABORATORY	39, 332		19, 429		0	60.00
65.00 06500 RESPIRATORY THERAPY	17, 138		41, 155		0	65.00
66. 00 06600 PHYSI CAL THERAPY	14, 084	0	6, 083	0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	5, 328		211		0	67.00
68. 00 06800 SPEECH PATHOLOGY	747	0	0	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0	1, 633 157, 328	1	0	69.00 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	36, 242	1	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	1, 626, 492	0	
76.00 03160 CARDI OPULMONARY	7, 330	2, 177	3, 445	105	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC 90.01 09001 FAMILY PRACTICE OF JAY COUNTY	0 57, 183		0 46, 906		0 0	90.00 90.01
90. 02 09002 JAY FAMILY MEDICINE	61, 900		40, 486	1 1	0	90.01
90. 03 09003 WOUND CLINIC	0	0	C	0	0	90.03
90. 04 09004 OP ORTHO CLINIC	0	0	C	0	0	90.04
90. 05 09005 JAY FAMILY FIRST HEALTH CARE	27,047		14, 191	1 1	0	90.05
90.06 09006 INFUSION CLINIC 90.07 09007 HEALTH BEGINNINGS PROGRAM	4, 378 16, 086		5, 042 1, 460		0	90.06 90.07
91. 00 09100 EMERGENCY	51, 346		165, 392		0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		,	,		-	92.00
93.00 04950 OUTPATIENT PSYCH	7, 771	0	513	0	0	93.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	542, 238	2, 706, 591	941, 463	1, 693, 891	0	118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	0	0	190.00
192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES	8, 925	-	2, 581			192.00
193.00 19300 NONPALD WORKERS	0	0	C	0		193.00
194. 00 07950 VACANT	0	0	0	0		194.00
194. 02 07952 WEST JAY CLINIC 194. 03 07953 JAY MERIDIAN URGENT CARE		0	0	0		194.02 194.03
200.00 Cross Foot Adjustments		0			0	200.00
201.00 Negative Cost Centers	0	0	C	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	551, 163	2, 706, 591	944, 044	1, 693, 891		202.00

	nancial Systems	IU HEALTH JAY				u of Form CMS-2	2552-10
CUST ALLU	CATI ON – GENERAL SERVI CE COSTS		Provider C	UN: 15-1320	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part I Date/Time Pre 5/27/2022 8:0	
	Cost Center Description	SOCI AL SERVI CE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	5	572772022 8.0	
GEN	IERAL SERVICE COST CENTERS	17.00	24.00	25.00	26.00		
$\begin{array}{c ccccc} 1. & 00 & 001 \\ 1. & 01 & 001 \\ 1. & 02 & 001 \\ 1. & 03 & 001 \\ 1. & 04 & 001 \\ 2. & 00 & 002 \\ 2. & 01 & 002 \\ 2. & 01 & 002 \\ 2. & 02 & 002 \\ 2. & 03 & 002 \\ 4. & 00 & 004 \\ 5. & 00 & 004 \\ 5. & 00 & 004 \\ 5. & 00 & 007 \\ 7. & 01 & 007 \\ 7. & 01 & 007 \\ 7. & 02 & 007 \\ 7. & 03 & 007 \\ 8. & 00 & 008 \\ 9. & 00 & 009 \\ 10. & 00 & 010 \\ 11. & 00 & 011 \\ 13. & 00 & 013 \\ 14. & 00 & 014 \\ 15. & 00 & 015 \\ \end{array}$	IERAL SERVICE COST CENTERS 100 CAP REL COSTS-BLDG & FIXT 101 CAP REL COSTS-BLDG & FIXT-MOB 102 CAP REL COSTS-BLDG & FIXT-POB 103 CAP REL COSTS-BLDG & FIXT-POB 104 CAP REL COSTS-BLDG & FIXT-POB 105 CAP REL COSTS-BLDG & FIXT-INTEREST 104 CAP REL COSTS-MVBLE EQUIP 105 CAP REL COSTS-MVBLE EQUIP 106 CAP REL COSTS-MVBLE EQUIP 107 CAP REL COSTS-MVBLE EQUIP 108 CAP REL COSTS-MVBLE EQUIP 109 CAP REL COSTS-MVBLE EQUIP 100 CAP REL COSTS-MVBLE EQUIP 101 CAP REL COSTS-MVBLE EQUIP 102 CAP REL COSTS-MVBLE EQUIP 103 CAP REL COSTS-MVBLE EQUIP 104 CAP REL COSTS-MVBLE EQUIP 105 CAP REL COSTS-MVBLE EQUIP 100 CAP REL COSTS-MVBLE EQUIP 101 CAP REL COSTS-MVBLE EQUIP 102 CAP REL COSTS-MVBLE EQUIP 103 OPERATION OF PLANT 104 OPERATION OF PLANT 105 OPERATION OF PLANT 106 DEPATION OF PLANT						$\begin{array}{c} 1.\ 00\\ 1.\ 01\\ 1.\ 02\\ 1.\ 03\\ 1.\ 04\\ 2.\ 00\\ 2.\ 01\\ 2.\ 02\\ 2.\ 03\\ 4.\ 00\\ 5.\ 00\\ 7.\ 00\\ 7.\ 00\\ 7.\ 00\\ 7.\ 01\\ 7.\ 02\\ 7.\ 03\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ \end{array}$
	000 MEDI CAL RECORDS & LI BRARY						16.00
	700 SOCIAL SERVICE PATIENT ROUTINE SERVICE COST CENTERS	0					17.00
	000 ADULTS & PEDIATRICS	0	6, 500, 233		0 6, 500, 233		30.00
	000 SUBPROVIDER - IPF	0	0		0 0 0 0		40.00
	300 NURSERY	U	0		0 0		43.00
50.00 050 52.00 052	000 OPERATI NG ROOM 200 DELI VERY ROOM & LABOR ROOM 300 ANESTHESI OLOGY	0	3, 107, 214 0		0 3, 107, 214 0 0 0 0		50.00 52.00 53.00
	100 RADI OLOGY-DI AGNOSTI C	0	2, 354, 018		0 2, 354, 018		54.00
60.00 060	DOO LABORATORY	0	2, 913, 214		0 2, 913, 214		60.00
	500 RESPIRATORY THERAPY	0	886, 881		0 886, 881		65.00
	000 PHYSI CAL THERAPY 700 OCCUPATI ONAL THERAPY	0	1, 317, 536 218, 314		0 1, 317, 536 0 218, 314		66.00 67.00
	300 SPEECH PATHOLOGY	Ő	31, 982		0 31, 982		68.00
	200 ELECTROCARDI OLOGY	0	2, 857		0 2, 857		69.00
	00 MEDICAL SUPPLIES CHARGED TO PATIENTS 200 IMPL. DEV. CHARGED TO PATIENTS	0	281, 283 64, 796		0 281, 283 0 64, 796		71.00
	BOO DRUGS CHARGED TO PATIENTS	0	4, 096, 138		0 4, 096, 138		73.00
	60 CARDI OPULMONARY	0	494, 188		0 494, 188		76.00
	PATIENT SERVICE COST CENTERS	0	0	1	0 0		90.00
	001 FAMILY PRACTICE OF JAY COUNTY	o	2, 094, 082		0 2,094,082		90.00
90.02 090	DO2 JAY FAMILY MEDICINE	Ō	2, 193, 962		0 2, 193, 962		90.02
	003 WOUND CLINIC	0	0		0 0		90.03
	004 OP ORTHO CLINIC 005 JAY FAMILY FIRST HEALTH CARE	0	0 1, 159, 380		0 1, 159, 380		90.04 90.05
	006 INFUSION CLINIC	0	339, 865		0 339, 865		90.05
90.07 090	007 HEALTH BEGINNINGS PROGRAM	0	936, 323		0 936, 323		90.07
	OO EMERGENCY	0	3, 965, 470		0 3, 965, 470		91.00
	200 OBSERVATION BEDS (NON-DISTINCT PART 250 OUTPATIENT PSYCH	o	239, 335		0 0 239, 335		92.00 93.00
	CIAL PURPOSE COST CENTERS	0	237, 333		0 239, 335		93.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	33, 197, 071		0 33, 197, 071		118.00
190.00190	000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	89, 138		0 89, 138		190.00
	200 PHYSICIANS' PRIVATE OFFICES	0	704, 211		0 704, 211		192.00
193.00193 194.00079	BOO NONPALD WORKERS	0	0 299, 717		0 0 0 299, 717		193.00 194.00
	252 WEST JAY CLINIC	o	277,717		0 299,717		194.00
194.03079	253 JAY MERIDIAN URGENT CARE	0	184, 664		0 184, 664		194.03
200.00	Cross Foot Adjustments	_	0		0 0		200.00
201.00 202.00	Negative Cost Centers TOTAL (sum lines 118 through 201)	0	-34, 774 34, 440, 027		0 -34, 774 0 34, 440, 027		201.00 202.00
202.00		9	0 r, 110, 027	I	5, 57, 770, 027		-02.00

alth Financial Systems LOCATION OF CAPITAL RE	LATED COSTS	IU HEALTH JA	Provi der CC	CN: 15-1320			Date/Time P	repai	red:
				CAPI TAL	RELATE) COSTS	5/27/2022 8	: 00 ;	am
Cost Center	Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	BLDG & FIXT-MOB		BLDG & I XT-POB	BLDG & FIXT-WJ		
		0	1.00	1.01		1.02	1.03		
00 00200 CAP REL COST 01 00201 CAP REL COST 02 00202 CAP REL COST	S-BLDG & FIXT S-BLDG & FIXT-MOB S-BLDG & FIXT-POB S-BLDG & FIXT-INT S-BLDG & FIXT-INTEREST S-WVBLE EQUIP S-MVBLE EQUIP - MOB S-MVBLE EQUIP - MOB S-MVBLE EQUIP - WJ IEFITS DEPARTMENT VE & GENERAL PLANT - MOB PLANT - MOB PLANT - POB PLANT - WJ NEN SERVICE	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 153 109, 751 189, 759 0 0 6, 063 6, 124 25, 139 18, 464 11, 319 0 0 0					0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 1. 00 1. 00 2. 00 2. 00 2. 00 2. 00 2. 00 7. 00 7. 00 7. 00 7. 00 7. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 11. 00 10.
5. 00 01600 MEDICAL RECO 7. 00 01700 SOCIAL SERVI		0	0		0	0		0 1	16.0 17.0
0. 00 03000 ADULTS & PED 0. 00 04000 SUBPROVI DER 8. 00 04300 NURSERY	I ATRI CS	0 0 0	100, 586 0 0		0 0 0	0 0 0		0 4	30.0 40.0 43.0
ANCI LLARY SERVICE 0.00 05000 OPERATING RC 2.00 05200 DELIVERY ROC 3.00 05300 ANESTHESI OLC 4.00 05400 RADI OLOGY-DI 0.00 06000 LABORATORY 0.00 06600 PHYSI CAL THE 0.00 06600 PHYSI CAL THE 7.00 06600 SPEECH PATHC 0.00 06600 SPEECH PATHC 0.00 06900 ELECTROCARDI 0.00 07100 MEDI CAL SUPF 0.00 07200 IMPL. DEV. C 0.00 07300 RUGS CHARGE 0.00 03160 CARDI OPULMON 00 02160 CARDI OPULMON	OM M & LABOR ROOM GY AGNOSTI C THERAPY RAPY . THERAPY LOGY OLOGY OLOGY VLI ES CHARGED TO PATI ENTS HARGED TO PATI ENTS D TO PATI ENTS IARY	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	40, 745 0 0 50, 971 26, 690 7, 461 33, 018 5, 991 194 0 0 0 0 0 0		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0 5 0 5 0 6 0 6 0 6 0 6 0 6 0 6 0 6 0 7 0 7 0 7	50. 0 52. 0 53. 0 54. 0 55. 0 55. 0 55. 0 55. 0 56. 0 57. 0 58. 0 71. 0 71. 0 72. 0 73. 0 76. 0
D. 00 09000 CLINIC 0.01 09001 FAMILY PRACT 0.02 09002 JAY FAMILY PRACT 0.03 09003 WOUND CLINIC O 0.04 09004 OP ORTHO CLINIC 0.05 09005 JAY FAMILY 0.05 09006 INFUSION CLI O 0.06 09006 INFUSION CLI O 0.00 09100 EMERGENCY O 0.00 09200 OBSERVATION S 0.00 09200 OBSERVATION S 0.00 04950 OUTPATIENT P S 0.00 SUBTOTALS (S NOREI MBURSABLE CO 0.00 19200 PH	I CE OF JAY COUNTY IEDI CI NE NI C I RST HEALTH CARE NI C INI NGS PROGRAM BEDS (NON-DI STI NCT PART SYCH DST CENTERS JUM OF LI NES 1 through 117) DST CENTERS COFFEE SHOP & CANTEEN PRI VATE OFFI CES		0 0 0 39, 479 6, 308 32, 069 48, 685 16, 034 786, 210 7, 869 0 0					0 9 0 9 0 9 0 9 0 9 0 9 0 9 0 9 0 9 0 9	90.0 92.0
93.00 19300 NONPALD WORK 94.00 07950 VACANT 94.02 07952 WEST JAY 94.03 07953 JAY MERIDIAN 90.00 Cross Foot A 91.00 Negative Cos 900 92.00 TOTAL (sum I) 1000	NIC I URGENT CARE djustments	0 0 0 0	0 26, 588 0 16, 382 0 837, 049		0 0 0 0 0	0 0 0 -34, 774 -34, 774		0 19 0 19 0 19 0 19 20 0 20 0 20 0 20	94.0 94.0 94.0 94.0 00.0

Health Financial Systems ALLOCATION OF CAPITAL RELATED COSTS	IU HEALTH JA	Y HOSPITAL Provider C	CN: 15-1320 P	In Lieu	u of Form CMS-: Worksheet B	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		FIOVICEIC	CN. 15-1520 FG Fi To	rom 01/01/2021	Part II Date/Time Pre	epared:
		CAP	ITAL RELATED CO	ISTS	5/27/2022 8:0	0 am
Cost Center Description	BLDG &	MVBLE EQUIP	MVBLE EQUIP -			
	FIXT-INTEREST 1.04	2.00	MOB 2.01	P0B 2. 02	WJ 2.03	
GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01 00101 CAP REL COSTS-BLDG & FIXT-MOB 1.02 00102 CAP REL COSTS-BLDG & FIXT-POB						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 2. 00 00200 CAP REL COSTS-MVBLE EQUIP						1.04 2.00
2. 01 00200 CAP REL COSTS-MVBLE EQUIP - MOB						2.00
2. 02 00202 CAP REL COSTS-MVBLE EQUI P - POB 2. 03 00203 CAP REL COSTS-MVBLE EQUI P - WJ						2.02 2.03
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	2, 581	0	0	0	
5. 00 00500 ADMINI STRATI VE & GENERAL 7. 00 00700 OPERATI ON OF PLANT	0	245, 566 424, 587		0	0	
7.01 00701 OPERATION OF PLANT - MOB	0	424, 307		Ō	0	7.01
7. 02 00702 OPERATION OF PLANT - POB 7. 03 00703 OPERATION OF PLANT - WJ	0	0	-	0	0	
8.00 00800 LAUNDRY & LINEN SERVICE	0	13, 565	0	Ō	0	8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	0	13, 702 56, 248	-	0	0	
11. 00 01100 CAFETERI A	0	41, 312	0	Ö	0	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY	0	25, 326 0		0	0	
15.00 01500 PHARMACY	0	22, 837	0	0	0	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE	0	0		0	0	
INPATIENT ROUTINE SERVICE COST CENTERS		225 050				20.00
30. 00 03000 ADULTS & PEDI ATRI CS 40. 00 04000 SUBPROVI DER – I PF	0	225, 059 0		0	0 0	
43. 00 04300 NURSERY	0	0	0 0	0	0	43.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 0PERATI NG ROOM	0	91, 165	1, 336	0	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	0	0		0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	114, 048	-	0	0	
60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY	0	59, 719 16, 694		0	0	
66. 00 06600 PHYSI CAL THERAPY	0	73, 878	0	0	0	66.00
67.00 06700 0CCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY	0	13, 405 434		0	0	
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73.00
76. 00 03160 CARDI OPULMONARY OUTPATI ENT SERVI CE COST CENTERS	0	0	2,214	0	0	76.00
90. 00 09000 CLINIC 90. 01 09001 FAMILY PRACTICE OF JAY COUNTY	0	0	0	0 0	0	
90.02 09002 JAY FAMILY MEDICINE	0	0	12, 756 12, 467	0	0	
90. 03 09003 WOUND CLINIC 90. 04 09004 0P ORTHO CLINIC	0	0	0	0	0	
90.05 09005 JAY FAMILY FIRST HEALTH CARE	0	88, 334	-	0	0	
90. 06 09006 INFUSION CLINIC 90. 07 09007 HEALTH BEGINNINGS PROGRAM	0	14, 113 71, 754		0	0	
91.00 09100 EMERGENCY	0	108, 933		0	0	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 93. 00 04950 OUTPATI ENT PSYCH	0	35, 877	0	o	0	92.00 93.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	0	1, 759, 137	31, 774	0	0	118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	17, 607		0		190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 193. 00 19300 NONPALD WORKERS	0	0 0	0	0 0		192.00 193.00
194. 00 07950 VACANT	0	59, 490	0	0	0	194.00 194.02
194. 02 07952 WEST_JAY_CLINIC 194. 03 07953 JAY_MERIDIAN_URGENT_CARE	0	0 36, 653	0	0		194.03
200.00Cross Foot Adjustments201.00Negative Cost Centers	_	0		0	0	200. 00 201. 00
201.00 TOTAL (sum lines 118 through 201)	0	1, 872, 887	31, 774	0		201.00

Heal th	Financial Systems	IU HEALTH JA	Y HOSPI TAL		In Lieu	」of Form CMS-2	2552-10
	TION OF CAPITAL RELATED COSTS		Provi der CC	F	eriod: rom 01/01/2021 o 12/31/2021	Worksheet B Part II Date/Time Pre 5/27/2022 8:0	pared:
	Cost Center Description	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	ADMI NI STRATI V E & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT - MOB	
		2A	4.00	5.00	7.00	7.01	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT				1		1.00
$\begin{array}{c} 1. \ 01\\ 1. \ 02\\ 1. \ 03\\ 1. \ 04\\ 2. \ 00\\ 2. \ 01\\ 2. \ 02\\ 2. \ 03\\ 4. \ 00\\ 5. \ 00\\ 7. \ 01\\ 7. \ 02\\ 7. \ 03\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 16. \ 00\\ 17. \ 00\\ 17. \ 00\\ \end{array}$	00100CAPRELCOSTS-BLDG & FIXT-MOB00101CAPRELCOSTS-BLDG & FIXT-MOB00102CAPRELCOSTS-BLDG & FIXT-WJ00104CAPRELCOSTS-BLDG & FIXT-INTEREST00200CAPRELCOSTS-MVBLEEQUI P00201CAPRELCOSTS-MVBLEEQUI P00202CAPRELCOSTS-MVBLEEQUI P00203CAPRELCOSTS-MVBLEEQUI P00400EMPLOYCEBENEFITSDEPARTMENT00500ADMI NI STRATI VE & GENERAL00700OPERATI ON OF00701OPERATI ON OFPLANTMOB00702OPERATI ON OFPLANTPOB00703OPERATI ON OFPLANTPUJ00800LAUNDRY & LI NENSERVI CE0090001000DI ETARY01100CAFETERI A01300NURSI NGADMI NI STRATI ON0140001400CENTRALSERVI CES & SUPPLY01500PHARMACY0170001600MEDI CALRECORDS & LI BRARY01700SOCI ALSERVI CEINPATI ENTROUTI NESERVI CEINPATI ENTROUTI NESERVI CE	3, 734 357, 390 614, 346 724 0 19, 628 19, 826 81, 387 59, 776 36, 645 0 33, 044 0 0	3, 734 125 180 0 0 11 107 59 43 391 0 169 0 0	357, 515 54, 510 624 870 2, 179 8, 625 7, 302 4, 377 26, 753 9, 790 16, 525 0 0	669, 036 3, 852 4, 776 0 4, 613 4, 659	5, 200 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 1. \ 01 \\ 1. \ 02 \\ 1. \ 03 \\ 1. \ 04 \\ 2. \ 00 \\ 2. \ 01 \\ 2. \ 02 \\ 2. \ 03 \\ 4. \ 00 \\ 5. \ 00 \\ 7. \ 00 \end{array}$
30.00 40.00 43.00	03000 ADULTS & PEDIATRICS 04000 SUBPROVIDER - IPF 04300 NURSERY	325, 645 0 0	581 0 0	36, 279 C C	0	0 0 0	30.00 40.00 43.00
50.00	ANCI LLARY SERVICE COST CENTERS	400.04/	050	44.440	07.000	0.40	50.00
	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 IMPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS	133, 246 0 0 165, 019 86, 409 24, 155 106, 896 19, 396 628 0 0 0 0 0	253 0 2900 3 137 164 30 6 0 0 0 0 0 0		5, 677 25, 121 4, 558 148 0 0 0 0	240 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	
76.00	03160 CARDI OPULMONARY OUTPATI ENT SERVI CE COST CENTERS	2, 214	49	3, 796	11, 772	397	76.00
90. 01 90. 02 90. 03 90. 04 90. 05 90. 06	09000 CLINIC 09001 FAMILY PRACTICE OF JAY COUNTY 09002 JAY FAMILY MEDICINE 09003 WOUND CLINIC 09004 OP ORTHO CLINIC 09005 JAY FAMILY FIRST HEALTH CARE 09006 INFUSION CLINIC 09007 HEALTH BEGINNINGS PROGRAM 09100 EMERGENCY	0 12, 756 12, 467 0 0 128, 017 20, 421 103, 823 157, 618	0 219 233 0 0 110 36 85 407	0 12, 028 12, 700 0 7, 703 2, 197 5, 728 27, 717	67, 816 66, 286 0 0 31, 124 4, 799	0 2, 289 2, 237 0 0 37 0 0 0 0	90.00 90.01 90.02 90.03 90.04 90.05 90.06 90.07 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	-07	21,111	57, 041	0	92.00
	04950 OUTPATIENT PSYCH	51, 911	12	1, 233	12, 200	0	
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	2, 577, 121	3, 700	353, 051	581, 829	5, 200	118.00
192.00 193.00 194.00 194.02	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 19300 NONPAID WORKERS 07950 VACANT 07952 WEST JAY CLINIC	25, 476 0 86, 078 0 53, 035	0 34 0 0 0	354 2, 203 0 1, 180 0 727	48, 527 0 20, 229 0	0 0 0 0	190.00 192.00 193.00 194.00 194.02 194.03
194. 03 200. 00	07953 JAY MERIDIAN URGENT CARE Cross Foot Adjustments	53, 035 0	0	727	12, 464	0	200.00
201.00 202.00	Negative Cost Centers	-34, 774 2, 706, 936	0 3, 734	0 357, 515	0 669, 036		201. 00 202. 00

Health Financial Systems	IU HEALTH JA	Y HOSPI TAL		In Lieu	ı of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		eriod: rom 01/01/2021	Worksheet B Part II	
			Te		Date/Time Pre 5/27/2022 8:0	pared:
Cost Center Description	OPERATION OF	OPERATI ON OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	PLANT - POB 7.02	<u>PLANT - WJ</u> 7.03	LINEN SERVICE 8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS			0.00		10100	
1. 00 00100 CAP REL COSTS-BLDG & FIXT 1. 01 00101 CAP REL COSTS-BLDG & FIXT-MOB						1.00 1.01
1.02 00102 CAP REL COSTS-BLDG & FIXT-POB						1.02
1. 03 00103 CAP REL COSTS-BLDG & FIXT-WJ 1. 04 00104 CAP REL COSTS-BLDG & FIXT-INTEREST						1.03 1.04
2.00 00200 CAP REL COSTS-BLDG & FIXT-INTEREST						2.00
2.01 00201 CAP REL COSTS-MVBLE EQUIP - MOB						2.01
2. 02 00202 CAP REL COSTS-MVBLE EQUIP - POB 2. 03 00203 CAP REL COSTS-MVBLE EQUIP - WJ						2.02 2.03
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMINI STRATI VE & GENERAL 7. 00 00700 OPERATI ON OF PLANT						5.00 7.00
7.01 00701 OPERATION OF PLANT - MOB						7.01
7. 02 00702 OPERATION OF PLANT - POB 7. 03 00703 OPERATION OF PLANT - WJ	5, 646 0	0				7.02 7.03
8. 00 00800 LAUNDRY & LI NEN SERVICE	0	0	26, 431			8.00
9. 00 00900 HOUSEKEEPI NG	0	0		33, 217	100 050	9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	0	0	-	976 717	108, 850 0	10.00
13.00 01300 NURSING ADMINISTRATION	0	0		439	0	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 01500 PHARMACY	0	0	, i i i i i i i i i i i i i i i i i i i	0 396	0	14.00 15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0		0	0	16.00
17. 00 01700 SOCI AL SERVI CE I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0	0	0	0	17.00
30. 00 03000 ADULTS & PEDI ATRI CS	0	0		3, 904	108, 850	30.00
40. 00 04000 SUBPROVI DER – I PF 43. 00 04300 NURSERY	0	0 0		0	0	40.00 43.00
ANCILLARY SERVICE COST CENTERS					0	43.00
50.00 05000 0PERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	4, 051 0	0		4, 476 0	0	50.00 52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	0	0		1, 978 1, 036	0	54.00 60.00
65. 00 06500 RESPIRATORY THERAPY	0	0		290	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	-	1, 282	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY	0	0 0	0	233 8	0	67.00 68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	0	0	69.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 72.00 07200 I MPL. DEV. CHARGED TO PATI ENTS	0	0	0	0	0	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73.00
76. 00 03160 CARDI OPULMONARY OUTPATI ENT SERVI CE COST CENTERS	0	0	0	601	0	76.00
90. 00 09000 CLINIC	0	0		0	0	90.00
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY 90. 02 09002 JAY FAMILY MEDICINE	0	0		3, 460 3, 382	0 0	90.01 90.02
90. 03 09003 WOUND CLINIC	0	0	0	0	0	90.03
90. 04 09004 OP ORTHO CLINIC 90. 05 09005 JAY FAMILY FIRST HEALTH CARE	0	0	-	0 1, 588	0	90.04 90.05
90. 06 09006 INFUSION CLINIC	0	0	0	245	0	90.05
90. 07 09007 HEALTH BEGI NNI NGS PROGRAM	0	0	-	1, 245	0	90.07
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1, 890	0	91.00 92.00
93. 00 04950 OUTPATIENT PSYCH	0	0	0	622	0	93.00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	4,051	0	26, 431	28, 768	108, 850	118.00
NONREI MBURSABLE COST CENTERS	1 1		1			
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSICIANS' PRIVATE OFFICES	0 1, 595	0 0		305 2, 476		190.00 192.00
193.00 19300 NONPALD WORKERS	0	0	0	0	0	193.00
194.0007950 VACANT 194.0207952 WEST JAY CLINIC	0	0 0	-	1, 032 0		194.00 194.02
194. 03 07953 JAY MERI DI AN URGENT CARE	0	0		636		194.03
200.00Cross Foot Adjustments201.00Negative Cost Centers		0		о	0	200. 00 201. 00
202.00 TOTAL (sum lines 118 through 201)	5, 646	0			108, 850	

Heal th	Financial Systems	IU HEALTH JA	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CC	F	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part II Date/Time Pre 5/27/2022 8:0	pared: 0 am
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI O N	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	
		11.00	13.00	14.00	15.00	16.00	
1 00	GENERAL SERVICE COST CENTERS				1		1 00
$\begin{array}{c} 1.\ 00\\ 1.\ 01\\ 1.\ 02\\ 1.\ 03\\ 1.\ 04\\ 2.\ 00\\ 2.\ 01\\ 2.\ 02\\ 2.\ 03\\ 4.\ 00\\ 5.\ 00\\ 7.\ 00\\ 7.\ 00\\ 7.\ 00\\ 7.\ 00\\ 7.\ 00\\ 7.\ 00\\ 7.\ 00\\ 7.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$	00100CAPRELCOSTS-BLDG & FIXT00101CAPRELCOSTS-BLDG & FIXT-MOB00102CAPRELCOSTS-BLDG & FIXT-POB00103CAPRELCOSTS-BLDG & FIXT-WJ00104CAPRELCOSTS-BLDG & FIXT-INTEREST00200CAPRELCOSTS-MVBLE00201CAPRELCOSTS-MVBLE00201CAPRELCOSTS-MVBLE00202CAPRELCOSTS-MVBLE00203CAPRELCOSTS-MVBLE00203CAPRELCOSTS-MVBLE00203CAPRELCOSTS-MVBLE00203CAPRELCOSTS-MVBLE00203CAPRELCOSTS-MVBLE00203CAPRELCOSTS-MVBLE0020400EMPLOYEEBENEFITSDEPARTMENT005001OPERATION OFPLANTMOB00702OPERATION OFPLANT-00703OPERATION OFPLANT-00700HOUSEKEEPI NG01000DIE01100CAFETERI A01300NURSI NG01400CENTRALSERVI CES& SUPPLY01500PHARMACY01600MEDI CAL01600MEDI CALRECORDS & LIBRARY	78, 961 6, 836 0 2, 990 0	79, 676 0 0 0	9, 79(85	60, 974 0 0	0	$\begin{array}{c} 1.\ 00\\ 1.\ 01\\ 1.\ 02\\ 1.\ 03\\ 1.\ 04\\ 2.\ 00\\ 2.\ 01\\ 2.\ 02\\ 2.\ 03\\ 4.\ 00\\ 5.\ 00\\ 7.\ 00\\ 7.\ 01\\ 7.\ 02\\ 7.\ 03\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$
17.00	01700 SOCIAL SERVICE	0	0	(0 0	0	17.00
30.00	03000 ADULTS & PEDI ATRI CS	11, 483	25, 489	2, 21	476	0	30.00
40.00	04000 SUBPROVI DER – I PF	0	0	(0	40.00
43.00	04300 NURSERY	0	0	(0 0	0	43.00
50.00	ANCI LLARY SERVI CE COST CENTERS	5, 917	13, 410	1, 560	180	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	5, 917	13,410	1, 500		0	52.00
53.00	05300 ANESTHESI OLOGY	0	0	(-	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	6, 092	0	313	-	0	54.00
60.00	06000 LABORATORY	5, 635	Ő	201		0	60.00
65.00	06500 RESPI RATORY THERAPY	2, 455	0	427	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	2, 018	0	63	3 0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	763	0		2 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	107	0	(0 0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0	17		0	69.00
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0	1,632		0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	376		0	72.00
	07300 DRUGS CHARGED TO PATI ENTS 03160 CARDI OPULMONARY	0 1, 050	64	36		0	
70.00	OUTPATIENT SERVICE COST CENTERS	1,030	04	50	4	0	70.00
90.00	09000 CLINIC	0	0	(0 0	0	90.00
90.01	09001 FAMILY PRACTICE OF JAY COUNTY	8, 192	4, 919	486	6 O	0	90.01
	09002 JAY FAMILY MEDICINE	8, 868	6, 441	420	0 0	0	90.02
90.03	09003 WOUND CLINIC	0	0	(0	90.03
90.04	09004 OP ORTHO CLINIC	0	0	(-	0	90.04
90. 05 90. 06	09005 JAY FAMILY FIRST HEALTH CARE	3, 875	2,612	147		0	90.05 90.06
	09006 I NFUSI ON CLI NI C 09007 HEALTH BEGI NNI NGS PROGRAM	627 2, 305	2, 035 4, 182	52 15		0	90.08
	09100 EMERGENCY	7, 356		1, 715		0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	,,	20,021	.,,,,,	.,	Ū	92.00
	04950 OUTPATIENT PSYCH	1, 113	0	Ę	5 0	0	
	SPECIAL PURPOSE COST CENTERS						1
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	77, 682	79, 676	9, 763	60, 974	0	118.00
190. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(0	0	190.00
	19200 PHYSI CLANS' PRI VATE OFFICES	1, 279		27			192.00
	19300 NONPAI D WORKERS	0	0	(193.00
194.00	07950 VACANT	0	0	(0 0		194.00
	07952 WEST JAY CLINIC	0	0	(0 0		194.02
	07953 JAY MERIDIAN URGENT CARE	0	0	(0	0	194.03
200.00 201.00		~		,		0	200. 00 201. 00
201.00	5	0 78, 961	0 79, 676	9, 790	60,974		201.00
202.00		70, 701	1 77,070	7, 190	00,774	0	202.00

near th	Financial Systems	IU HEALTH JA	Y HOSPI TAL		In Lie	u of Form CMS-2	552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CO	CN: 15-1320	Period: From 01/01/2021	Worksheet B Part II	
					To 12/31/2021	Date/Time Prep 5/27/2022 8:00	
	Cost Center Description	SOCI AL SERVI CE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments		1372172022 0.00	
		17.00	24.00	25.00	26.00		
	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
$\begin{array}{c} 1. \ 01 \\ 1. \ 02 \\ 1. \ 03 \\ 1. \ 04 \\ 2. \ 00 \\ 2. \ 01 \\ 2. \ 02 \\ 2. \ 03 \\ 4. \ 00 \\ 5. \ 00 \\ 7. \ 00 \\ 7. \ 01 \\ 7. \ 02 \\ 7. \ 03 \\ 8. \ 00 \\ 9. \ 00 \\ 10. \ 00 \\ 11. \ 00 \\ 13. \ 00 \\ 14. \ 00 \\ 15. \ 00 \\ 15. \ 00 \\ 16. \ 00 \end{array}$	00101 CAP REL COSTS-BLDG & FIXT-MOB 00102 CAP REL COSTS-BLDG & FIXT-POB 00103 CAP REL COSTS-BLDG & FIXT-WJ 00104 CAP REL COSTS-BLDG & FIXT-INTEREST 00200 CAP REL COSTS-MVBLE EQUIP 00201 CAP REL COSTS-MVBLE EQUIP - MOB 00202 CAP REL COSTS-MVBLE EQUIP - POB 00203 CAP REL COSTS-MVBLE EQUIP - WJ 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00701 OPERATION OF PLANT - MOB 00702 OPERATION OF PLANT - MOB 00703 OPERATION OF PLANT - WJ 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY						$\begin{array}{c} 1.01\\ 1.02\\ 1.03\\ 1.04\\ 2.00\\ 2.01\\ 2.02\\ 2.03\\ 4.00\\ 5.00\\ 7.00\\ 7.00\\ 7.00\\ 7.00\\ 7.00\\ 7.00\\ 7.00\\ 7.00\\ 10.00\\ 10.00\\ 11.00\\ 13.00\\ 13.00\\ 14.00\\ 15.00\\ 16.00\\ \end{array}$
	01700 SOCIAL SERVICE	0					17.00
	03000 ADULTS & PEDIATRICS	0	617, 878		0 617, 878		30.00
	04000 SUBPROVI DER – I PF 04300 NURSERY	0 0	0		0 0 0 0		40.00 43.00
	ANCI LLARY SERVI CE COST CENTERS	0	0		0		45.00
52.00	05000 OPERATI NG ROOM 05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0	267, 295 0 0		0 267, 295 0 0 0 0		50.00 52.00 53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	232, 565		0 232, 565		54.00
	06000 LABORATORY 06500 RESPI RATORY THERAPY	0	141, 257 41, 193		0 141, 257 0 41, 193		60.00 65.00
	06600 PHYSI CAL THERAPY	0	146, 604		0 146, 604		66. 00
	06700 OCCUPATI ONAL THERAPY	0	26, 754		0 26, 754		67.00
	06800 SPEECH PATHOLOGY	0	1, 207		0 1, 207		68.00
	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	30 2, 917		0 30 0 2,917		69.00 71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	2,917 672		0 2,917		72.00
	07300 DRUGS CHARGED TO PATIENTS	0	84, 158		0 84, 158		73.00
	03160 CARDI OPULMONARY	0	19, 983		0 19, 983		76.00
	OUTPATIENT SERVICE COST CENTERS	0	0	1	0 0		90.00
	09000 CEINIC 09001 FAMILY PRACTICE OF JAY COUNTY	0	0 112, 165		0 112, 165		90.00 90.01
	09002 JAY FAMILY MEDICINE	0	113, 034		0 113,034		90.02
	09003 WOUND CLINIC	0	0		0 0		90.03
	09004 OP ORTHO CLINIC	0	0		0 0		90.04
	09005 JAY FAMILY FIRST HEALTH CARE 09006 INFUSION CLINIC	0	175, 213 30, 607		0 175, 213 0 30, 607		90. 05 90. 06
	09007 HEALTH BEGINNINGS PROGRAM	0	141, 787		0 141, 787		90.00 90.07
	09100 EMERGENCY	0	255, 651		0 255, 651		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
	04950 OUTPATIENT PSYCH	0	67, 096		0 67,096		93.00
	SPECIAL PURPOSE COST CENTERS	0	2 479 044		0 2, 478, 066		110 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	U	2, 478, 066	I	0 2, 478, 066		118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	32, 122		0 32, 122		190.00
	19200 PHYSICIANS' PRIVATE OFFICES	0	56, 141		0 56, 141		192.00
	19300 NONPAI D WORKERS 07950 VACANT	0	0 108, 519		0 0 0 108, 519		193.00 194.00
	07950 VACANI 07952 WEST JAY CLINIC	0	108, 519		0 108, 519		194.00 194.02
	07953 JAY MERI DI AN URGENT CARE	0	66, 862		0 66, 862		194.02
200.00	Cross Foot Adjustments		0		0 0		200.00
201.00		0	-34, 774		0 -34, 774		201.00
202.00	TOTAL (sum lines 118 through 201)	0	2, 706, 936	l	0 2, 706, 936		202.00

OST A	Financial Systems NLLOCATION - STATISTICAL BASIS	IU HEALTH JA'	Provider CC	CN: 15-1320	Peri od:	u of Form CMS-2 Worksheet B-1	
					From 01/01/2021 To 12/31/2021	Date/Time Pre	
			CAPI	TAL RELATED (COSTS	5/27/2022 8:0	<u> </u>
	Cost Center Description	BLDG & FIXT	BLDG &	BLDG &	BLDG &	BLDG &	
		(SQUARE FEET)	FI XT-MOB	FI XT-POB	FIXT-WJ	FIXT-INTEREST	
			(SQUARE FEET-MOB)	(SQUARE FEET-POB)	(SQUARE FEET-WJ)	(SQUARE FEET)	
	OFNERAL CERVILOF COCT OFNITERC	1.00	1.01	1.02	1.03	1.04	
. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	82, 011					1 1.0
. 01	00101 CAP REL COSTS-BLDG & FIXT-MOB	0	21, 755				1. (
. 02 . 03	00102 CAP REL COSTS-BLDG & FIXT-POB 00103 CAP REL COSTS-BLDG & FIXT-WJ	0	0	9, 53	8 0 3, 728		1.
. 03	00104 CAP REL COSTS-BLDG & FIXT-INTEREST	0	0		0 0	82, 011	
. 00	00200 CAP REL COSTS-MVBLE EQUIP						2.
. 01 . 02	00201 CAP REL COSTS-MVBLE EQUIP - MOB 00202 CAP REL COSTS-MVBLE EQUIP - POB						2. 2.
. 03	00203 CAP REL COSTS-MVBLE EQUIP - WJ						2.
. 00 . 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	113 10, 753	0 1, 419			113 10, 753	
. 00	00700 OPERATION OF PLANT	18, 592	0		0 0	18, 592	
. 01 . 02	00701 OPERATION OF PLANT - MOB 00702 OPERATION OF PLANT - POB	0	496 0	61	5 O	0	
. 02 . 03	00703 OPERATION OF PLANT - POB	0	0		0 0	0	
. 00	00800 LAUNDRY & LINEN SERVICE	594	0		0 0	594	
. 00 0. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	600 2, 463	0			600 2, 463	
1.00	01100 CAFETERI A	1, 809	0		0 0	1, 809	11.
3.00 4.00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	1, 109	0			1, 109 0	1
	01500 PHARMACY	1,000	0		0 0	1,000	
	01600 MEDICAL RECORDS & LIBRARY	0	0		0 0	0	
7.00	01700 SOCIAL SERVICE	0	0		0 0	0	17.
0. 00	03000 ADULTS & PEDI ATRI CS	9, 855	0		0 0	9, 855	
0.00 3.00	04000 SUBPROVI DER – I PF 04300 NURSERY	0	0			0	
5.00	ANCI LLARY SERVICE COST CENTERS						
0.00 2.00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	3, 992 0	915 0	6, 40	2 0	3, 992 0	
3.00	05300 ANESTHESI OLOGY	0	0		0	0	
4.00	05400 RADI OLOGY-DI AGNOSTI C	4, 994	0		0 0	4, 994	
0.00 5.00	06000 LABORATORY 06500 RESPI RATORY THERAPY	2, 615 731	0			2, 615	
6.00	06600 PHYSI CAL THERAPY	3, 235	Ö		0 0	3, 235	66.
7.00 8.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	587 19	0			587	
	06900 ELECTROCARDI OLOGY	0	0		0 0	0	
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	
	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0			0	
	03160 CARDI OPULMONARY	0	1, 516		0 0	0	
0. 00	OUTPATIENT SERVICE COST CENTERS	0	0		0 0	0	90.
	09001 FAMILY PRACTICE OF JAY COUNTY	0	8, 733		0	0	
	09002 JAY FAMILY MEDICINE	0	8, 536			0	
	09003 WOUND CLINIC 09004 OP ORTHO CLINIC	0	0			0	
0. 05	09005 JAY FAMILY FIRST HEALTH CARE	3, 868	140		0 0	3, 868	
0. 06 0. 07	09006 INFUSION CLINIC 09007 HEALTH BEGINNINGS PROGRAM	618 3, 142	0			618 3, 142	
1.00	09100 EMERGENCY	4, 770	0		0 0	4, 770	
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1 571	0		0	1 571	92.
3.00	04950 OUTPATIENT PSYCH SPECIAL PURPOSE COST CENTERS	1, 571	0		<u> </u>	1, 571	93.
18.00		77, 030	21, 755	7, 01	7 0	77, 030	118.
90.00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	771	0		0 0	771	190.
92.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	2, 52	1 3, 728	0	192.
	19300 NONPAI D WORKERS 07950 VACANT	0 2, 605	0			0 2,605	193. 194.
94.02	07952 WEST JAY CLINIC	0	0			0	194.
	07953 JAY MERIDIAN URGENT CARE	1, 605	0		0 0	1, 605	
00. 00 01. 00							200. 201.
02.00	Cost to be allocated (per Wkst. B,	837, 049	0	-34, 77	4 O	0	202.
	Part I)	10. 206545					1

Health Fir	nancial Systems	IU HEALTH JA	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLO	CATION - STATISTICAL BASIS				Period: From 01/01/2021	Worksheet B-1	
					To 12/31/2021	Date/Time Pre 5/27/2022 8:0	
			CAP	ITAL RELATED	COSTS		
	Cost Center Description	BLDG & FIXT	BLDG &	BLDG &	BLDG &	BLDG &	
		(SQUARE FEET)	FI XT-MOB	FI XT-POB	FIXT-WJ	FIXT-INTEREST	
			(SQUARE	(SQUARE	(SQUARE	(SQUARE FEET)	
			FEET-MOB)	FEET-POB)	FEET-WJ)		
		1.00	1.01	1.02	1.03	1.04	
204.00	Cost to be allocated (per Wkst. B, Part II)						204.00
205.00	Unit cost multiplier (Wkst. B, Part						205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

To 12/231/2021 Dute/Time Cost Center Description Contral ReLATED Costs PROFECTION PROFECTION Cost Center Description WIRLE COUP - MOBE COUPE - MOBE COUPE - POB COUNTER COST - RUG & FIXT-000 PROFECTION - MOBE COUPE - M		Financial Systems LLOCATION - STATISTICAL BASIS	IU HEALTH JA	Provi der C		Peri od:	u of Form CMS-2 Worksheet B-1	
Const. Center: Description Center: Description Center: Description Center: Description Center: Description PRIONEE Center: Center: Description 1 Construct: Center: Cent						From 01/01/2021 To 12/31/2021		
Control Control POIL (SUMARE FEEL-MAR) POIL (SUMARE FEEL-MAR) POIL (SUMARE FEEL-MAR) POIL (SUMARE FEEL-MAR) POIL (SUMARE FEEL-MAR) 1 0 0 0 2.00 2.01 2.02 2.02 3.00 1.01 0 0 0.05 0.05 3.00 3.00 1.01 0 0 0.05 0.05 3.00 3.00 3.00 1.01 0 0.05 0.05 3.17 3.00 <td></td> <td></td> <td></td> <td>CAPI TAL REI</td> <td>LATED COSTS</td> <td></td> <td>572772022 8.0</td> <td></td>				CAPI TAL REI	LATED COSTS		572772022 8.0	
Image: Constraint of the		Cost Center Description		MOB (SQUARE	POB (SQUARE	WJ (SQUARE	BENEFI TS DEPARTMENT (GROSS	
1.00 00100 CAP REL COSTS-BLOG & FIXT			2.00	2.01	2.02	2.03	,	
1.01 0101 CAP REL 005TS-ELDG & FIXT-NOB			l	1	1		l	
30.00 30.00 <th< td=""><td>$\begin{array}{c} 1. \ 01 \\ 1. \ 02 \\ 1. \ 03 \\ 1. \ 04 \\ 2. \ 00 \\ 2. \ 01 \\ 2. \ 02 \\ 2. \ 03 \\ 4. \ 00 \\ 5. \ 00 \\ 7. \ 01 \\ 7. \ 01 \\ 7. \ 02 \\ 7. \ 03 \\ 8. \ 00 \\ 9. \ 00 \\ 10. \ 00 \\ 11. \ 00 \\ 13. \ 00 \\ 13. \ 00 \\ 14. \ 00 \\ 15. \ 00 \\ 16. \ 00 \end{array}$</td><td>00101 CAP REL COSTS-BLDG & FIXT-MOB 00102 CAP REL COSTS-BLDG & FIXT-POB 00103 CAP REL COSTS-BLDG & FIXT-WJ 00104 CAP REL COSTS-BLDG & FIXT-INTEREST 00200 CAP REL COSTS-MVBLE EQUIP - MOB 00201 CAP REL COSTS-MVBLE EQUIP - MOB 00202 CAP REL COSTS-MVBLE EQUIP - POB 00203 CAP REL COSTS-MVBLE EQUIP - WJ 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT - MOB 00702 OPERATION OF PLANT - MOB 00703 OPERATION OF PLANT - POB 00703 OPERATION OF PLANT - POB 00703 OPERATION OF PLANT - WJ 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY</td><td>0 0 113 10, 753 18, 592 0 0 0 0 594 600 2, 463 1, 809 1, 109 0 1, 000 0</td><td>21, 755 0 0 0 0 1, 419 0 496 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0</td><td>9, 53 (((((((((((((((((((</td><td>0 3, 728 0 0</td><td>11, 526, 084 385, 010 554, 883 0 0 33, 182 331, 261 180, 587</td><td>$\begin{array}{c} 5.\ 00\\ 7.\ 00\\ 7.\ 01\\ 7.\ 02\\ 7.\ 03\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$</td></th<>	$\begin{array}{c} 1. \ 01 \\ 1. \ 02 \\ 1. \ 03 \\ 1. \ 04 \\ 2. \ 00 \\ 2. \ 01 \\ 2. \ 02 \\ 2. \ 03 \\ 4. \ 00 \\ 5. \ 00 \\ 7. \ 01 \\ 7. \ 01 \\ 7. \ 02 \\ 7. \ 03 \\ 8. \ 00 \\ 9. \ 00 \\ 10. \ 00 \\ 11. \ 00 \\ 13. \ 00 \\ 13. \ 00 \\ 14. \ 00 \\ 15. \ 00 \\ 16. \ 00 \end{array}$	00101 CAP REL COSTS-BLDG & FIXT-MOB 00102 CAP REL COSTS-BLDG & FIXT-POB 00103 CAP REL COSTS-BLDG & FIXT-WJ 00104 CAP REL COSTS-BLDG & FIXT-INTEREST 00200 CAP REL COSTS-MVBLE EQUIP - MOB 00201 CAP REL COSTS-MVBLE EQUIP - MOB 00202 CAP REL COSTS-MVBLE EQUIP - POB 00203 CAP REL COSTS-MVBLE EQUIP - WJ 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT - MOB 00702 OPERATION OF PLANT - MOB 00703 OPERATION OF PLANT - POB 00703 OPERATION OF PLANT - POB 00703 OPERATION OF PLANT - WJ 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0 0 113 10, 753 18, 592 0 0 0 0 594 600 2, 463 1, 809 1, 109 0 1, 000 0	21, 755 0 0 0 0 1, 419 0 496 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9, 53 (((((((((((((((((((0 3, 728 0 0	11, 526, 084 385, 010 554, 883 0 0 33, 182 331, 261 180, 587	$\begin{array}{c} 5.\ 00\\ 7.\ 00\\ 7.\ 01\\ 7.\ 02\\ 7.\ 03\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$
40.00 0adoo 0adoo 0ado 0ado 40.00 0stration 0stratiostration 0stration <		INPATIENT ROUTINE SERVICE COST CENTERS	~	-		-	· · ·	
43.00 O O O O ANCILLARY SERVICE COST CENTERS 3.992 915 6,402 0 781.7 52.00 05200 DELIVERY ROM & LABOR ROM 0					1			1
ANCL LARY SERVICE COST CENTERS								1
52:00 OS200 DELIVERY ROM & LABOR ROM 0 0 0 53:00 OS300 ANESTHESIOLOGY 0 0 0 54:00 OS400 RADIOLOGY-DI AGNOSTI C 4,994 0 0 0 66:00 06000 RESPIRATORY 2,615 0 0 2433. 66:00 06500 RESPIRATORY THERAPY 731 0 0 923. 76:00 0500 CUTONAL THERAPY 3,235 0 0 92.3 66:00 06000 PEECH PATHOLOGY 19 0 0 92.3 67:00 0700 CULPATIONAL THERAPY 0 0 0 0 18.4 70:00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 71:00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 70:00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 <td>+</td> <td></td> <td>1</td> <td></td> <td></td> <td></td> <td>1</td> <td></td>	+		1				1	
53.00 OS300 ANESTHESI OLOGY 0 0 0 54.00 OS400 RADIOLOGY-DIAGNOSTI C 4,994 0 0 0 894,6 60.00 OG000 LABORATORY 2,615 0 0 0 423,2 66.00 OG000 PHSICAL THERAPY 731 0 0 0 504,7 67.00 OS000 SPEECH PATHOLOGY 19 0 0 0 2,2 68.00 O6000 SPEECH PATHOLOGY 19 0 0 0 18,4 69.00 OTOO MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 72.00 O7200 IMPL, DEV. CHARGED TO PATIENTS 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
54.00 05400 RADIOLOGY-DIAGNOSTIC 4,994 0 0 0894.8 60.00 06000 LABORATORY 2,615 0 0 0 8.6 60.00 06500 RESPI RATORY THERAPY 7.31 0 0 42.3.2 66.00 06500 RESPI RATORY THERAPY 3.235 0 0 0 62.3.2 66.00 00 0.0 0 0 0 0 2.2.3 66.00 00 0.0 0 0 0 0 9.2.3 66.00 0.00 0.0 0 0 0 0 9.2.3 66.00 0.00 0.0 0 0 0 0 0 9.2.3 7.00 0.00 0.00 0			0				0	
60.00 06000 LABORATORY 2, 615 0 0 0 423, 235 66.00 06600 PHYSI CAL THERAPY 3, 235 0 0 0 423, 235 67.00 06000 PHYSI CAL THERAPY 587 0 0 0 92, 335 68.00 06000 PECETROCARDIOLOGY 19 0 0 0 18, 4 69.00 06900 ELECTROCARDIOLOGY 0			4 994				894, 806	
65.00 06500 RESPI RATORY THERAPY 731 0 0 423.2 66.00 06600 PHYSI CAL THERAPY 3,235 0 0 0 504.7 76.00 06700 OCCUPATIONAL THERAPY 587 0 0 0 22.3 68.00 06800 SPEECH PATHOLOGY 19 0 0 0 18.4 69.00 6900 MODO 0 0 0 0 18.4 69.00 07000 MELL CHARGED TO PATIENTS 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 70.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 152.0 00.00 09000 CLINIC 0 8,733 0 0 677.4 90.00 09000 CLINIC 0 8,536 0 0 778.1 90.01 090001						0 0	8, 610	
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68:00 06800 SPEECH PATHOLOGY 19 0 0 0 18.4 69:00 06900 ELECTROCARDIOLOGY 0 <t< td=""><td></td><td></td><td></td><td></td><td></td><td>0 0</td><td>504, 725</td><td></td></t<>						0 0	504, 725	
69.00 64900 ELECTROCARDIOLOGY 0 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 72.00 77200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 001700 MEUGS CHARGED TO PATIENTS 0 0 0 0 0160 CARDI OPULMONARY 0 1,516 0 0 0 01700 MEON TERVICE COST CENTERS 0 0 0 0 0 90.00 09000 CLINIC 0 8,536 0 0 718,1 90.01 09000 FAMILY MEDICINE 0 8,536 0 0 0 0 90.03 WOUND CLINIC 0						0 0	92, 328	
71:00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 72:00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 73:00 70300 RGS CHARGED TO PATIENTS 0 0 0 0 00 03160 CARDI OPULMONARY 0 1,516 0 0 152,00 00 09000 CLINIC 0 0 0 0 0 152,00 00.01 09001 FAMILY PRACTICE OF JAY COUNTY 0 8,733 0 0 677,4 90.02 09002 LINIC 0 0 0 0 0 0 0 0 718,1 90.02 09002 JAY FAMILY MEDICINE 0	68.00	06800 SPEECH PATHOLOGY	19	0	(0 0	18, 466	68.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 73.00 DRUGS CHARGED TO PATIENTS 0 <td></td> <td></td> <td>0</td> <td>0 0</td> <td></td> <td>0 0</td> <td>0</td> <td></td>			0	0 0		0 0	0	
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OUTPATI ENT SERVICE COST CENTERS 90.00 09000 CLINIC 0 0 0 90.01 09001 FAMI LY PRACTICE OF JAY COUNTY 0 8,733 0 0 90.02 JAY FAMI LY MEDICINE 0 8,536 0 0 718,1 90.03 09003 WOUND CLINIC 0 0 0 0 0 90.04 0PORD FAMI LY FIRST MEALTH CARE 0 8,536 0 0 0 90.05 09005 JAY FAMI LY FIRST HEALTH CARE 3,868 140 0 0 339,9 90.06 09006 INFUSION CLINIC 618 0 0 109,9 90.07 09007 HEALTH BEGINNINGS PROGRAM 3,142 0 0 1262,2 91.00 09200 DBSERVATION BEDS (NON-DI STINCT PART 1,571 0 0 262,2 92.00 09200 DBSERVATION BEDS (NON-DI STINCT PART 1,571 0 0 35,6 93.00 04950 0UTPATIENT PSYCH 1,571			0	U 1 E14			152,004	
90.00 09000 CLINIC 0			0	۱, STO	9	0 0	152,000	1 70.00
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90.03 09003 WOUND CLINIC 0			0	8, 733		-	677, 447	
90.04 09004 0P ORTHO CLINIC 0 0 0 90.05 JAY FAMILY FIRST HEALTH CARE 3,868 140 0 0 339,9 90.06 09006 INFUSION CLINIC 618 0 0 0 2339,9 90.07 09007 HEALTH BEGINNINGS PROGRAM 3,142 0 0 0 262,2 91.00 09100 EMERGENCY 4,770 0 0 0 1,256,3 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART - - - - 93.00 04950 OUTPATIENT PSYCH 1,571 0 0 0 35,6 SPECIAL PURPOSE COST CENTERS TH8.00 SUBTOTALS (SUM OF LINES 1 through 117) 77,030 21,755 7,017 0 11,421,9 190.00 IFT, FLOWER, COFFEE SHOP & CANTEEN 771 0 0 0 0 0 0 192.00 19300 NONPAI D WORKERS 0 0 0 0 0 0 194.00 <td>90.02</td> <td>09002 JAY FAMILY MEDICINE</td> <td>0</td> <td>8, 536</td> <td></td> <td>0 0</td> <td>718, 163</td> <td>90.02</td>	90.02	09002 JAY FAMILY MEDICINE	0	8, 536		0 0	718, 163	90.02
90.05 09005 JAY FAMILY FIRST HEALTH CARE 3,868 140 0 0 339,9 90.06 09006 INFUSION CLINIC 618 0 0 109,9 90.07 09007 HEALTH BEGINNINGS PROGRAM 3,142 0 0 0 262,2 91.00 09100 EMERGENCY 4,770 0 0 0 1,256,3 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART			0	0 0		0 0	0	90.03
90.06 09006 INFUSION CLINIC 618 0 0 109, 9 90.07 09007 HEALTH BEGINNINGS PROGRAM 3, 142 0 0 262, 2 91.00 09100 EMERGENCY 4, 770 0 0 1, 256, 3 92.00 09200 DBSERVATION BEDS (NON-DISTINCT PART 1, 571 0 0 35, 6 93.00 04950 OUTPATIENT PSYCH 1, 571 0 0 35, 6 93.00 V9000 GIFT, ELOWSE COST CENTERS 111, 421, 9 11, 421, 9 11, 421, 9 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 77, 030 21, 755 7, 017 0 11, 421, 9 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 771 0 0 0 11, 421, 9 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 0 14, 1 193.00 19300 NONPAI D WORKERS 0 0 0 0 0 0 0 <td< td=""><td></td><td></td><td>0</td><td>0 0</td><td>(</td><td>0 0</td><td>0</td><td></td></td<>			0	0 0	(0 0	0	
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91.00 09100 EMERGENCY 4,770 0 0 1,256,3 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART 1,571 0 0 0 35,6 93.00 04950 0UTPATIENT PSYCH 1,571 0 0 0 35,6 SPECIAL PURPOSE COST CENTERS INONREI MBURSABLE COST CENTERS NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 771 0 0 0 192.00 19200 PHYSI CLANS' PRI VATE OFFICES 0 0 2,521 3,728 104,1 193.00 19300 NONPAID WORKERS 0 0 0 0 0 194.00 07950 VACANT 2,605 0 0 0 0 194.00 07950 VACANT 2,605 0 0 0 0 194.02 07952 WEST JAY CLINIC 0 0 0 0 0 200.00 Cross Foot Adjustments 1,605 0 0 0 0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td>0 0</td> <td>109,900</td> <td></td>						0 0	109,900	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 04950 0UTPATIENT PSYCH 1,571 0 0 35,6 93.00 04950 OUTPATIENT PSYCH 1,571 0 0 0 35,6 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 77,030 21,755 7,017 0 11,421,9 NONREI IBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 771 0 0 0 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 0 0 193.00 19300 NONPAI D WORKERS 0 0 0 0 0 0 194.02 07952 WEST JAY CLINIC 0 0 0 0 0 0 194.03 07953 JAY MERIDIAN URGENT CARE 1,605 0 0 0 0 0 200.00 Cross Foot Adjustments 1 605 0 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>262, 255</td> <td></td>							262, 255	
93.00 04950 0UTPATIENT PSYCH 1,571 0 0 35,6 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 77,030 21,755 7,017 0 11,421,9 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 771 0 0 0 11,421,9 190.00 19200 PHYSI CIANS' PRIVATE OFFICES 0 0 0 0 11,421,9 190.00 19200 PHYSI CIANS' PRIVATE OFFICES 0 0 0 0 0 19300 NONPAI D WORKERS 0			4,770			0 0	1, 200, 315	92.00
SPECIAL PURPOSE COST CENTERS SPECIAL PURPOSE COST CENTERS Contract Co			1.571	0		0 0	35, 631	1
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 77,030 21,755 7,017 0 11,421,9 NONREI MBURSABLE COST CENTERS			.,			<u> </u>	007001	10100
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 771 0 0 0 192.00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 2,521 3,728 104,1 193.00 19300 NONPAI D WORKERS 0 0 0 0 194.00 07950 VACANT 2,605 0 0 0 194.02 07952 WEST JAY CLINIC 0 0 0 0 194.03 07953 JAY MERI DI AN URGENT CARE 1,605 0 0 0 200.00 Cross Foot Adj ustments	118.00	SUBTOTALS (SUM OF LINES 1 through 117)	77,030	21, 755	7, 01	7 0	11, 421, 933]118.00
192.00 19200 PHYSI CLANS' PRI VATE OFFICES 0 2,521 3,728 104,1 193.00 19300 NONPAI D WORKERS 0 0 0 0 194.00 07950 VACANT 2,605 0 0 0 194.02 07952 WEST JAY CLINIC 0 0 0 0 194.03 07953 JAY MERIDIAN URGENT CARE 1,605 0 0 0 200.00 Cross Foot Adjustments								
193.00 19300 NONPAI D WORKERS 0 0 0 194.00 07950 VACANT 2,605 0 0 194.02 07952 WEST JAY CLINIC 0 0 0 194.03 07953 JAY MERIDIAN URGENT CARE 1,605 0 0 200.00 Cross Foot Adjustments 0 0 0					(0 0		190.00
194.00 07950 VACANT 2,605 0 0 0 194.02 07952 WEST JAY CLINIC 0 0 0 0 194.03 07953 JAY MERIDIAN URGENT CARE 1,605 0 0 0 200.00 Cross Foot Adjustments 0 0 0 0 0			0	0	2, 52	3, 728		
194.02 07952 WEST_JAY_CLINIC 0 0 0 0 194.03 07953 JAY_MERIDIAN_URGENT_CARE 1,605 0 0 0 200.00 Cross Foot_Adjustments 0 0 0 0			2 405					193.00 194.00
194. 03 07953 JAY MERIDIAN URGENT CARE 1,605 0 0 0 200. 00 Cross Foot Adjustments 1,605 0 0 0			2,000			0 n		194.00
200.00 Cross Foot Adjustments			1. 605			0 0		194.02
						1		200.00
		Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I) 1,872,887 31,774 0 0 2,188,7	202.00		1, 872, 887	31, 774		0 0	2, 188, 712	202.00

Health Fir	nancial Systems	IU HEALTH JA	Y HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COST ALLO	CATION - STATISTICAL BASIS				Period:	Worksheet B-1	
					From 01/01/2021 To 12/31/2021	Date/Time Pre 5/27/2022 8:0	
			CAPI TAL REI				
	Cost Center Description	MVBLE EQUIP	MVBLE EQUIP -	MVBLE EQUIP -	MVBLE EQUIP -	EMPLOYEE	
		(SQUARE FEET)	MOB	POB	WJ	BENEFI TS	
			(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)	22. 837022	1. 460538	0.00000	0. 000000	0. 189892	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)					3, 734	204.00
205.00	Unit cost multiplier (Wkst. B, Part					0. 000324	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

Health Financial Systems	IU HEALTH JA	AY HOSPI TAL		In Lieu	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		eriod: rom 01/01/2021	Worksheet B-1	
			Ť		Date/Time Pre 5/27/2022 8:0	
Cost Center Description	Reconciliatio	ADMI NI STRATI V	OPERATION OF	OPERATION OF	OPERATION OF	
	n	E & GENERAL (ACCUM. COST)	PLANT	PLANT - MOB	PLANT - POB (SQUARE	
		(ACCUM. CUST)	(SQUARE FEET)	(SQUARE FEET-MOB)	FEET-POB)	
	5A	5.00	7.00	7.01	7.02	
GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
1. 01 00101 CAP REL COSTS-BLDG & FIXT-MOB						1.00
1.02 00102 CAP REL COSTS-BLDG & FIXT-POB						1.02
1. 03 00103 CAP REL COSTS-BLDG & FIXT-WJ 1. 04 00104 CAP REL COSTS-BLDG & FIXT-INTEREST						1.03
2. 00 00200 CAP REL COSTS-BLDG & FIXT-INTEREST						2.00
2.01 00201 CAP REL COSTS-MVBLE EQUIP - MOB						2.01
2. 02 00202 CAP REL COSTS-MVBLE EQUIP - POB						2.02
2.03 00203 CAP REL COSTS-MVBLE EQUIP - WJ 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						2.03 4.00
5. 00 00500 ADMINI STRATI VE & GENERAL	-8, 397, 568	26, 077, 233				5.00
7.00 00700 OPERATION OF PLANT	0	3, 976, 262		10.040		7.00
7.01 00701 0PERATION OF PLANT - MOB 7.02 00702 0PERATION OF PLANT - POB	0	45, 496 63, 488		19, 840 0	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	158, 905		0	0	8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	0	629, 122 532, 589		0	0	9.00 10.00
11. 00 01100 CAFETERIA	0	319, 248		0	0	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	0	1, 951, 342		0	0	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY	0	714, 088 1, 205, 311		0	0	14.00 15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY	0	1, 203, 311	0	0	0	16.00
17. 00 01700 SOCI AL SERVI CE	0	0	0	0	0	17.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	0	2, 646, 136	9, 855	0	0	30.00
40. 00 04000 SUBPROVI DER - 1 PF	0			0	0	40.00
43. 00 04300 NURSERY	0	0	0	0	0	43.00
ANCI LLARY SERVI CE COST CENTERS	0	1, 177, 372	11, 309	915	6, 402	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	913	0, 402	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	0	1, 452, 143 2, 017, 977		0	0	54.00 60.00
65. 00 06500 RESPIRATORY THERAPY	0	587, 292		0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	806, 705		0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY	0	129, 256 22, 601	587	0	0	67.00 68.00
69. 00 06900 ELECTROCARDI OLOGY	0	909		0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	93, 761	0	0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0			0	0	72.00
75. 00 07500 DR0GS CHARGED TO PATTENTS 76. 00 03160 CARDI OPULMONARY	0			1, 516	0	
OUTPATIENT SERVICE COST CENTERS		1	1			
90.00 09000 CLINIC 90.01 09001 FAMILY PRACTICE OF JAY COUNTY	0	0	0 0	0	0	90.00 90.01
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY 90. 02 09002 JAY FAMILY MEDICINE	0	877, 314 926, 358		8, 733 8, 536	0	90.01
90. 03 09003 WOUND CLINIC	0	0	0	0	0	90.03
90. 04 09004 OP ORTHO CLINIC	0	0	0	0	0	90.04
90. 05 09005 JAY FAMILY FIRST HEALTH CARE 90. 06 09006 INFUSION CLINIC	0	561, 817 160, 217		140	0	90.05 90.06
90. 07 09007 HEALTH BEGI NNI NGS PROGRAM	0	417, 789		0	0	90.07
91.00 09100 EMERGENCY	0	2, 021, 660	4, 770	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 93.00 04950 OUTPATIENT PSYCH	0	89, 959	1, 571	o	0	92.00 93.00
SPECIAL PURPOSE COST CENTERS		07,737	1,371	0	0	75.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-8, 397, 568	25, 751, 658	74, 925	19, 840	6, 402	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	0	25, 803	771	o	0	190.00
190. 00 19000 GTFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSICIANS' PRIVATE OFFICES	0	160, 659		0		190.00
193.00 19300 NONPALD WORKERS	0	0	0	О	0	193.00
194.00 07950 VACANT 194.02 07952 WEST_JAY_CLINIC	0	86, 078	2,605	0		194.00 194.02
194. 02 07952 WEST JAY CLINIC 194. 03 07953 JAY MERIDIAN URGENT CARE	0	53, 035	1,605	0		194.02
200.00 Cross Foot Adjustments				-		200.00
201.00 Negative Cost Centers		0 207 540	5 254 720	00 410	101 /57	201.00
202.00 Cost to be allocated (per Wkst. B, Part I)		8, 397, 568	5, 256, 720	90, 410	121, 457	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)		0. 322027		4. 556956	13. 611678	
204.00 Cost to be allocated (per Wkst. B, Part II)		357, 515	669, 036	5, 200	5, 646	204.00
	1	I	1	I		<u> </u>

Heal th Fi	nancial Systems	IU HEALTH JA	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALL	OCATION - STATISTICAL BASIS		Provider C		Period: From 01/01/2021	Worksheet B-1	
					To 12/31/2021	Date/Time Pre 5/27/2022 8:0	
	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. 013710	7. 76549	2 0. 262097	0. 632747	205.00
206.00	II) NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	IU HEALTH JA		CN. 15 1220 D		J of Form CMS-	
CUST ALLUCATION - STATISTICAL BASIS		Provider C		eriod: com 01/01/2021 o 12/31/2021	Worksheet B-1 Date/Time Pre 5/27/2022 8:0	pared:
Cost Center Description	OPERATION OF PLANT - WJ (SQUARE	LAUNDRY & LI NEN SERVI CE (TOTAL	HOUSEKEEPING (SQUARE FEET)	DI ETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	
	FEET-WJ) 7.03	PATIENT DAYS) 8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.01 00101 CAP REL COSTS-BLDG & FIXT 1.02 00102 CAP REL COSTS-BLDG & FIXT-MOB 1.02 00103 CAP REL COSTS-BLDG & FIXT-POB 1.03 00103 CAP REL COSTS-BLDG & FIXT-WJ 1.04 00104 CAP REL COSTS-BLDG & FIXT-INTEREST 2.00 00200 CAP REL COSTS-MVBLE EQUI P 2.01 00201 CAP REL COSTS-MVBLE EQUI P MOB 2.02 00202 CAP REL COSTS-MVBLE EQUI P POB 2.03 00203 CAP REL COSTS-MVBLE EQUI P PUB 2.03 00202 CAP REL COSTS-MVBLE EQUI P WJ 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500	3, 728					1.00 1.01 1.02 1.03 1.04 2.00 2.01 2.02 2.03 4.00 5.00 7.00 7.01 7.02 7.03
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE	0 0 0 0 0 0 0 0 0 0	1,808 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	83, 850 2, 463 1, 809 1, 109 0 1, 000 0	8, 790 0 0 0 0 0 0 0	16, 241 1, 406 0 615 0 0	8.00 9.00 10.00 11.00 13.00 14.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS 40. 00 04000 SUBPROVI DER - I PF 43. 00 04300 NURSERY	0 0 0	1,808 0 0	0	8, 790 0 0	2, 362 0 0	30.00 40.00 43.00
ANCI LLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM	0	0	11, 309	0	1, 217	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM 53.00 05300 ANESTHESI OLOGY 3	0 0 0	0 0 0	0	0 0 0	0 0 1, 253	52.00 53.00 54.00
60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0 0 0		731	0 0 0	1, 159 505 415	65.00
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0		19	0 0 0	157 22 0	68.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 73. 00 07300 DRUGS CHARGED TO PATIENTS	0		0 0	0 0 0	0 0 0 0	71.00 72.00
76.00 03160 CARDI OPULMONARY	0	0		0		76.00
OUTPATI ENT SERVICE COST CENTERS 90.00 09000 CLINIC 90.01 09001 FAMILY PRACTICE OF JAY COUNTY	0	0		0	0 1, 685	
90. 02 09002 JAY FAMILY MEDICINE 90. 03 09003 WOUND CLINIC	0		8, 733 8, 536	0	1, 824 0	90.02
90.04 09004 OP ORTHO CLINIC 90.05 09005 JAY FAMILY FIRST HEALTH CARE	0	0	0 4, 008	0 0	0 797	
90. 06 09006 I NFUSI ON CLI NI C 90. 07 09007 HEALTH BEGI NNI NGS PROGRAM	0	0	618 3, 142	0 0	129 474	90.07
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 93. 00 04950 OUTPATIENT PSYCH	0	0	4, 770 1, 571	0	1, 513 	92.00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	0	1, 808	72, 620	8, 790	15, 978	118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 193. 00 19300 NONPAI D WORKERS 194. 00 07950 VACANT 194. 02 07952 WEST JAY CLINIC	0 3, 728 0 0 0		1	0 0 0 0	263 0 0	190.00 192.00 193.00 194.00 194.02
194.03 07953 JAY MERIDIAN URGENT CARE 200.00 Cross Foot Adjustments	0	0	1, 605	0		194.02 194.03 200.00 201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	0	246, 320		879, 882	551, 163	202.00
203.00Unit cost multiplier (Wkst. B, Part I)204.00Cost to be allocated (per Wkst. B, Part II)	0. 000000 0	136. 238938 26, 431		100. 100341 108, 850	33. 936519 78, 961	203. 00 204. 00

Health Fir	nancial Systems	IU HEALTH JA	Y HOSPI TAL		In Li	eu of Form CMS-	2552-10
COST ALLO	CATION - STATISTICAL BASIS		Provider C	CN: 15-1320	Period: From 01/01/202	Worksheet B-1	
			_		To 12/31/202		
	Cost Center Description	OPERATI ON OF	LAUNDRY &	HOUSEKEEPI N	G DI ETARY	CAFETERI A	
		PLANT - WJ	LINEN SERVICE	(SQUARE FEET) (MEALS	(MAN HOURS)	
		(SQUARE	(TOTAL		SERVED)		
		FEET-WJ)	PATIENT DAYS)				
		7.03	8.00	9.00	10.00	11.00	
205.00	Unit cost multiplier (Wkst. B, Part	0. 000000	14. 618916	0. 3961	48 12. 38339	4. 861831	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	IU HEALTH JA	Y HOSPITAL Provider CO		Period:	u of Form CMS-2 Worksheet B-1	
				From 01/01/2021 To 12/31/2021	Date/Time Pre 5/27/2022 8:0	
Cost Center Description	NURSI NG ADMI NI STRATI O N (DI RECT NRSI NG HRS)	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.)	PHARMACY (COSTED REQUIS.)	MEDI CAL RECORDS & LI BRARY (GROSS CHARGES)	SOCI AL SERVI CE (TI ME SPENT)	
GENERAL SERVICE COST CENTERS	13.00	14.00	15.00	16.00	17.00	
1.00 00100 CAP REL COSTS-BLDG & FIXT 1.01 00101 CAP REL COSTS-BLDG & FIXT-MOB 1.02 00102 CAP REL COSTS-BLDG & FIXT-POB 1.03 00103 CAP REL COSTS-BLDG & FIXT-POB 1.04 00104 CAP REL COSTS-BLDG & FIXT-INTEREST 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.01 00201 CAP REL COSTS-MVBLE EQUIP - MOB 2.02 00202 CAP REL COSTS-MVBLE EQUIP - POB 2.03 00203 CAP REL COSTS-MVBLE EQUIP - POB 2.03 00203 CAP REL COSTS-MVBLE EQUIP - WJ 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT 7.01 00701 OPERATION OF PLANT 7.02 00702 OPERATION OF PLANT 7.03 00703 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE 9.00 009000 HOUSEKEEPING 10.00 01100 CAFETERIA 13.00 01300 NURSI NG ADMINI STRATION 14.00<	4, 973 0 0 0	562, 612 4, 884 0	1, 945, 48	0 82, 370, 503		1.00 1.01 1.02 1.03 1.04 2.00 2.01 2.02 2.03 4.00 5.00 7.00 7.01 7.02 7.03 8.00 9.00 10.00 11.00 13.00 14.00 15.00 16.00 17.00
17. 00 01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	0	0	1	0 0	0	
30. 00 03000 ADULTS & PEDI ATRI CS 40. 00 04000 SUBPROVI DER - I PF 43. 00 04300 NURSERY	1, 591 0 0	127, 014 0 0		7 8, 694, 626 0 0 0 0	0 0 0	30.00 40.00 43.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	837	89, 632	5, 75	8 5, 945, 200	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESIOLOGY	0	0		0 0 0 0	0	52.00 53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	0	18,014	5, 82		0	54.00 60.00
65.00 06500 RESPIRATORY THERAPY	0	11, 579 24, 527		0 8, 257, 662 0 1, 596, 976	-	65.00
66. 00 06600 PHYSI CAL THERAPY	0	3, 625		0 1, 507, 265	0	66.00
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	126 0		0 415,028 0 27,700	0	67.00 68.00
69. 00 06900 ELECTROCARDI OLOGY	0	973			-	•
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	93, 761		0 233, 958		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	21, 599		0 276, 140		•
73. 00 07300 DRUGS CHARGED TO PATI ENTS 76. 00 03160 CARDI OPULMONARY	0	0 2, 053	1, 868, 07 12		0	•
OUTPATIENT SERVICE COST CENTERS				· · ·		1
90. 00 09000 CLI NI C 90. 01 09001 FAMI LY PRACTI CE OF JAY COUNTY	0 307	0 27, 954		0	0	90.00 90.01
90.02 09002 JAY FAMILY MEDICINE	402	24, 128		0 1, 087, 008		90.01
90. 03 09003 WOUND CLINIC	0	0		0 0	0	90.03
90. 04 09004 0P ORTHO CLINIC 90. 05 09005 JAY FAMILY FIRST HEALTH CARE	0	0		0 0 0 170, 150	0	90.04 90.05
90. 05 09005 JAY FAMILY FIRST HEALTH CARE 90. 06 09006 INFUSION CLINIC	163 127	8, 457 3, 005			0	90.05
90. 07 09007 HEALTH BEGI NNI NGS PROGRAM	261	870	17		0	90.07
91.00 09100 EMERGENCY	1, 281	98, 567	44, 11	9 20, 634, 194	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 93. 00 04950 OUTPATIENT PSYCH	0	306		0 305, 514	0	92.00 93.00
SPECIAL PURPOSE COST CENTERS			1		-	
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	4, 973	561, 074	1, 945, 48	7 82, 370, 503	0	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	1, 538		0 0	0	192.00
193. 00 19300 NONPALD WORKERS	0	0		0 0		193.00
194.00 07950 VACANT 194.02 07952 WEST JAY CLINIC	0	0				194.00 194.02
194. 03 07953 JAY MERI DI AN URGENT CARE	0	0		o o		194.02
200.00 Cross Foot Adjustments						200.00
201.00Negative Cost Centers202.00Cost to be allocated (per Wkst. B,	2, 706, 591	944, 044	1, 693, 89	1 ^	_	201.00 202.00
Part I)	2,100,071	744, 044	1, 073, 09			
203.00 Unit cost multiplier (Wkst. B, Part I)	544. 257189	1. 677966	0. 87067	7 0. 000000	0.000000	203.00

Health Fi	nancial Systems	IU HEALTH JA	Y HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COST ALLO	CATION - STATISTICAL BASIS		Provider CO		Period: From 01/01/2021	Worksheet B-1	
					To 12/31/2021	Date/Time Pre 5/27/2022 8:0	
	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, 676	9, 790	60, 97	0	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part	16. 021717	0. 017401	0. 03134	0. 000000	0. 000000	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

Health Financial Systems	IU HEALTH JA	Y HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-1320	Period: From 01/01/2021 To 12/31/2021		pared: 0 am
		Title	XVIII	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.		Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	(500 000		(500 0	20		00.00
30. 00 03000 ADULTS & PEDI ATRI CS 40. 00 04000 SUBPROVI DER - I PF	6, 500, 233		6, 500, 2		-	30.00
40. 00 04000 SUBPROVIDER - TPF 43. 00 04300 NURSERY	0			0 0		40.00 43.00
ANCI LLARY SERVICE COST CENTERS	U			0 0	0	43.00
50. 00 05000 OPERATING ROOM	3, 107, 214		3, 107, 2	14 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0,101,211		0,107,2	0 0		52.00
53.00 05300 ANESTHESI OLOGY	0			0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	2, 354, 018		2, 354, 0	18 0	0	54.00
60. 00 06000 LABORATORY	2, 913, 214		2, 913, 2	14 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	886, 881	0	886, 8		0	65.00
66.00 06600 PHYSI CAL THERAPY	1, 317, 536	0	1, 317, 5		0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	218, 314	0	218, 3		0	67.00
68. 00 06800 SPEECH PATHOLOGY	31, 982	0	31, 9		0	68.00
69. 00 06900 ELECTROCARDI OLOGY	2,857		2,8		0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	281, 283 64, 796		281, 2 64, 7		0	71.00 72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	4, 096, 138		4, 096, 1		-	73.00
76. 00 03160 CARDI OPULMONARY	4,070,130		4, 090, 1		-	76.00
OUTPATIENT SERVICE COST CENTERS	171,100				<u> </u>	10.00
90. 00 09000 CLINIC	0			0 0	0	90.00
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	2, 094, 082		2, 094, 0	82 0	0	90.01
90. 02 09002 JAY FAMILY MEDICINE	2, 193, 962		2, 193, 9	62 0	0	90.02
90. 03 09003 WOUND CLINIC	0			0 0	0	90.03
90. 04 09004 OP ORTHO CLINIC	0			0 0	0	90.04
90.05 09005 JAY FAMILY FIRST HEALTH CARE	1, 159, 380		1, 159, 3		0	90.05
90.06 09006 INFUSION CLINIC	339, 865		339, 8		0	90.06
90. 07 09007 HEALTH BEGI NNI NGS PROGRAM	936, 323		936, 3		-	90.07
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	3, 965, 470 1, 241, 619		3, 965, 4 1, 241, 6		0	91.00 92.00
93. 00 04950 0UTPATIENT PSYCH	239, 335		239, 3			92.00
200.00 Subtotal (see instructions)	34, 438, 690	0			-	200.00
201.00 Less Observation Beds	1, 241, 619	0	1, 241, 6			200.00
202.00 Total (see instructions)	33, 197, 071	0				202.00
				1		•

	Financial Systems ATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2021 To 12/31/2021	u of Form CMS-2 Worksheet C Part I Date/Time Pre 5/27/2022 8:0	
			Title	XVIII	Hospi tal	Cost	
			Charges				
	Cost Center Description	Inpati ent	Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA Inpatient Ratio	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			•	L		
30.00	03000 ADULTS & PEDIATRICS	5, 600, 547		5, 600, 54	17		30.00
40.00	04000 SUBPROVI DER – I PF	0			0		40.00
43.00	04300 NURSERY	0			0		43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	24, 306	5, 920, 894	5, 945, 20	0. 522642	0.00000	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0.000000	0.00000	52.00
53.00	05300 ANESTHESI OLOGY	0	0		0 0.000000	0.00000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	720, 478	12, 564, 873				
60.00	06000 LABORATORY	954, 939	7, 302, 723	8, 257, 66		0.00000	
65.00	06500 RESPI RATORY THERAPY	1, 040, 508	556, 468			0.00000	
66.00	06600 PHYSI CAL THERAPY	487, 960	1, 019, 305			0. 000000	
67.00	06700 OCCUPATI ONAL THERAPY	310, 754	104, 274			0.00000	
68.00	06800 SPEECH PATHOLOGY	15, 293	12, 407			0. 000000	
69.00	06900 ELECTROCARDI OLOGY	59, 506	1, 104, 499			0.00000	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	34, 068	199, 890			0. 000000	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	6, 186	269, 954				
73.00	07300 DRUGS CHARGED TO PATIENTS	4, 148, 681	9, 391, 230				
76.00	03160 CARDI OPULMONARY	223, 812	2,015,811	2, 239, 62	0. 220657	0. 000000	76.00
	OUTPATIENT SERVICE COST CENTERS	1 1		1			
90.00	09000 CLINIC	0	0		0 0.000000	0.00000	
90.01	09001 FAMILY PRACTICE OF JAY COUNTY	397	1,087,271			0.00000	
90.02	09002 JAY FAMILY MEDICINE	0	976, 958				
90.03	09003 WOUND CLINIC	0	0		0 0.000000	0.000000	
90.04	09004 OP ORTHO CLINIC	0	0		0 0.000000	0.00000	
90. 05	09005 JAY FAMILY FIRST HEALTH CARE	0	170, 150			0.00000	
90.06	09006 INFUSION CLINIC	0	1, 832, 927			0.00000	
90.07	09007 HEALTH BEGI NNI NGS PROGRAM	60, 592	119,055			0.000000	
91.00	09100 EMERGENCY	866, 872	19, 767, 322				
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	3, 094, 079				
93.00	04950 OUTPATIENT PSYCH	0	305, 514			0. 000000	
200.00		14, 554, 899	67, 815, 604	82, 370, 50	03		200.00
201.00			(T. 045				201.00
202.00	Total (see instructions)	14, 554, 899	67, 815, 604	82, 370, 50	03		202.00

COMPUTATION OF RATID OF COSTS TO CHARGES Provider CCN: 15-1320 Period: From 01/01/2021 To 12/31/2021 Worksheet C Date/Time Prepared: 27/2022 8: 00 an Cost Center Description PPS Inpatient Ratio Title XVIII Hospital Cost 30.00 03000 ADULTS & PEDIATRICS 0.00 30.00 30.00 30.00 30.00 03000 ADULTS & PEDIATRICS 0.00 40.00 30.00 40.00 40.00 040.00 SERVICE COST CENTERS 30.00 40.00 50.00 50.00 05200 DELIVERY ROM & LABOR ROM 0.000000 52.00 50.00 51.00 05200 DELIVERY ROM & LABOR ROM 0.000000 52.00 52.00 52.00 05200 DELIVERY ROM & LABOR ROM 0.000000 66.00 66.00 66.00 06500 RESPIRATORY THERAPY 0.000000 66.00 66.00 66.00 06500 RESPIRATORY THERAPY 0.000000 67.00 67.00 71.00 0.000000 72.00 73.00 73.00 73.00 70.00 0.000000 67.00 0.0000000 67.00 68.00	Health Financial Systems	IU HEALTH JAY	HOSPI TAL	In Lieu	ı of Form CMS-	2552-10
Cost Center Description PPS Inpatient Ratio PPS Inpatient Ratio PPS Inpatient Ratio 30.00 03000 ADULTS & PEDLATRICS 30.00 40.00 040000 NURSERY 43.00 ANCILLARY SERVICE COST CENTERS 43.00 50.00 05000 OPERATING ROM 0.000000 60.00 06500 RESPIRATORY 0.000000 61.00 06500 RESPIRATORY 0.000000 61.00 06500 RESPIRATORY 0.000000 61.00 06500 RESPIRATORY 0.000000 61.00 06000 SPEECH PATHOLOGY 0.000000 61.00 06000 SPEECH PATHOLOGY 0.000000 62.00 06000 SPEECH PATHOLOGY 0.000000 63.00 06000 SPEECH PATHOLOGY 0.000000 64.00 0.000000 67.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000			Provider CCN: 15-1320	From 01/01/2021	Part I Date/Time Pr	
Ratio 11.00 30.00 03000 AUUTS & PEDIATRICS 30.00 41.00 43.00 04000 SUBPRVIDER - 1PF 43.00 43.00 04300 AUUTS & TPF 43.00 60.00 06000 CPEATING ROOM 0.000000 52.00 50.00 05000 CPEATING ROOM 0.000000 52.00 50.00 05300 AWESTHESI OLOGY 0.000000 53.00 51.00 054000 FLAIDERY ROOM & LABOR ROOM 0.000000 53.00 52.00 05300 AWESTHESI OLOGY 0.000000 54.00 60.00 066000 LABORATORY 0.000000 65.00 60.00 066000 PHYSI CAL THERAPY 0.000000 65.00 60.00 066000 PHYSI CAL THERAPY 0.000000 65.00 60.00 066000 PHYSI CAL THERAPY 0.000000 67.00 71.00 07100 KEDICAL THERAPY 0.000000 67.00 72.00 07200 IMPL, DEV. CHARGED TO PATIENTS 0.000000 71.00 72.00 07200 IMPL, DEV. CHARGED TO PATIENTS 0.000000 73.00 73.00 <			Title XVIII	Hospi tal	Cost	
11.00 11.00 30.00 03000 ADULTS & PEDIATRICS 30.00 40.00 04000 BUBROVI DER - IPF 40.00 43.00 04300 NURSERY 43.00 ANCILLARY SERVICE COST CENTERS 50.00 50.00 05000 OPERATING ROOM 0.000000 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 50.00 05500 OPERATING ROOM 0.000000 50.00 05500 OPERATING ROOM 0.000000 50.00 53.00 53.00 50.00 05000 ALBERTHARDRY 0.000000 60.00 66000 LABORATORY 0.000000 61.00 06700 LCURATIONAL THERAPY 0.000000 62.00 06500 RESPI RATORY THERAPY 0.000000 63.00 06500 DECECH PATHOLOGY 0.000000 64.00 06600 PHYSI CAL THERAPY 0.000000 65.00 66.00 66.00 60.00 06500 ELECTROCARDI LLOGY 0.000000 71.00 0.010 MUBLES CHARGED TO PATIENTS 0.000000 72.00 0.000000 71.00	Cost Center Description	PPS Inpatient				
INPATLENT ROUTINE SERVICE COST CENTERS 30.00 30.00 03000 ADULTS & PEDIATRICS 30.00 40.00 04000 SUBPROVIDER - IPF 43.00 ANCLLARY SERVICE COST CENTERS 50.00 50.00 05000 (PEPATINO ROOM 0.000000 50.00 05000 (PEVRY ROM & LABOR ROOM 0.000000 52.00 05200 (DEUCYR ROM & LABOR ROOM 0.000000 53.00 05300 (ANESTHESI OLGGY 0.000000 54.00 05400 (PEV) FROM & LABOR ROOM 0.000000 60.00 066000 LABORATORY 0.000000 54.00 60.00 066000 LABORATORY 0.000000 66.00 60.00 06600 PHYSIGLAT HERAPY 0.000000 66.00 60.00 06600 SPECH PATHOLOGY 0.000000 67.00 67.00 06700 OCCUPATI ONAL THERAPY 0.000000 67.00 69.00 06700 OCUPATI ONAL THERAPY 0.000000 67.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 71.00 72.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 72.00 <td></td> <td>Ratio</td> <td></td> <td></td> <td></td> <td></td>		Ratio				
30. 00 03000 ADULTS & PEDIATRICS 30. 00 40. 00 04000 SUBPROVI DER - 1 PF 43. 00 43. 00 04300 NUBSERV 43. 00 ANCI LLARY SERVICE COST CENTERS 50. 00 50. 00 50. 00 50000 PERATINO ROOM 0. 000000 53. 00 53. 00 53. 00 53. 00 54. 00 05400 RADIOLOGY-DI AGNOSTI C 0. 000000 60. 00 60500 RESPITATORY THERAPY 0. 000000 60. 00 66500 RSDI RATORY THERAPY 0. 000000 66. 00 66. 00 66. 00 66. 00 67. 00 6600 PHYSI CAL THERAPY 0. 000000 66. 00 67. 00 6600 DEGOD CALBORATORY 0. 000000 67. 00 68. 00 6800 SPECH PATHOLOGY 0. 000000 67. 00 69. 00 671.00 COPATINAL SPATIENTS 0. 000000 71. 00 07100 MELOTARGED TO PATIENTS 0. 000000 73. 00 70. 00 03160 CARDI		11.00				
40.00 04000 SUBPROVIDER - 1PF 40.00 ANCILLARY SERVICE COST CENTERS 43.00 ANCILLARY SERVICE COST CENTERS 50.00 50.00 05000 0PERATING ROOM 0.000000 52.00 50.200 50.200 50.200 51.00 05300 AUSTILLARY SERVICE 60.000 52.00 50.200 51.200 52.200 50.00 05300 AUSTILLARY SERVICE 0.000000 51.00 05300 AUSTILLARY SERVICE 0.000000 60.00 66.00 66.00 66.00 66.00 61.00 06600 PLEXTINGRAPY 0.000000 66.00 62.00 06600 PERCINCAL THERAPY 0.000000 66.00 63.00 06600 SPECIN PATHORAL THERAPY 0.000000 66.00 64.00 6600 SPECINCAL THERAPY 0.000000 71.00 71.00 72.00 72.00 72.00 72.00 73.00 73.00 07300 DIVIS CHARGED TO PATIENTS 0.0000000						
43.00 04300 NURSERY 43.00 ANCI LLARY SERVICE COST CENTERS 50.00 52.00 50.00 52.00 50.00 53.00 53.00 53.00 53.00 53.00 53.00 54.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 66.00 71.00 71.00 71.00 71.00 71.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td></t<>						
ANCI LLARY SERVICE COST CENTERS 50. 00 05000 DEFRATING ROOM 0.000000 52.00 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 52.00 53. 00 05300 ANESTHESI OLOGY 0.000000 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 54.00 60. 00 06000 LABORATORY 0.000000 64.00 60. 00 06500 RESPI RATORY THERAPY 0.000000 65.00 60. 00 6500 CCUPATI ONAL THERAPY 0.000000 65.00 61.00 06600 PHYSI CLAT THERAPY 0.000000 68.00 62.00 06500 RESPI RATORY THERAPY 0.000000 68.00 63.00 06400 SPEECH PATHOLOGY 0.000000 69.00 64.00 06900 ELECTROCARDI OLOGY 0.000000 71.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 72.00 72.00 DAVL DEV. CHARGED TO PATI ENTS 0.000000 73.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 73.00 70.00						40.00
50.00 OSO00 OPERATING ROOM 0.000000 52.00 52.00 DELIVERY ROOM & LABOR ROOM 0.000000 52.00 53.00 OS300 ANESTHESI OLOGY 0.000000 53.00 64.00 OS400 RADI OLOGY-OH AGNOSTI C 0.000000 64.00 65.00 OS400 RADI OLOGY-OH AGNOSTI C 0.000000 65.00 66.00 OS500 RESPI RATORY THERAPY 0.000000 65.00 67.00 OCAPATI ONAL THERAPY 0.000000 66.00 67.00 OCAPATI ONAL THERAPY 0.000000 68.00 68.00 O6800 SPEECH PATHOLOGY 0.000000 69.00 69.00 OF900 ELECTROCARDI OLOGY DEVILONAL THERAPY 0.000000 71.00 71.00 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.000000 72.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 73.00 73.00 07300 OCUPUMONARY 0.000000 73.00 74.00 O9000 CLINIC 0.000000 90.01 90.01 O9001 FAMILY PRACTICE OF JAY COUNTY 0.000000 90.01	43.00 04300 NURSERY					43.00
52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 52.00 53.00 OS200 ARESTHESIOLOGY 0.000000 53.00 64.00 OS400 RABDIOLOGY-DIAGNOSTIC 0.000000 60.00 65.00 OS600 RESTRESIOLOGY 0.000000 60.00 65.00 OS600 PHYSICAL THERAPY 0.000000 60.00 66.00 OS600 CCUPATIONAL THERAPY 0.000000 67.00 67.00 OS700 OCCUPATIONAL THERAPY 0.000000 67.00 68.00 OS600 FLECTROCARDIOLOGY 0.000000 67.00 69.00 OG900 LLECTROCARDIOLOGY 0.000000 71.00 71.00 OT200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 72.00 73.00 OT300 DRUGS CHARGED TO PATI ENTS 0.000000 73.00 73.00 OT300 DRULMARY 0.000000 73.00 73.00 OT300 DRULMARY 0.000000 90.01 90.01 PAMI LY PRACTICE OF JAY COUNTY	ANCILLARY SERVICE COST CENTERS					
53.00 05300 ANESTHESI OLOGY 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 54.00 06.00 LABORATORY 0.000000 66.00 66.00 06500 RESPI RATORY THERAPY 0.000000 66.00 06500 0600 LABORATORY 0.000000 67.00 06700 0CCUPATI ONAL THERAPY 0.000000 67.00 06700 0CCUPATI ONAL THERAPY 0.000000 68.00 06800 SPEECH PATHOLOCY 0.000000 68.00 071.00 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 73.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 73.00 74.00 0300 DAUGARY 0.000000 74.00 75.00 0300 DRUGS CHARGED TO PATI ENTS 0.000000 76.00 70.00 UTPATI ENT SERVICE COST CENTERS 0.000000 90.01	50.00 05000 OPERATING ROOM	0. 000000				50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 54.00 60.00 06000 LABORATORY 0.000000 65.00 65.00 06500 RESPI RATORY THERAPY 0.000000 66.00 66.00 06600 PHYSI CAL THERAPY 0.000000 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0.000000 68.00 68.00 06800 SPEECH PATHOLOGY 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 71.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 72.00 72.00 O7200 INPL <dev. charged="" ents<="" pati="" td="" to=""> 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 73.00 74.00 09000 CLINIC 0.000000 90.01 90.00 09000 CLINIC 0.000000 90.02 90.00 09001 FAMI LY PRACTICE OF JAY COUNTY 0.000000 90.02 90.01 09001 FAMI LY PRACTICE OF JAY COUNTY 0.000000 90.02 90.02</dev.>	52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
60.00 06000 LABORATORY 0.000000 60.00 65.00 06500 RESPIRATORY THERAPY 0.000000 65.00 66.00 OK600 PRSICAL THERAPY 0.000000 67.00 67.00 OCCUPATI ONAL THERAPY 0.000000 67.00 68.00 SPECH PATHOLOGY 0.000000 68.00 69.00 G6900 ELECTROCARDI OLOGY 0.000000 68.00 71.00 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 71.00 72.00 O7200 IMPL DEV. CHARGED TO PATI ENTS 0.000000 73.00 73.00 O7300 RUGS CHARGED TO PATI ENTS 0.000000 73.00 73.00 74.00 O3160 CARDI OPULMONARY 0.000000 73.00 76.00 75.00 O9000 CLIN IC 0.000000 90.01 90.01 75.00 O9000 CLIN IC 0.000000 90.02 90.02 76.00 O000000 0.000000 90.01 90.01 70.00 O90002 JAY FAMI LY PRACTI CE OF JAY COUNTY 0.00000	53. 00 05300 ANESTHESI OLOGY	0. 000000				53.00
65.00 06500 RESPI RATORY THERAPY 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 0.000000 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0.000000 68.00 68.00 06800 SPEECH PATHOLOGY 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 71.00 71.00 OT100 MEDL CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 72.00 73.00 D7300 DRUGS CHARGED TO PATI ENTS 0.000000 73.00 76.00 03160 CARDI OPULMONARY 0.000000 73.00 0010 OPO01 FAMI LY PRACTI CE OST CENTERS 90.00 90.01 90.01 ONOT FAMI LY PRACTI CE OF JAY COUNTY 0.000000 90.02 90.03 90003 WOUND CLI NI C 0.000000 90.02 90.01 FAMI LY PRACTI CE OF JAY COUNTY 0.000000 90.03 90.04 90004 P ORTHO CLI NI C 0.000000 90.04 90.05 JAY FAMI LY FIRST HEALTH CARE	54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
66.00 06600 PHYSI CAL THERAPY 0.000000 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 69.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 69.00 71.00 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.000000 71.00 72.00 TO200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72.00 73.00 O7300 DRUGS CHARGED TO PATIENTS 0.000000 73.00 76.00 03160 CARDI OPULMONARY 0.000000 70.00 00.00 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 00.01 09000 CLINIC 0.000000 90.02 90.02 JAY FAMILY MEDICINE 0.000000 90.02 90.03 09003 WOUND CLINIC 0.000000 90.02 90.04 0904 PORTHO CLINIC 0.000000 90.03 90.05 JAY FAMILY MEDI CINE 0.000000 90.04 90.05 09005 JAY FAMILY FIRST HEALTH CARE 0.000000	60. 00 06000 LABORATORY	0. 000000				60.00
67.00 06700 0CCUPATI 0NAL THERAPY 0.00000 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 68.00 69.00 06900 ELCTROCARD IOLOGY 0.000000 69.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 72.00 73.00 03160 CARDI OPULMONARY 0.000000 76.00 0017PATI ENT SERVICE COST CENTERS 0.000000 90.01 90.01 90.00 09001 CLINIC 0.000000 90.02 90.02 JAY FAMI LY MEDI CI NE 0.000000 90.02 90.03 09003 WOUND CLI NI C 0.000000 90.02 90.04 09004 OP ORTHO CLI NI C 0.000000 90.03 90.05 JAY FAMI LY FIRST HEALTH CARE 0.000000 90.05 90.05 09006 IAY FAMI LY FIRST HEALTH CARE 0.000000 90.06 90.06 090000 INFUSI ON CLI NI C	65. 00 06500 RESPI RATORY THERAPY	0. 000000				65.00
68.00 06800 SPEECH PATHOLOGY 0.000000 68.00 69.00 06900 ELECTROCARD I OLOGY 0.000000 69.00 71.00 O7100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73.00 74.00 03160 CARDI OPULMONARY 0.000000 73.00 75.00 000000 INIC 0.000000 76.00 00.00 09000 CLI NI C 0.000000 90.01 90.01 O9001 FAMILY PRACTICE OF JAY COUNTY 0.000000 90.01 90.02 09002 JAY FAMILY MEDICINE 0.000000 90.02 90.03 09003 WOUND CLINIC 0.000000 90.03 90.04 OP ONTHO CLINIC 0.000000 90.04 90.05 09005 JAY FAMILY FIRST HEALTH CARE 0.000000 90.05 90.06 09007 IHEALTH BEGI NININGS PROGRAM 0.000000 90.07 90.06 09007 IHEALTH BEGI NININGS PROGRAM 0.000000 90.07 91.00	66.00 06600 PHYSI CAL THERAPY	0. 000000				66.00
69.00 06900 ELECTROCARDIOLOGY 0.000000 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 71.00 72.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73.00 76.00 03160 CARDIOPULMONARY 0.000000 76.00 0UTPATIENT SERVICE COST CENTERS 0.000000 90.01 90.00 09001 FAMILY PRACTICE OF JAY COUNTY 0.000000 90.02 90.01 09001 FAMILY PRACTICE OF JAY COUNTY 0.000000 90.02 90.02 09002 JAY FAMILY MEDICINE 0.000000 90.02 90.03 09004 OP ORTHO CLINIC 0.000000 90.03 90.04 09004 OP ORTHO CLINIC 0.000000 90.04 90.05 09005 JAY FAMILY FIRST HEALTH CARE 0.000000 90.05 90.05 09006 INSI NO CLINIC 0.000000 90.06 90.05 09007 HALTH BEGINNINGS PROGRAM 0.000000 90.06 90.07 91.00<	67.00 06700 OCCUPATI ONAL THERAPY	0. 000000				67.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 72.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73.00 76.00 03160 CARDI OPLUMONARY 0.000000 73.00 00 09000 CLINIC 0.000000 70.00 00.00 09000 FAMILY PRACTICE OST CENTERS 90.00 90.00 09001 FAMILY PRACTICE OF JAY COUNTY 0.000000 90.01 90.02 JAY FAMILY MEDICINE 0.000000 90.01 90.03 09003 WOUND CLINIC 0.000000 90.03 90.04 09004 OP ORTHO CLINIC 0.000000 90.04 90.05 09005 JAY FAMILY FIRST HEALTH CARE 0.000000 90.04 90.05 09006 INFUSION CLINIC 0.000000 90.06 90.07 90.001 EMERGENCY 0.000000 90.06 90.07 90.001 EMERGENCY 0.000000 90.06 90.020 0825RVATION BEDS (NON-DISTINCT PART 0.00	68.00 06800 SPEECH PATHOLOGY	0. 000000				68.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 73.00 73.00 03160 CARDIO PULMONARY 0.000000 73.00 001000 001PATIENT SERVICE COST CENTERS 0.000000 76.00 00100 09000 CLINIC 0.000000 90.00 90.00 09000 CLINIC 0.000000 90.01 90.02 09002 JAY FAMILY PRACTICE OF JAY COUNTY 0.000000 90.02 90.03 09003 WOUND CLINIC 0.000000 90.02 90.04 09004 OP ORTHO CLINIC 0.000000 90.04 90.05 09005 JAY FAMILY FIRST HEALTH CARE 0.000000 90.05 90.06 09006 INFUSION CLINIC 0.000000 90.04 90.07 09007 HEALTH BEGINNINGS PROGRAM 0.000000 90.07 91.00 09100 EMERGENCY 0.000000 91.00 92.00 09200 DSERVATION BEDS (NON-DISTINCT PART 0.000000 92.00 92.00 09200 BSERVATION DEDS (NON-DISTINCT PART 0.000000 92.00 93.00 04950	69.00 06900 ELECTROCARDI OLOGY	0. 000000				69.00
73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73.00 76.00 03160 CARDI OPULMONARY 0.000000 76.00 0UTPATIENT SERVICE COST CENTERS 0.000000 90.00 90.00 90.00 09000 CLINIC 0.000000 90.01 90.01 09001 FAMILY PRACTICE OF JAY COUNTY 0.000000 90.01 90.02 09002 JAY FAMILY MEDICINE 0.000000 90.02 90.03 09003 WOUND CLINIC 0.000000 90.02 90.04 09004 OP THO CLINIC 0.000000 90.04 90.05 09005 JAY FAMILY FIRST HEALTH CARE 0.000000 90.04 90.07 09007 HEALTH BEGINNINGS PROGRAM 0.000000 90.07 90.07 09007 HEALTH BEGINNINGS PROGRAM 0.000000 91.00 92.00 092000 DSERVATION BEDS (NON-DI STINCT PART 0.000000 92.00 92.00 02200 0BSERVATION BEDS (NON-DI STINCT PART 0.0000000 93.00 93.00 04950 0UTPATIENT PSYCH 0.000000 93.00 920.00 <td>71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS</td> <td>0. 000000</td> <td></td> <td></td> <td></td> <td>71.00</td>	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
76.00 03160 CARDI OPULMONARY 0.000000 76.00 OUTPATIENT SERVICE COST CENTERS 0.000000 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.01 90.01 90.02 90.02 90.02 90.02 90.02 90.02 90.02 90.02 90.02 90.02 90.02 90.02 90.02 90.03 90.04 90.02 90.03 90.04 90.02 90.03 90.04 90.04 90.04 90.04 90.04 90.05 90.05 90.05 90.05 90.05 90.05 90.05 90.05 90.06 90.05 90.06 90.05 90.06 90.07 90.06 90.07 90.06 90.07 90.06 90.07<	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00
OUTPATI ENT SERVICE COST CENTERS 90.00 OUTPATI ENT SERVICE COST CENTERS 90.00 90.00 CLINIC 90.00 90.01 90.00 90.01 90.00 90.01 90.00 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.02 90.02 90.02 90.02 90.02 90.03 90.004 90.03 90.004 90.03 90.04 90.03 90.04 90.04 90.04 90.04 90.04 90.04 90.04 90.05 90.05 90.05 90.05 90.05 90.05 90.05 90.06 90.05 90.06 90.07 90.06 90.07 90.07 90.06 90.07 90.06 90.07 90.06 90.07 90.07 90.07 90.07 90.07 90.07 90.07 90.07 90.07 90.07 90.07 90.07 90.07 90.07 90.07 90.07 90.07 90.07 90.00 90.07	73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
90.00 09000 CLINIC 0.000000 90.00 90.01 09001 FAMILY PRACTICE OF JAY COUNTY 0.000000 90.01 90.02 09002 JAY FAMILY MEDICINE 0.000000 90.02 90.03 09003 WOUND CLINIC 0.000000 90.03 90.04 09004 OP ORTHO CLINIC 0.000000 90.04 90.05 JAY FAMILY FIRST HEALTH CARE 0.000000 90.05 90.06 O9006 INFUSION CLINIC 0.000000 90.05 90.07 09007 HEALTH BEGINNINGS PROGRAM 0.000000 90.07 91.00 09100 EMERGENCY 0.000000 90.07 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0.000000 91.00 92.00 04550 UTPATIENT PSYCH 0.000000 92.00 93.00 C4950 Subtotal (see instructions) 200.00 201.00	76.00 03160 CARDI OPULMONARY	0. 000000				76.00
90.01 09001 FAMI LY PRACTICE OF JAY COUNTY 0.000000 90.01 90.02 09002 JAY FAMI LY MEDICINE 0.000000 90.02 90.03 09003 WOUND CLINIC 0.000000 90.03 90.04 09004 OP ORTHO CLINIC 0.000000 90.04 90.05 09005 JAY FAMI LY FIRST HEALTH CARE 0.000000 90.05 90.06 09006 INFUSION CLINIC 0.000000 90.06 90.07 09007 HEALTH BEGINNINGS PROGRAM 0.000000 90.07 91.00 09100 EMERGENCY 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.000000 92.00 92.00 04950 OUTPATIENT PSYCH 0.000000 93.00 200.00 Subtotal (see instructions) 200.000 93.00 201.00 Less Observation Beds 201.00 201.00	OUTPATIENT SERVICE COST CENTERS	· · · · ·				
90.02 09002 JAY FAMILY MEDICINE 0.000000 90.02 90.03 09003 WOUND CLINIC 0.000000 90.03 90.04 09004 OP ORTHO CLINIC 0.000000 90.04 90.05 09005 JAY FAMILY FIRST HEALTH CARE 0.000000 90.05 90.06 09006 INFUSION CLINIC 0.000000 90.06 90.07 09007 HEALTH BEGINNINGS PROGRAM 0.000000 90.07 91.00 09100 EMERGENCY 0.000000 91.00 92.00 09200 DBSERVATION BEDS (NON-DISTINCT PART 0.000000 92.00 93.00 04950 OUTPATIENT PSYCH 0.000000 93.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00	90. 00 09000 CLINIC	0. 000000				90.00
90.03 09003 WOUND CLINIC 0.000000 90.03 90.04 09004 0P ORTHO CLINIC 0.000000 90.04 90.05 09005 JAY FAMILY FIRST HEALTH CARE 0.000000 90.05 90.06 09006 INFUSION CLINIC 0.000000 90.06 90.07 09007 HEALTH BEGINNINGS PROGRAM 0.000000 90.07 91.00 09100 EMERGENCY 0.000000 91.00 92.00 095ERVATION BEDS (NON-DISTINCT PART 0.000000 92.00 93.00 04950 OUTPATIENT PSYCH 0.000000 93.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00	90.01 09001 FAMILY PRACTICE OF JAY COUNTY	0. 000000				90.01
90.04 09004 0P ORTHO CLINIC 0.00000 90.04 90.05 09005 JAY FAMILY FIRST HEALTH CARE 0.000000 90.05 90.06 09006 INFUSION CLINIC 0.000000 90.06 90.07 09007 HEALTH BEGINNINGS PROGRAM 0.000000 90.07 91.00 09100 EMERGENCY 0.000000 91.00 92.00 095ERVATION BEDS (NON-DISTINCT PART 0.000000 92.00 93.00 04790 0UTPATIENT PSYCH 0.000000 93.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00	90.02 09002 JAY FAMILY MEDICINE	0. 000000				90.02
90.05 09005 JAY FAMILY FIRST HEALTH CARE 0.00000 90.05 90.06 09006 INFUSION CLINIC 0.000000 90.06 90.07 09007 HEALTH BEGINNINGS PROGRAM 0.000000 90.07 91.00 09100 EMERGENCY 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.000000 92.00 93.00 04950 OUTPATIENT PSYCH 0.000000 93.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00	90. 03 09003 WOUND CLINIC	0. 000000				90.03
90.06 09006 INFUSION CLINIC 0.00000 90.06 90.07 09007 HEALTH BEGINNINGS PROGRAM 0.000000 90.07 91.00 09100 EMERGENCY 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.000000 92.00 93.00 04950 OUTPATIENT PSYCH 0.000000 93.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00	90.04 09004 OP ORTHO CLINIC	0. 000000				90.04
90.07 09007 HEALTH BEGINNINGS PROGRAM 0.00000 90.07 91.00 09100 EMERGENCY 0.00000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.000000 92.00 93.00 04950 OUTPATIENT PSYCH 0.000000 93.00 200.00 Subtotal (see instructions) 200.00 201.00	90.05 09005 JAY FAMILY FIRST HEALTH CARE	0. 000000				90.05
91.00 09100 EMERGENCY 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.000000 92.00 93.00 04950 OUTPATIENT PSYCH 0.000000 93.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00	90.06 09006 INFUSION CLINIC	0. 000000				90.06
92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0.000000 92.00 93.00 04950 0UTPATIENT PSYCH 0.000000 93.00 200.00 Subtotal (see instructions) 200.00 200.00 201.00	90. 07 09007 HEALTH BEGINNINGS PROGRAM	0. 000000				90.07
93.00 04950 OUTPATIENT PSYCH 0.000000 93.00 200.00 Subtotal (see instructions) 200.00 200.00 201.00	91.00 09100 EMERGENCY	0. 000000				91.00
200.00 Subtotal (see instructions) 200.00 201.00 201.00 201.00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000				92.00
201.00 Less Observation Beds 201.00	93.00 04950 OUTPATIENT PSYCH	0. 000000				93.00
	200.00 Subtotal (see instructions)					200.00
202.00 Total (see instructions) 202.00	201.00 Less Observation Beds					201.00
	202.00 Total (see instructions)					202.00

Health Financial Systems	IU HEALTH JA	Y HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-1320	Period: From 01/01/2021 To 12/31/2021		pared: 0 am
		Ti tl	e XIX	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	(500 000		(500 0)		(500 000	
30. 00 03000 ADULTS & PEDI ATRI CS	6, 500, 233		6, 500, 23		6, 500, 233	
40. 00 04000 SUBPROVI DER - I PF	0			0 0	0	
43. 00 04300 NURSERY ANCI LLARY SERVICE COST CENTERS	0			0 0	0	43.00
50. 00 05000 OPERATING ROOM	3, 107, 214		3, 107, 2	4 0	3, 107, 214	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	3, 107, 214		5, 107, 2		3, 107, 214	
53. 00 05300 ANESTHESI OLOGY	0			0 0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 354, 018		2, 354, 0	18 0	2, 354, 018	
60. 00 06000 LABORATORY	2, 913, 214		2, 913, 2		2, 913, 214	
65. 00 06500 RESPI RATORY THERAPY	886, 881	0	886, 8	31 0	886, 881	
66. 00 06600 PHYSI CAL THERAPY	1, 317, 536	0	1, 317, 5	36 0	1, 317, 536	66.00
67.00 06700 OCCUPATI ONAL THERAPY	218, 314	0	218, 3		218, 314	
68.00 06800 SPEECH PATHOLOGY	31, 982	0	31, 9		31, 982	
69. 00 06900 ELECTROCARDI OLOGY	2, 857		2, 8		2, 857	
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	281, 283		281, 2		281, 283	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	64, 796		64, 7		64, 796	
73. 00 07300 DRUGS CHARGED TO PATI ENTS 76. 00 03160 CARDI OPULMONARY	4, 096, 138 494, 188		4, 096, 13 494, 18		4, 096, 138 494, 188	
OUTPATIENT SERVICE COST CENTERS	494, 100		494, 10		494, 100	70.00
90. 00 09000 CLINIC	0			0 0	0	90.00
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	2, 094, 082		2, 094, 08		2,094,082	
90. 02 09002 JAY FAMILY MEDICINE	2, 193, 962		2, 193, 9		2, 193, 962	
90. 03 09003 WOUND CLINIC	0			0 0	0	
90.04 09004 OP ORTHO CLINIC	0			0 0	0	90.04
90.05 09005 JAY FAMILY FIRST HEALTH CARE	1, 159, 380		1, 159, 3	30 0	1, 159, 380	90.05
90.06 09006 INFUSION CLINIC	339, 865		339, 8		339, 865	
90. 07 09007 HEALTH BEGI NNI NGS PROGRAM	936, 323		936, 33		936, 323	
91.00 09100 EMERGENCY	3, 965, 470		3, 965, 4		3, 965, 470	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 241, 619		1, 241, 6		1, 241, 619	
93.00 04950 OUTPATLENT PSYCH 200.00 Subtotal (see instructions)	239, 335 34, 438, 690	0	239, 3		239, 335 34, 438, 690	
201.00 Less Observation Beds	34, 438, 690	U	34, 438, 6 1, 241, 6		34, 438, 690	
202.00 Total (see instructions)	33, 197, 071	C				
	33, 177, 071		1 33, 177, 0		55, 177, 071	1202.00

COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Pre 5/27/2022 8:0	epared:
				e XIX	Hospi tal	972772022 8:0 PPS	ju alli
			Charges		nospi tui	113	
	Cost Center Description	Inpati ent	Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA Inpatient Ratio	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			•			
30.00	03000 ADULTS & PEDIATRICS	5, 600, 547		5, 600, 54	17		30.00
40.00	04000 SUBPROVI DER – I PF	0			0		40.00
43.00	04300 NURSERY	0			0		43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	24, 306	5, 920, 894	5, 945, 20	0. 522642	0.00000	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0.000000	0.00000	52.00
53.00	05300 ANESTHESI OLOGY	0	0		0 0.000000	0.00000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	720, 478	12, 564, 873	13, 285, 35	0. 177189	0.00000	54.0
60.00	06000 LABORATORY	954, 939	7, 302, 723			0.00000	
65.00	06500 RESPI RATORY THERAPY	1, 040, 508	556, 468			0.00000	
66.00	06600 PHYSI CAL THERAPY	487, 960	1, 019, 305	1, 507, 26	0. 874124	0.00000	66.00
67.00	06700 OCCUPATI ONAL THERAPY	310, 754	104, 274			0.00000	
68.00	06800 SPEECH PATHOLOGY	15, 293	12, 407	27,70		0.00000	
69.00	06900 ELECTROCARDI OLOGY	59, 506	1, 104, 499			0.00000	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	34, 068	199, 890			0.00000	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	6, 186	269, 954			0.00000	
73.00	07300 DRUGS CHARGED TO PATIENTS	4, 148, 681	9, 391, 230			0.00000	
76.00	03160 CARDI OPULMONARY	223, 812	2,015,811	2, 239, 62	0. 220657	0.00000	76.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0		0 0. 000000	0.000000	
90. 01	09001 FAMILY PRACTICE OF JAY COUNTY	397	1, 087, 271	1, 087, 66		0.000000	
90.02	09002 JAY FAMILY MEDICINE	0	976, 958	976, 95		0.000000	
90.03	09003 WOUND CLINIC	0	0		0 0. 000000	0. 000000	
90.04	09004 OP ORTHO CLINIC	0	0		0 0. 000000	0. 000000	
90.05	09005 JAY FAMILY FIRST HEALTH CARE	0	170, 150			0.000000	
90.06	09006 INFUSION CLINIC	0	1, 832, 927			0. 000000	
90.07	09007 HEALTH BEGI NNI NGS PROGRAM	60, 592	119, 055			0. 000000	
91.00	09100 EMERGENCY	866, 872	19, 767, 322			0. 000000	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	3, 094, 079			0. 000000	
93.00	04950 OUTPATI ENT PSYCH	0	305, 514			0. 000000	
200.00		14, 554, 899	67, 815, 604	82, 370, 50	03		200.0
201.00							201.00
202.00) Total (see instructions)	14, 554, 899	67, 815, 604	82, 370, 50	03		202.00

Health Financial Systems	IU HEALTH JAY	HOSPI TAL	In Lieu	ı of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1320	Peri od: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Pro 5/27/2022 8:0	
		Title XIX	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS	1 1				
30.00 03000 ADULTS & PEDI ATRI CS					30.00
40. 00 04000 SUBPROVIDER - IPF					40.00
43.00 04300 NURSERY					43.00
ANCI LLARY SERVICE COST CENTERS	1				
50.00 05000 OPERATING ROOM	0. 522642				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
53.00 05300 ANESTHESI OLOGY	0. 000000				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 177189				54.00
60. 00 06000 LABORATORY	0. 352789				60.00
65. 00 06500 RESPI RATORY THERAPY	0. 555350				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 874124				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 526022				67.00
68.00 06800 SPEECH PATHOLOGY	1. 154585				68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 002454				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 202280				71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 234649				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 302523				73.00
76.00 03160 CARDI OPULMONARY	0. 220657				76.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C	0. 000000				90.00
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	1. 925295				90.01
90. 02 09002 JAY FAMILY MEDICINE	2. 245708				90.02
90. 03 09003 WOUND CLINIC	0. 000000				90.03
90. 04 09004 OP ORTHO CLINIC	0. 000000				90.04
90. 05 09005 JAY FAMILY FIRST HEALTH CARE	6. 813870				90.05
90.06 09006 INFUSION CLINIC	0. 185422				90.06
90. 07 09007 HEALTH BEGI NNI NGS PROGRAM	5. 212016				90.07
91.00 09100 EMERGENCY	0. 192180				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 401289				92.00
93. 00 04950 OUTPATI ENT PSYCH	0. 783385				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 JAY HOSPITAL In Lieu of Form CMS-2552-									
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RA	ATIOS NET OF	Provider C	CN: 15-1320	Period:	Worksheet C				
REDUCTIONS FOR MEDICAID ONLY				From 01/01/2021 To 12/31/2021	Part II Date/Time Pre	narod			
				10 12/31/2021	5/27/2022 8:0	ipareu. 10 am			
	Title XIX		Hospi tal PPS						
Cost Center Description	Total Cost	Capital Cost	Operating	Capi tal	Operating				
	(Wkst. B,	(Wkst. B,	Cost Net of	Reduction	Cost				
	Part I, col.	Part II col.	Capital Cos	t	Reducti on				
	26)	26)	(col. 1 -		Amount				
			col. 2)						
	1.00	2.00	3.00	4.00	5.00				
ANCI LLARY SERVI CE COST CENTERS				- = [_]	-				
50. 00 05000 OPERATING ROOM	3, 107, 214	267, 295			0				
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0				
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0				
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 354, 018	232, 565			0				
60. 00 06000 LABORATORY	2, 913, 214	141, 257			0	00.00			
65. 00 06500 RESPI RATORY THERAPY	886, 881	41, 193			0				
66. 00 06600 PHYSI CAL THERAPY	1, 317, 536	146, 604			0				
67.00 06700 OCCUPATI ONAL THERAPY	218, 314				0				
68.00 06800 SPEECH PATHOLOGY	31, 982	1, 207			0				
69. 00 06900 ELECTROCARDI OLOGY	2,857	30			0				
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	281, 283	2, 917			0				
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	64, 796				0				
73.00 07300 DRUGS CHARGED TO PATIENTS	4, 096, 138	84, 158			0				
76.00 03160 CARDI OPULMONARY	494, 188	19, 983	474, 2	05 0	0	76.00			
	0	0	1	0	0	00.00			
90.00 09000 CLINIC 90.01 09001 FAMILY PRACTICE OF JAY COUNTY	0	0		0 0	0				
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY 90. 02 09002 JAY FAMILY MEDICINE	2,094,082	112, 165			0				
90. 02 109002 JAY FAMILY MEDICINE 90. 03 109003 WOUND CLINIC	2, 193, 962	113, 034			0				
90. 03 109003 WOUND CLINIC 90. 04 109004 OP ORTHO CLINIC	0	0		0 0	0				
90.05 09005 JAY FAMILY FIRST HEALTH CARE	1, 159, 380	175, 213	984, 1	47 0	0				
90.06 09006 INFUSION CLINIC	339, 865	30, 607			0				
90. 07 09007 HEALTH BEGI NNINGS PROGRAM	936, 323	141, 787			0				
91. 00 09100 EMERGENCY	3, 965, 470				0				
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 241, 619				0				
93. 00 04950 OUTPATIENT PSYCH	239, 335	67, 096			0				
200.00 Subtotal (sum of lines 50 thru 199)	27, 938, 457	1, 978, 210			-	200.00			
201.00 Less Observation Beds	1, 241, 619					201.00			
202.00 Total (line 200 minus line 201)	26, 696, 838					202.00			
	, , 000	.,,,							

Health Financial Systems	IU HEALTH JA	Y HOSPI TAL		In Li	eu of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RA REDUCTIONS FOR MEDICAID ONLY	ATIOS NET OF	Provider C	CN: 15-1320	Period: From 01/01/202 To 12/31/202	
	_		e XIX	Hospi tal	PPS
Cost Center Description	Cost Net of	Total Charges			
	Capital and	(Worksheet C,	Cost to		
	Operati ng	Part I,	Charge Rati	0	
	Cost	column 8)	(col. 6 /		
	Reduction		col. 7)		
	6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	3, 107, 214	5, 945, 200			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0.0000		52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0.0000		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 354, 018	13, 285, 351	0. 1771	89	54.00
60. 00 06000 LABORATORY	2, 913, 214	8, 257, 662	0. 3527	89	60.00
65. 00 06500 RESPI RATORY THERAPY	886, 881	1, 596, 976	0. 5553	50	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 317, 536	1, 507, 265	0. 87412	24	66.00
67.00 06700 OCCUPATI ONAL THERAPY	218, 314	415, 028	0. 5260	22	67.00
68.00 06800 SPEECH PATHOLOGY	31, 982	27, 700	1. 1545	85	68.00
69.00 06900 ELECTROCARDI OLOGY	2,857	1, 164, 005	0. 0024	54	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	281, 283	233, 958	1. 2022	80	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	64, 796	276, 140	0. 2346	49	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	4, 096, 138	13, 539, 911	0. 3025	23	73.00
76.00 03160 CARDI OPULMONARY	494, 188	2, 239, 623	0. 2206	57	76.00
OUTPATIENT SERVICE COST CENTERS			•		
90. 00 09000 CLINIC	0	0	0.0000	00	90.00
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	2,094,082	1, 087, 668	1. 9252	95	90.01
90. 02 09002 JAY FAMILY MEDICINE	2, 193, 962				90.02
90. 03 09003 WOUND CLINIC	0			00	90.03
90.04 09004 OP ORTHO CLINIC	0	l o	0.0000		90.04
90. 05 09005 JAY FAMILY FIRST HEALTH CARE	1, 159, 380	170, 150			90.05
90.06 09006 INFUSION CLINIC	339, 865				90.06
90. 07 09007 HEALTH BEGI NNI NGS PROGRAM	936, 323				90.07
91.00 09100 EMERGENCY	3, 965, 470				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 241, 619				92.00
93. 00 04950 OUTPATI ENT PSYCH	239, 335				93.00
200.00 Subtotal (sum of lines 50 thru 199)	27, 938, 457				200.00
201.00 Less Observation Beds	1, 241, 619				201.00
202.00 Total (line 200 minus line 201)	26, 696, 838				202.00
			•	1	1

Health Financial Systems	IU HEALTH JA	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C	CN: 15-1320	Peri od:	Worksheet D	
				From 01/01/2021	Part II	
				To 12/31/2021	Date/Time Pre 5/27/2022 8:0	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	, (column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS	1		1			
50.00 05000 OPERATING ROOM	267, 295	5, 945, 200				
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0			0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0.0000		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	232, 565					54.00
60. 00 06000 LABORATORY	141, 257				4, 491	60.00
65. 00 06500 RESPI RATORY THERAPY	41, 193					65.00
66. 00 06600 PHYSI CAL THERAPY	146, 604					66.00
67.00 06700 OCCUPATI ONAL THERAPY	26, 754					67.00
68.00 06800 SPEECH PATHOLOGY	1, 207				264	68.00
69. 00 06900 ELECTROCARDI OLOGY	30				0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 917					71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	672					72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	84, 158					73.00
76.00 03160 CARDI OPULMONARY	19, 983	2, 239, 623	0.00892	66, 208	591	76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0				0	90.00
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	112, 165				0	90.01
90.02 09002 JAY FAMILY MEDICINE	113, 034	976, 958			0	90.02
90. 03 09003 WOUND CLINIC	0	0	0.0000		0	90.03
90. 04 09004 OP ORTHO CLINIC	0	0			0	90.04
90.05 09005 JAY FAMILY FIRST HEALTH CARE	175, 213				0	90.05
90.06 09006 INFUSION CLINIC	30, 607				0	90.06
90. 07 09007 HEALTH BEGI NNI NGS PROGRAM	141, 787	179, 647			0	90.07
91.00 09100 EMERGENCY	255, 651				427	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	118, 022				0	92.00
93. 00 04950 OUTPATI ENT PSYCH	67, 096				0	93.00
200.00 Total (lines 50 through 199)	1, 978, 210	76, 769, 956	l	1, 991, 363	32, 288	200. 00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS Provider CCN: 15-1320 Priod: From 01/01/2021 To 12/31/2021 Worksheet D Part IV Date/Time Prepared: 50.00 am Cost Center Description Non Physician Anesthetist Cost Nursing Program Program Post-Stepdown Adjustments Al II et Heal th Al II et Heal th Adjustments Al II et Heal th Al II et Heal t	Health F	Financial Systems	Y HOSPI TAL		In Lieu of Form CMS-2552-10			
Cost Center Description Non Physician Anesthetist Cost Nursing Program Adjustments Nursing Program Adjustments Allied Health Post-Stepdown Adjustments 50.00 05200 [DELIVERY ROM & LABOR ROM 0 0 000] OPERATING ROM 0 0 000 0						From 01/01/2021 Part IV To 12/31/2021 Date/Time P 5/27/2022 8		pared: 0 am
Anesthetist Cost Program Post-Stepdown Adjustments Post-Stepdown Adjustments ANCI LLARY SERVICE COST CENTERS 1.00 2A 2.00 3A 3.00 50.00 05000 OPERATING ROOM 0 0 0 0 0 50.00 52.00 05200 DELIVERY ROM & LABOR ROM 0 0 0 0 0 52.00 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 53.00 05000 0				Title	XVIII			
ANCI LLARY SERVICE COST CENTERS 50. 00 05000 DPERATI NG ROM 0		Cost Center Description	Anesthetist	Program Post-Stepdown	Program	Post-Stepdown	Allied Health	
50.00 05000 OPERATING ROOM 0 0 0 0 0 0 0 0 0 0 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0			1.00	2A	2.00	3A	3.00	
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 OK400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 0 54.00 60.00 06000 LABORATORY 0	A	ANCILLARY SERVICE COST CENTERS			_			
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	50.00 C	D5000 OPERATING ROOM	0	0		0 0	0	50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C 0	52.00 C	D5200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
60.00 06000 LABORATORY 0	53.00 C	D5300 ANESTHESI OLOGY	0	0		0 0	0	53.00
65.00 06500 RESPIRATORY THERAPY 0 0 0 0 66.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 67.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 71.00 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 72.00 73.00 03160 CARDI OPULMONARY 0 0 0 0 76.00 90.01 O9001 FAMI LY PRACTICE OF JAY COUNTY 0 0 0 0 90.01 90.02 90003 WOUND CLINIC 0 0 0 0 0 90.02 90.03 09003 WOUND CLINIC 0 0 0 0	54.00 C	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
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 68.00 71.00 07100 MEDI CAL SUPLI ES CHARGED TO PATI ENTS 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 73.00 76.00 03160 CARDI OPULMONARY 0 0 0 0 0 73.00 90.01 FAMI LY PRACTI CE OF JAY COUNTY 0 0 0 0 0 90.01 90.02 JAY FAMI LY MEDI CI NE 0 0 0 0 90.02 </td <td>60.00 C</td> <td>D6000 LABORATORY</td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td>60.00</td>	60.00 C	D6000 LABORATORY	0	0		0 0	0	60.00
67.00 06700 OCCUPATIONAL THERAPY 0 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 69.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 73.00 76.00 03160 CARDI OPULMONARY 0 0 0 0 73.00 04.00 09000 CLI NI C 0 0 0 0 90.00 090.01 09000 TI INI C 0 0 0 0 0 90.01 90.02 09002 JAY FAMI LY MEDI CI NE 0 0 0 0 90.02 90.03 09003 WOUND CLI NI C 0 0 0 0 90.0	65.00 C	06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
68.00 06800 SPEECH PATHOLOGY 0 <td>66. 00 C</td> <td>D6600 PHYSI CAL THERAPY</td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td>66.00</td>	66. 00 C	D6600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
69.00 06900 ELECTROCARDIOLOGY 0 0 0 0 0 0 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 73.00 76.00 03160 CARDIOPULMONARY 0	67.00 C	06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 73.00 76.00 03160 CARDI OPULMONARY 0 0 0 0 0 73.00 76.00 001PATI ENT SERVI CE COST CENTERS 0 0 0 0 0 0 0 76.00 00100 CLINIC 0 0 0 0 0 0 90.00 90.01 90.01 09001 FAMI LY PRACTICE OF JAY COUNTY 0 0 0 0 90.02 90.02 JAY FAMI LY MEDI CI NE 0 0 0 90.02 90.03 90.03 90.03 90.04 90.04 90.05 90.05 90.05 90.05 90.05 90.05 90.05 90.05 90.05 90.05 90.05 90.05 90.05 90.06 90.05 90.06 90.06 90.05	68.00 C	06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
72.00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 73.00 76.00 03160 CARDI OPULMONARY 0 <td>69.00 C</td> <td>06900 ELECTROCARDI OLOGY</td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td>69.00</td>	69.00 C	06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 73.00 76.00 03160 CARDI OPULMONARY 0 0 0 0 0 0 0 76.00 0UTPATI ENT SERVICE COST CENTERS 0	71.00 0	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
76.00 03160 CARDI OPULMONARY 0 0 0 0 0 0 0 0 0 0 76.00 OUTPATI ENT SERVICE COST CENTERS 0 0 0 0 0 0 0 90.00 90.01 90.01 90.01 90.01 FAMILY PRACTICE OF JAY COUNTY 0 0 0 0 0 90.01 90.01 90.02 JAY FAMILY MEDICINE 0 0 0 0 90.02 90.03 90.04 90.03 90.04 90.03 90.04 90.03 90.04 90.04 90.04 90.04 90.04 90.04 90.04 90.04 90.04 90.04 90.04 90.04 90.05 90.04 90.05 90.04 90.05 90.04 90.05 90.05 90.05 90.06 1NFUSI 0N CLINIC 0 0 0 0 90.05 90.06 09006 INFUSI 0N CLINIC 0 0 0 0 0 90.06 90.06 90.07 </td <td></td> <td></td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td>72.00</td>			0	0		0 0	0	72.00
OUTPATI ENT SERVICE COST CENTERS 90.00 09000 CLINIC 0 0 0 0 90.00 90.01 09001 FAMILY PRACTICE OF JAY COUNTY 0	73.00 0	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
90.00 09000 CLINIC 0 0 0 0 0 90.00 90.01 09001 FAMILY PRACTICE OF JAY COUNTY 0 0 0 0 0 90.01 90.02 09002 JAY FAMILY MEDICINE 0 0 0 0 0 90.02 90.03 09003 WOUND CLINIC 0 0 0 0 90.03 90.04 09 004 0P ORTHO CLINIC 0 0 0 0 90.04 90.05 JAY FAMILY FIRST HEALTH CARE 0 0 0 0 90.05 90.06 09006 INFUSION CLINIC 0 0 0 0 90.05 90.06 09006 INFUSION CLINIC 0 0 0 0 90.06 90.07 09007 HEALTH BEGINNINGS PROGRAM 0 0 0 0 0 90.07	76.00 0	03160 CARDI OPULMONARY	0	0		0 0	0	76.00
90.01 09001 FAMI LY PRACTICE OF JAY COUNTY 0 0 0 0 90.01 90.02 09002 JAY FAMI LY MEDI CI NE 0 0 0 0 90.02 90.03 09003 WOUND CLI NI C 0 0 0 0 90.03 90.04 09004 OP ORTHO CLI NI C 0 0 0 0 90.04 90.05 JAY FAMI LY FIRST HEALTH CARE 0 0 0 0 90.05 90.06 09006 I NFUSI ON CLI NI C 0 0 0 0 90.06 90.07 09007 HEALTH BEGI NNI NGS PROGRAM 0 0 0 0 90.07	C	DUTPATIENT SERVICE COST CENTERS						
90.02 JAY FAMILY MEDICINE 0 0 0 0 90.02 90.03 09003 WOUND CLINIC 0 0 0 0 90.03 90.04 09004 OP ORTHO CLINIC 0 0 0 0 90.04 90.05 09005 JAY FAMILY FIRST HEALTH CARE 0 0 0 0 90.05 90.06 09006 INFUSION CLINIC 0 0 0 0 90.06 90.07 09007 HEALTH BEGINNINGS PROGRAM 0 0 0 0 90.07	90.00	09000 CLINIC	0	0		0 0	0	90.00
90. 03 09003 WOUND CLINIC 0 0 0 0 90. 03 90. 04 09004 OP ORTHO CLINIC 0 0 0 0 90. 04 90. 05 09005 JAY FAMILY FIRST HEALTH CARE 0 0 0 0 90. 05 90. 06 09006 INFUSION CLINIC 0 0 0 0 90. 06 90. 07 09007 HEALTH BEGINNINGS PROGRAM 0 0 0 0 90. 07 <td>90.01</td> <td>09001 FAMILY PRACTICE OF JAY COUNTY</td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td>90.01</td>	90.01	09001 FAMILY PRACTICE OF JAY COUNTY	0	0		0 0	0	90.01
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 0 90. 07			0	0		0 0	0	
90.05 09005 JAY FAMILY FIRST HEALTH CARE 0 0 0 0 90.05 90.06 09006 INFUSION CLINIC 0 0 0 0 0 90.06 90.07 09007 HEALTH BEGINNINGS PROGRAM 0 0 0 0 0 90.07			0	0		0 0	0	90.03
90.06 09006 I NFUSI ON CLINIC 0 0 0 0 90.06 90.07 09007 HEALTH BEGI NNI NGS PROGRAM 0 0 0 0 0 0 90.07			0	0		0 0	0	
90. 07 09007 HEALTH BEGINNINGS PROGRAM 0 0 0 0 0 90. 07	90.05	09005 JAY FAMILY FIRST HEALTH CARE	0	0		0 0	0	90.05
	90.06	D9006 INFUSION CLINIC	0	0		0 0	0	90.06
91.00 09100 EMERGENCY 0 0 0 0 91.00	90.07	09007 HEALTH BEGI NNI NGS PROGRAM	0	0		0 0	0	
			0	0		0 0	0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 92. 00			0			0	0	
93. 00 04950 OUTPATIENT PSYCH 0 0 0 0 93. 00	93.00 0	04950 OUTPATI ENT PSYCH	0	0		0 0	0	93.00
200.00 Total (lines 50 through 199) 0	200.00	Total (lines 50 through 199)	0	0		0 0	0	200.00

Health Financial Systems IU HEALTH JAY HOSPITAL In Lieu of Form CMS-2552-										
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PAS				Date/Time Pre 5/27/2022 8:0					
			XVIII	Hospi tal	Cost					
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost					
	Medi cal	(sum of cols.	Outpatient	(from Wkst.	to Charges					
	Educati on	1, 2, 3, and	Cost (sum of		(col. 5 ÷					
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)					
			and 4)		(see					
					instructions)					
	4.00	5.00	6.00	7.00	8.00					
ANCI LLARY SERVICE COST CENTERS			1		0.00000					
50.00 O5000 OPERATING ROOM	0	0		0 5, 945, 200						
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0.00000					
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0.000000					
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 13, 285, 351	0.000000					
60. 00 06000 LABORATORY	0	0		0 8, 257, 662	0.000000					
65. 00 06500 RESPIRATORY THERAPY	0	0		0 1, 596, 976						
66.00 06600 PHYSI CAL THERAPY	0	0		0 1, 507, 265						
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0 415, 028						
68.00 06800 SPEECH PATHOLOGY	0	0		0 27,700						
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 1, 164, 005	0.000000					
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0		0 233, 958						
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 276, 140						
73. 00 07300 DRUGS CHARGED TO PATI ENTS	0	0		0 13, 539, 911	0.000000					
76.00 03160 CARDI OPULMONARY	0	0		0 2, 239, 623	0. 000000	76.00				
OUTPATIENT SERVICE COST CENTERS		0	1		0.000000					
90. 00 09000 CLINIC	0	0		0 0	0.000000					
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY	0	0		0 1,087,668						
90. 02 09002 JAY FAMILY MEDICINE 90. 03 09003 WOUND CLINIC	0	0		0 976, 958						
	0	0		0 0	0.000000					
	0	0		0 170 150	0.000000					
	0	0		0 170, 150						
	0	0		0 1, 832, 927	0.000000					
90. 07 09007 HEALTH BEGI NNI NGS PROGRAM 91. 00 09100 EMERGENCY	0	0		0 179, 647 0 20, 634, 194						
	0	0								
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 93. 00 04950 OUTPATI ENT PSYCH	0	0		0 3, 094, 079 0 305, 514						
200.00 Total (lines 50 through 199)	0	0		0 76, 769, 956		200.00				
	0	0	1	0 10, 109, 930	l	200.00				

Health Financial Systems	IU HEALTH JAY	HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provider C	CN: 15-1320	Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2021		
				To 12/31/2021	Date/Time Pre 5/27/2022 8:0	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Outpati ent	Inpatient	I npati ent	Outpati ent	Outpatient	
·	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Throug	n Charges	Pass-Through	
	(col. 6 ÷		Costs (col.	8	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS			1		1	
50.00 05000 OPERATI NG ROOM	0. 000000	24, 306		0 0	-	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0		52.00
53.00 05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	212, 499		0 0	0	54.00
60. 00 06000 LABORATORY	0. 000000	262, 531		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	276, 792		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	64, 207		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	32, 084		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	6, 068		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	12, 371		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	9, 150		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	6, 186		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	984, 513		0 0		73.00
76.00 03160 CARDI OPULMONARY	0. 000000	66, 208		0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS	1 1					
90. 00 09000 CLINIC	0. 000000	0		0 0		90.00
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	0. 000000	0		0 0	-	90.01
90. 02 09002 JAY FAMILY MEDICINE	0. 000000	0		0 0	0	90.02
90. 03 09003 WOUND CLINIC	0. 000000	0		0 0	0	90.03
90. 04 09004 OP ORTHO CLINIC	0. 000000	0		0 0	0	90.04
90. 05 09005 JAY FAMILY FIRST HEALTH CARE	0. 000000	0		0 0	0	90.05
90.06 09006 INFUSION CLINIC	0. 000000	0		0 0	0	90.06
90. 07 09007 HEALTH BEGI NNI NGS PROGRAM	0. 000000	0		0 0	0	90.07
91. 00 09100 EMERGENCY	0. 000000	34, 448		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0 0	0	92.00
93.00 04950 OUTPATIENT PSYCH	0. 000000	0		0 0	-	93.00
200.00 Total (lines 50 through 199)		1, 991, 363	I	0 0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provider C		Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Pre	epared:
		Title	e XVIII	Hospi tal	5/27/2022 8:0 Cost	o am
			Charges	nosprea	Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Reimbursed	Reimbursed	Reimbursed	(see inst.)	
	From	Services (see		Services Not	()	
	Worksheet C,	inst.)	Subject To	Subject To		
	Part I, col.		Ded. & Coins			
	9		(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS	·					
50. 00 05000 OPERATING ROOM	0. 522642	C	1, 095, 01	2 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	C		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	c c)	0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 177189	c c	2, 561, 90	4 0	0	54.00
60. 00 06000 LABORATORY	0. 352789	c c	1, 551, 43	1 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 555350	c c	110, 00	7 0	0	65.00
66.00 06600 PHYSI CAL THERAPY	0. 874124	c c	293, 71	1 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 526022	C C	29, 19	6 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	1. 154585	C C	48	4 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 002454	C C	228, 83	6 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 202280	C	24, 36	9 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 234649	C C	40, 59	1 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 302523	C	1, 681, 29	0 95, 481	0	73.00
76.00 03160 CARDI OPULMONARY	0. 220657	C C	642,07	6 0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0. 000000	C		0 0	0	90.00
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	1. 925295	c c	269, 07	7 52, 265	0	90.01
90.02 09002 JAY FAMILY MEDICINE	2. 245708	C	403, 48	5 95, 465	0	90.02
90. 03 09003 WOUND CLINIC	0. 000000	c c		0 0	0	90.03
90.04 09004 OP ORTHO CLINIC	0. 000000	C C		0 0	0	90.04
90.05 09005 JAY FAMILY FIRST HEALTH CARE	6. 813870	c c	56, 19	0 15, 043	0	90.05
90.06 09006 INFUSION CLINIC	0. 185422	C C	742, 57	4 359	0	90.06
90. 07 09007 HEALTH BEGINNINGS PROGRAM	5. 212016	C	18, 59	3 0	0	90.07
91.00 09100 EMERGENCY	0. 192180		3, 421, 01	1 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 401289	C	730, 81	1 898	0	92.00
93. 00 04950 OUTPATIENT PSYCH	0. 783385	C	32, 70	7 0	0	93.00
200.00 Subtotal (see instructions)		C	13, 933, 35	5 259, 511	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	1	C	13, 933, 35	5 259, 511	0	202.00

Health Financial Systems IU HEALTH JAY HOSPITAL In Lieu of Form CMS-2552								
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST			Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Pro 5/27/2022 8:			
			XVIII	Hospi tal	Cost			
		sts						
Cost Center Description	Cost	Cost						
	Reimbursed	Reimbursed						
	Servi ces	Services Not						
	Subject To	Subject To						
	Ded. & Coins.	Ded. & Coins.						
	(see inst.)	(see inst.)						
	6.00	7.00						
ANCI LLARY SERVI CE COST CENTERS		-	1					
50.00 05000 OPERATING ROOM	572, 299	0				50.00		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00		
53. 00 05300 ANESTHESI OLOGY	0	0				53.00		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	453, 941	0				54.00		
60. 00 06000 LABORATORY	547, 328	0				60.00		
65. 00 06500 RESPI RATORY THERAPY	61, 092	0				65.00		
66. 00 06600 PHYSI CAL THERAPY	256, 740	0				66.00		
67.00 06700 OCCUPATI ONAL THERAPY	15, 358	0				67.00		
68.00 06800 SPEECH PATHOLOGY	559	0				68.00		
69. 00 06900 ELECTROCARDI OLOGY	562	0				69.00		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	29, 298	0				71.00		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	9, 525	0				72.00		
73.00 07300 DRUGS CHARGED TO PATIENTS	508, 629	28, 885				73.00		
76.00 03160 CARDI OPULMONARY	141, 679	0				76.00		
OUTPATIENT SERVICE COST CENTERS								
90. 00 09000 CLINIC	0	0				90.00		
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	518, 053	100, 626				90.01		
90.02 09002 JAY FAMILY MEDICINE	906, 109	214, 387				90.02		
90. 03 09003 WOUND CLINIC	0	0				90.03		
90.04 09004 OP ORTHO CLINIC	0	0				90.04		
90.05 09005 JAY FAMILY FIRST HEALTH CARE	382, 871	102, 501				90.05		
90.06 09006 INFUSION CLINIC	137, 690	67				90.06		
90. 07 09007 HEALTH BEGI NNI NGS PROGRAM	96, 907	0				90.07		
91.00 09100 EMERGENCY	657, 450	0				91.00		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	293, 266	360				92.00		
93. 00 04950 OUTPATIENT PSYCH	25, 622	0				93.00		
200.00 Subtotal (see instructions)	5, 614, 978	446, 826				200.00		
201.00 Less PBP Clinic Lab. Services-Program	0,011,770					201.00		
Only Charges								
202.00 Net Charges (line 200 - line 201)	5, 614, 978	446, 826				202.00		

Health Financial Systems	IU HEALTH JAY HOSPITAL				In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi de	er CC		Peri od:	Worksheet D	
					From 01/01/2021	Part I	
					To 12/31/2021	Date/Time Pre 5/27/2022 8:0	epared:
			Title XIX		Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Be			Total Patient	Per Diem	
cost center bescription	Related Cost	Adjustme		Capi tal	Days	(col. 3 /	
	(from Wkst.	Aujustille	···	Related Cost		col. 4)	
	B, Part II,			(col. 1 -		COI. 4)	
	col. 26)			col. 2)			
	1.00	2.00		3.00	4,00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00		3.00	4.00	5.00	
30. 00 ADULTS & PEDIATRICS	617, 878	120	, 682	487, 19	6 2, 386	204. 19	30.00
40. 00 SUBPROVIDER - IPF	017,078	130	, 002	407, 19	0 2,300	0.00	•
43. 00 NURSERY	0		0		0 0	0.00	
200.00 Total (lines 30 through 199)	617, 878			487, 19	6 2,386		200.00
Cost Center Description	Inpati ent	Inpatier	\+	407, 19	0 2,300		200.00
cost center bescription							
	Program days	Program Capital C					
		(col. 5					
		col. 6)					
	6,00	7.00	,				
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00					
30. 00 ADULTS & PEDIATRICS	40	0	, 168				30.00
40. 00 SUBPROVIDER - IPF	40	0	, 100				40.00
43. 00 NURSERY	0		0				40.00
200.00 Total (lines 30 through 199)	40		, 168				200.00
200. 00 10 tai (111185 30 till 00gli 199)	1 40	0	, 100	l			200.00

Health Financial Systems	IU HEALTH JAY HOSPITAL In Lieu of Form CM						
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C	CN: 15-1320	Peri od:	Worksheet D		
				From 01/01/2021	Part II	norod.	
				To 12/31/2021	Date/Time Pre 5/27/2022 8:0	pared: O am	
		Ti tl	e XIX	Hospi tal 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		
ANCILLARY SERVICE COST CENTERS	1	I	1	T	1		
50.00 05000 OPERATING ROOM	267, 295				-		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0.0000				
53. 00 05300 ANESTHESI OLOGY	0	0	0.0000		0	53.00	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	232, 565		0. 01750			54.00	
60. 00 06000 LABORATORY	141, 257					60.00	
65. 00 06500 RESPI RATORY THERAPY	41, 193					65.00	
66. 00 06600 PHYSI CAL THERAPY	146, 604					66.00	
67.00 06700 OCCUPATI ONAL THERAPY	26, 754				365		
68.00 06800 SPEECH PATHOLOGY	1, 207				-		
69. 00 06900 ELECTROCARDI OLOGY	30					69.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 917				77	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	672				0	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	84, 158						
76.00 03160 CARDI OPULMONARY	19, 983	2, 239, 623	0.00892	3, 842	34	76.00	
OUTPATIENT SERVICE COST CENTERS							
90. 00 09000 CLINIC	0						
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	112, 165						
90.02 09002 JAY FAMILY MEDICINE	113, 034				-	90.02	
90. 03 09003 WOUND CLINIC	0	0			0	90.03	
90. 04 09004 OP ORTHO CLINIC	0	0	0.0000		0	90.04	
90.05 09005 JAY FAMILY FIRST HEALTH CARE	175, 213				0	90.05	
90.06 09006 INFUSION CLINIC	30, 607				0	90.06	
90. 07 09007 HEALTH BEGI NNI NGS PROGRAM	141, 787				0	90.07	
91. 00 09100 EMERGENCY	255, 651				379		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	118, 022					92.00	
93.00 04950 OUTPATI ENT PSYCH	67, 096				0	93.00	
200.00 Total (lines 50 through 199)	1, 978, 210	76, 769, 956		125, 431	2, 323	200.00	

Health Financial Systems	IU HEALTH JA				u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVIC	E OTHER PASS THROUGH COS	TS Provider C		Period: From 01/01/2021 To 12/31/2021	Worksheet D Part III Date/Time Pre 5/27/2022 8:0	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
	Program	Program	Post-Stepdowr	n Cost	Medi cal	
	Post-Stepdown	Ũ	Adjustments		Educati on	
	Adjustments				Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CEN	ERS					
30. 00 03000 ADULTS & PEDI ATRI CS	0	0		0 0	0	30.00
40. 00 04000 SUBPROVIDER - IPF	0	0		0 0	0	40.00
43.00 04300 NURSERY	0	0		o o	0	43.00
200.00 Total (lines 30 through 199)	0	0		o o	0	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patient	t Per Diem	I npati ent	
	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,	-	col. 6)		
	instructions)	minus col. 4)				
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CEN	ERS					
30.00 03000 ADULTS & PEDIATRICS	0	0	2, 38	6 0.00	40	30.00
40. 00 04000 SUBPROVIDER - IPF	0	0		0 0.00	0	40.00
43.00 04300 NURSERY		0		0.00	0	43.00
200.00 Total (lines 30 through 199)		0	2, 38	6	40	200.00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7					
	x col. 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CEN	ERS					
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
40. 00 04000 SUBPROVIDER - IPF	0					40.00
43.00 04300 NURSERY	0					43.00
200.00 Total (lines 30 through 199)						200.00

Health Financial Systems	IU HEALTH JAY	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PASS			Period: From 01/01/2021 To 12/31/2021	Date/Time Pre 5/27/2022 8:0	pared: 0 am
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description		Nursing Program Post-Stepdown Adjustments	Nursing Program	Post-Stepdown Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0		0 0	0 0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0 0	52.00
53.00 05300 ANESTHESI OLOGY	0	0		0 0	0 0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0 0	54.00
60. 00 06000 LABORATORY	0	0		0 0	0 0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0 0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0 0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0 0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0 0	73.00
76.00 03160 CARDI OPULMONARY	0	0		0 0	0 0	76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0		0 (0 0	90.00
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	0	0		0 0	0 0	90.01
90.02 09002 JAY FAMILY MEDICINE	0	0		0 0	0 0	90.02
90. 03 09003 WOUND CLINIC	0	0		0 0	0 0	90.03
90. 04 09004 OP ORTHO CLINIC	0	0		0 0	0 0	90.04
90.05 09005 JAY FAMILY FIRST HEALTH CARE	0	0		0 0	0 0	90.05
90.06 09006 INFUSION CLINIC	0	0		0 0	0 0	90.06
90. 07 09007 HEALTH BEGI NNI NGS PROGRAM	0	0		0 0	0 0	90.07
91.00 09100 EMERGENCY	0	0		0 0	0 0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00
93.00 04950 OUTPATIENT PSYCH	0	0		0 0	0 0	93.00
200.00 Total (lines 50 through 199)	0	0		0 0	0 0	200.00

Health Financial Systems	IU HEALTH JA	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	RVICE OTHER PAS			Period: From 01/01/2021 To 12/31/2021	Date/Time Pre 5/27/2022 8:0	
			e XIX	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Education	1, 2, 3, and	Cost (sum of		(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVICE COST CENTERS			1		0.00000	
50.00 O5000 OPERATING ROOM	0	0		0 5, 945, 200		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0.00000	
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0.000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 13, 285, 351	0.000000	
60. 00 06000 LABORATORY	0	0		0 8, 257, 662	0.000000	
65. 00 06500 RESPIRATORY THERAPY	0	0		0 1, 596, 976		
66.00 06600 PHYSI CAL THERAPY	0	0		0 1, 507, 265		
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0 415, 028		
68.00 06800 SPEECH PATHOLOGY	0	0		0 27,700		
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 1, 164, 005	0.000000	
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0		0 233, 958		
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 276, 140		
73. 00 07300 DRUGS CHARGED TO PATI ENTS	0	0		0 13, 539, 911	0.000000	
76.00 03160 CARDI OPULMONARY	0	0		0 2, 239, 623	0. 000000	76.00
OUTPATIENT SERVICE COST CENTERS	0	0	1		0.000000	
90. 00 09000 CLINIC	0	0		0 0	0.000000	
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY	0	0		0 1,087,668		
90. 02 09002 JAY FAMILY MEDICINE 90. 03 09003 WOUND CLINIC	0	0		0 976, 958		
	0	0		0 0	0.000000	
	0	0		0 170 150	0.000000	
90. 05 09005 JAY FAMILY FIRST HEALTH CARE 90. 06 09006 INFUSION CLINIC	0	0		0 170, 150 0 1, 832, 927	0. 000000 0. 000000	
	0	0				
90. 07 09007 HEALTH BEGINNINGS PROGRAM 91. 00 09100 EMERGENCY	0	0		0 179, 647 0 20, 634, 194		
	0	0				
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 93. 00 04950 OUTPATI ENT PSYCH	0	0		0 3, 094, 079 0 305, 514		
200.00 Total (lines 50 through 199)	0	0		0 76, 769, 956		200.00
	0	0	1	0 10, 107, 930	l	IZ00.00

Health Financial Systems	IU HEALTH JAY	HOSPI TAL			In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI		Provider C	CN: 15-1320		ri od:	Worksheet D	
THROUGH COSTS					om 01/01/2021	Part IV	
				То	12/31/2021	Date/Time Pre 5/27/2022 8:0	pared:
		Ti †I	e XIX		Hospi tal	572772022 8:0 PPS	u am
Cost Center Description	Outpati ent	Inpatient	I npati ent		Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program		Program	Program	
	to Charges	Charges	Pass-Throug	h	Charges	Pass-Through	
	(col. 6 ÷	5.1.1. g = -	Costs (col.		g	Costs (col. 9	
	col. 7)		x col. 10)	-		x col. 12)	
	9.00	10.00	11.00		12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0. 000000	0		0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	0	52.00
53.00 05300 ANESTHESI OLOGY	0. 000000	0	1	0	0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	11, 253	1	0	0	0	54.00
60.00 06000 LABORATORY	0. 000000	19, 425	1	0	0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	4, 212	1	0	0	0	65.00
66.00 06600 PHYSI CAL THERAPY	0. 000000	5, 801	1	0	0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	5, 667		0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	0		0	0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	0. 000000	1, 652		0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	6, 202		0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	36, 433		0	0	0	73.00
76.00 03160 CARDI OPULMONARY	0. 000000	3, 842		0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90. 00 09000 CLI NI C	0. 000000	0		0	0	0	90.00
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	0. 000000	384		0	0	0	90.01
90.02 09002 JAY FAMILY MEDICINE	0. 000000	0		0	0	0	90.02
90. 03 09003 WOUND CLINIC	0. 000000	0		0	0	0	90.03
90. 04 09004 OP ORTHO CLINIC	0. 000000	0		0	0	0	90.04
90.05 09005 JAY FAMILY FIRST HEALTH CARE	0. 000000	0		0	0	0	90.05
90.06 09006 INFUSION CLINIC	0. 000000	0		0	0	0	90.06
90. 07 09007 HEALTH BEGI NNI NGS PROGRAM	0. 000000	0		0	0	0	90.07
91.00 09100 EMERGENCY	0. 000000	30, 560		0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0	0	0	92.00
93.00 04950 OUTPATIENT PSYCH	0. 000000	0		0	0	0	93.00
200.00 Total (lines 50 through 199)		125, 431		0	0	0	200.00

	Financial Systems IU HEALTH JAY H CATION OF INPATIENT OPERATING COST	Provider CCN: 15-1320	Period: From 01/01/2021	u of Form CMS-2 Worksheet D-1	
			To 12/31/2021	Date/Time Pre 5/27/2022 8:0	
	Cost Center Description	Title XVIII	Hospi tal	Cost	
	PART I - ALL PROVIDER COMPONENTS			1.00	
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	(s. oveluding nowborn)	I	3, 589	1 1
00 00 00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da	bed and newborn days)	rivate room days,	2, 386 0	2
00 00	do not complete this line. Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		or 21 of the cost	1, 808 640	4
	reporting period	5 / 5			
00	Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	5		0	6
00	Total swing-bed NF type inpatient days (including private roc reporting period			562	
00	Total swing-bed NF type inpatient days (including private roc reporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	8
00	Total inpatient days including private room days applicable t newborn days) (see instructions)	the Program (excludin	g swing-bed and	652	9
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instruct		room days)	640	10
00	Swing-bed SNF type inpatient days applicable to title XVIII of December 31 of the cost reporting period (if calendar year, e	only (including private	room days) after	0	11
00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period		te room days)	0	12
. 00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y	X only (including priva	te room days)	0	13
	Medically necessary private room days applicable to the Progr	ram (excluding swing-bed	days)	0	
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0 0	
. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servic	es through December 31	of the cost		117
. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	ces after December 31 of	the cost		18
. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	es through December 31 o	f the cost	0.00	19
00	reporting period Medicaid rate for swing-bed NF services applicable to service reporting period	es after December 31 of	the cost	0.00	20
. 00 . 00	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb		ting period (line	6, 500, 233 0	21 22
. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reporti	ng period (line 6	0	23
. 00	x line 18) Swing-bed cost applicable to NF type services through December	er 31 of the cost report	ing period (line	0	24
. 00	7 x line 19) Swing-bed cost applicable to NF type services after December	31 of the cost reportin	g period (line 8	0	25
. 00	x line 20) Total swing-bed cost (see instructions)			1, 374, 803	
	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			5, 125, 430	27
	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	ed and observation bed c	harges)	0	
. 00	Semi-private room charges (excluding swing-bed charges)			0	30
00	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	÷ line 28)		0. 000000 0. 00	
00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 mi		ctions)	0.00	
	Average per diem private room cost differential (line 34 x li	ne 31)		0.00	
	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost	and private room cost d	ifferential (line	0 5, 125, 430	36 37
	27 minus Line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ			0 140 40	1
. 00	Adjusted general inpatient routine service cost per diem (see			2, 148. 13	38
. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr	-		1, 400, 581 0	

Health Financial Systems	IU HEALTH JAY	HOSPI TAL		In Lie	eu of Form CMS-	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider C		Period: From 01/01/2021	Worksheet D-1	
				To 12/31/2021	Date/Time Pre	
		Title	e XVIII	Hospi tal	5/27/2022 8:0 Cost	JU am
Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
	Inpati ent	Inpatient	Diem (col. 1		(col. 3 x	
	<u>Cost</u> 1.00	<u>Days</u> 2.00	÷ col. 2) 3.00	4.00	<u>col.4)</u> 5.00	-
42.00 NURSERY (title V & XIX only)	0	C				42.00
Intensive Care Type Inpatient Hospital Units					1	40.00
43.00 I NTENSI VE CARE UNI T 44.00 CORONARY CARE UNI T						43.00
45. 00 BURN I NTENSI VE CARE UNI T						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY) Cost Center Description			<u> </u>			47.00
Cost center bescription					1.00	
48.00 Program inpatient ancillary service cost (W	st. D-3, col. 3	line 200)			708, 247	48.00
49.00 Total Program inpatient costs (sum of lines	41 through 48)(see instructi	ons)		2, 108, 828	49.00
PASS THROUGH COST ADJUSTMENTS 50.00 Pass through costs applicable to Program ing	atient routine (services (fro	m Wkst D su	m of Parts I and		50.00
					Ĭ	00.00
51.00 Pass through costs applicable to Program in	patient ancillar	y services (f	rom Wkst. D,	sum of Parts II	0	51.00
and IV) 52.00 Total Program excludable cost (sum of lines	50 and 51)				0	52.00
53.00 Total Program inpatient operating cost exclu		ated, non-ph	vsician anest	hetist, and		
medical education costs (line 49 minus line						
TARGET AMOUNT AND LIMIT COMPUTATION						54.00
54.00 Program di scharges 55.00 Target amount per di scharge					0.00	
56.00 Target amount (line 54 x line 55)					0.00	
57.00 Difference between adjusted inpatient operation	ting cost and ta	rget amount (line 56 minus	line 53)	0	
58.00 Bonus payment (see instructions) 59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by th						58.00 59.00
59.00 Lesser of lines 53/54 or 55 from the cost re market basket	eporting period (enui ng 1996,	updated and co	unpounded by the	0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year					0.00	
61.00 If line 53/54 is less than the lower of line					0	61.00
which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see		s (Tines 54 x	60), or 1% o	r the target		
62.00 Relief payment (see instructions)	,				0	62.00
63.00 Allowable Inpatient cost plus incentive payr	nent (see instru	ctions)			0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST 64.00 Medicare swing-bed SNF inpatient routine cost	sts through Dece	mber 31 of th	e cost report	ing period (See	1, 374, 803	64.00
instructions)(title XVIII only)				ing period (bee	1, 0, 1, 000	
65.00 Medicare swing-bed SNF inpatient routine cos	sts after Decembe	er 31 of the	cost reporting	g period (See	0	65.00
instructions)(title XVIII only)66.00 Total Medicare swing-bed SNF inpatient routi	ne costs (line)	54 nlus line	65)(title XVI	LL only) For	1, 374, 803	66.00
CAH (see instructions)			00)(11110 XVI	ri oniy). Toi	1, 374, 003	00.00
67.00 Title V or XIX swing-bed NF inpatient routin	ne 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	ne costs after D	acombor 31 of	the cost ren	orting period	c c	68.00
(line 13 x line 20)		sceniber 51 01	the cost rep	bitting period		00.00
69.00 Total title V or XIX swing-bed NF inpatient					0	69.00
70.00 Skilled nursing facility/other nursing facil				`	1	70.00
70.00 Skilled nursing facility/other nursing facil 71.00 Adjusted general inpatient routine service of	2		•)		71.00
72.00 Program routine service cost (line 9 x line			,			72.00
73.00 Medically necessary private room cost applic	U U	•				73.00
74.00 Total Program general inpatient routine serv 75.00 Capital-related cost allocated to inpatient				Part II column		74.00
26, line 45)	Toutine service	0313 (110	worksheet b, i			/ 0.00
76.00 Per diem capital-related costs (line 75 ÷ li						76.00
77.00 Program capital-related costs (line 9 x line 78.00 Inpatient routine service cost (line 74 minu						77.00
78.00 Inpatient routine service cost (line 74 minu 79.00 Aggregate charges to beneficiaries for exces		rovider recor	ds)			78.00
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 Inpatient routine service cost limitation (1 83.00 Reasonable inpatient routine service costs						82.00
84.00 Program inpatient ancillary services (see in		-,				84.00
85.00 Utilization review - physician compensation	(see instruction					85.00
86.00 Total Program inpatient operating costs (sur		rough 85)				86.00
PART IV - COMPUTATION OF OBSERVATION BED PAS 87.00 Total observation bed days (see instructions					578	87.00
3 .		line 2)			2, 148. 13	
88.00 Adjusted general inpatient routine cost per					1, 241, 619	

Health Financial Systems	IU HEALTH JA	Y HOSPI TAL		In Lie	2552-10	
COMPUTATION OF INPATIENT OPERATING COST		Provider C		Period: From 01/01/2021	Worksheet D-1	
				To 12/31/2021		pared: 0 am
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	617, 878	6, 500, 233	0. 09505	5 1, 241, 619	118, 022	90.00
91.00 Nursing Program cost	0	6, 500, 233	0.00000	0 1, 241, 619	0	91.00
92.00 Allied health cost	0	6, 500, 233	0.00000	0 1, 241, 619	0	92.00
93.00 All other Medical Education	0	6, 500, 233	0.00000	0 1, 241, 619	0	93.00

		r CCN: 15-1320	Peri od: From 01/01/2021 To 12/31/2021	J of Form CMS-2 Worksheet D-1 Date/Time Prep 5/27/2022 8:00	pare
	Cost Center Description	Title XIX	Hospi tal	PPS	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
00	Inpatient days (including private room days and swing-bed days, exclu			3, 589	
00 00	Inpatient days (including private room days, excluding swing-bed and Private room days (excluding swing-bed and observation bed days). If		rivate room days	2, 386 0	
00	do not complete this line.	you have only p	Trvate room days,	0	J.
00	Semi-private room days (excluding swing-bed and observation bed days)			1, 808	
00	Total swing-bed SNF type inpatient days (including private room days) reporting period	through Decemb	er 31 of the cost	640	5.
00	Total swing-bed SNF type inpatient days (including private room days)	after December	31 of the cost	0	6.
	reporting period (if calendar year, enter 0 on this line)				
00	Total swing-bed NF type inpatient days (including private room days)	through Decembe	r 31 of the cost	563	7.
00	reporting period 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)			0	0.
00	Total inpatient days including private room days applicable to the Pr	ogram (excludin	g swing-bed and	40	9.
0. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (inc	luding private	room days)	0	10.
5. 00	through December 31 of the cost reporting period (see instructions)	ruaring private	room days)	0	10.
1.00	Swing-bed SNF type inpatient days applicable to title XVIII only (inc		room days) after	0	11.
2.00	December 31 of the cost reporting period (if calendar year, enter 0 o Swing-bed NF type inpatient days applicable to titles V or XIX only (to room days)	0	12.
2.00	through December 31 of the cost reporting period	riici uuriig priva	te room uays)	0	12.
3.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (0	13.
	after December 31 of the cost reporting period (if calendar year, ent	er O on this li	ne)		
	Medically necessary private room days applicable to the Program (excl Total nursery days (title V or XIX only)	uaing swing-bea	days)	0	
	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT				
7.00	Medicare rate for swing-bed SNF services applicable to services throu	gh December 31	of the cost		17.
3. 00	reporting period Medicare rate for swing-bed SNF services applicable to services after	December 31 of	the cost		18.
	reporting period				
9.00	Medicaid rate for swing-bed NF services applicable to services throug	h December 31 o	f the cost	0.00	19.
0. 00	reporting period Medicaid rate for swing-bed NF services applicable to services after	December 31 of	the cost	0.00	20.
	reporting period				
	Total general inpatient routine service cost (see instructions)			6, 500, 233	
	Swing-bed cost applicable to SNF type services through December 31 of	the cost repor	ting period (line	0	22.
2.00					22.
	5 x line 17) Swing-bed cost applicable to SNF type services after December 31 of t	he cost reporti	ng period (line 🕯	0	
3. 00	Swing-bed cost applicable to SNF type services after December 31 of t x line 18) $$				23.
	Swing-bed cost applicable to SNF type services after December 31 of t x line 18) Swing-bed cost applicable to NF type services through December 31 of			0 0	23.
3. 00 4. 00	Swing-bed cost applicable to SNF type services after December 31 of t x line 18) Swing-bed cost applicable to NF type services through December 31 of 7 x line 19)	the cost report	ing period (line	0	23. 24.
3.00 4.00 5.00	Swing-bed cost applicable to SNF type services after December 31 of t x line 18) Swing-bed cost applicable to NF type services through December 31 of 7 x line 19) Swing-bed cost applicable to NF type services after December 31 of th x line 20)	the cost report	ing period (line	0	23. 24. 25.
3.00 4.00 5.00 6.00	Swing-bed cost applicable to SNF type services after December 31 of t x line 18) Swing-bed cost applicable to NF type services through December 31 of 7 x line 19) Swing-bed cost applicable to NF type services after December 31 of th x line 20) Total swing-bed cost (see instructions)	the cost report e cost reportin	ing period (line g period (line 8	0 0 1, 374, 803	23. 24. 25. 26.
3. 00 4. 00 5. 00 5. 00	Swing-bed cost applicable to SNF type services after December 31 of t x line 18) Swing-bed cost applicable to NF type services through December 31 of 7 x line 19) Swing-bed cost applicable to NF type services after December 31 of th x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21)	the cost report e cost reportin	ing period (line g period (line 8	0	23 24 25 26
3.00 4.00 5.00 5.00 7.00	Swing-bed cost applicable to SNF type services after December 31 of t x line 18) Swing-bed cost applicable to NF type services through December 31 of 7 x line 19) Swing-bed cost applicable to NF type services after December 31 of th x line 20) Total swing-bed cost (see instructions)	the cost report e cost reportin 	ing period (line g period (line 8	0 0 1, 374, 803	23. 24. 25. 26. 27.
 . 00 	Swing-bed cost applicable to SNF type services after December 31 of t x line 18) Swing-bed cost applicable to NF type services through December 31 of 7 x line 19) Swing-bed cost applicable to NF type services after December 31 of th x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and ob Private room charges (excluding swing-bed charges)	the cost report e cost reportin 	ing period (line g period (line 8	0 0 1, 374, 803 5, 125, 430 0 0	23. 24. 25. 26. 27. 28. 29.
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Swing-bed cost applicable to SNF type services after December 31 of t x line 18) Swing-bed cost applicable to NF type services through December 31 of 7 x line 19) Swing-bed cost applicable to NF type services after December 31 of th x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and ob Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)	the cost report e cost reportin minus line 26) servation bed c	ing period (line g period (line 8	0 0 1, 374, 803 5, 125, 430 0 0 0 0	23 24 25 26 27 28 29 30
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Swing-bed cost applicable to SNF type services after December 31 of t x line 18) Swing-bed cost applicable to NF type services through December 31 of 7 x line 19) Swing-bed cost applicable to NF type services after December 31 of th x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and ob Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 2	the cost report e cost reportin minus line 26) servation bed c	ing period (line g period (line 8	0 0 1, 374, 803 5, 125, 430 0 0 0 0 0 0.000000	23 24 25 26 27 28 29 30 31
 . 00 	Swing-bed cost applicable to SNF type services after December 31 of t x line 18) Swing-bed cost applicable to NF type services through December 31 of 7 x line 19) Swing-bed cost applicable to NF type services after December 31 of th x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and ob Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)	the cost report e cost reportin minus line 26) servation bed c	ing period (line g period (line 8	0 0 1, 374, 803 5, 125, 430 0 0 0 0	23. 24. 25. 26. 27. 28. 29. 30. 31. 32.
 . 00 . 00<td>Swing-bed cost applicable to SNF type services after December 31 of t x line 18) Swing-bed cost applicable to NF type services through December 31 of 7 x line 19) Swing-bed cost applicable to NF type services after December 31 of th x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and ob Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 2 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line</td><td>the cost report e cost reportin minus line 26) servation bed c 8)</td><td>ing period (line g period (line 8 harges)</td><td>0 1, 374, 803 5, 125, 430 0 0 0. 000000 0. 000000 0. 00 0. 00 0. 00</td><td>23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34.</td>	Swing-bed cost applicable to SNF type services after December 31 of t x line 18) Swing-bed cost applicable to NF type services through December 31 of 7 x line 19) Swing-bed cost applicable to NF type services after December 31 of th x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and ob Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 2 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line	the cost report e cost reportin minus line 26) servation bed c 8)	ing period (line g period (line 8 harges)	0 1, 374, 803 5, 125, 430 0 0 0. 000000 0. 000000 0. 00 0. 00 0. 00	23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34.
3. 00 4. 00 5. 00 5. 00 5. 00 5. 00 3. 00 9. 00 1. 00 2. 00 3. 00 4. 00 5. 00	Swing-bed cost applicable to SNF type services after December 31 of t x line 18) Swing-bed cost applicable to NF type services through December 31 of 7 x line 19) Swing-bed cost applicable to NF type services after December 31 of th x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 <u>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</u> General inpatient routine service charges (excluding swing-bed and ob Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 2 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room cost differential (line 34 x line 31)	the cost report e cost reportin minus line 26) servation bed c 8)	ing period (line g period (line 8 harges)	0 1, 374, 803 5, 125, 430 0 0 0.00000 0.00000 0.000 0.00 0.000 0.00 0.00	23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35.
3. 00 4. 00 5. 00 5. 00 6. 00 7. 00 3. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 5. 00	Swing-bed cost applicable to SNF type services after December 31 of t x line 18) Swing-bed cost applicable to NF type services through December 31 of 7 x line 19) Swing-bed cost applicable to NF type services after December 31 of th x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and ob Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 2 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line	the cost report e cost reportin <u>minus line 26)</u> servation bed c 8) 33)(see instru	ing period (line g period (line 8 harges) ctions)	0 1, 374, 803 5, 125, 430 0 0 0 0 0 0 0 0 0 0 0 0 0	23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36.
3. 00 4. 00 5. 00 5. 00 5. 00 5. 00 5. 00 5. 00 5. 00 5. 00 5. 00 5. 00 5. 00 5. 00 5. 00 5. 00 5. 00 5. 00	Swing-bed cost applicable to SNF type services after December 31 of t x line 18) Swing-bed cost applicable to NF type services through December 31 of 7 x line 19) Swing-bed cost applicable to NF type services after December 31 of th x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and ob Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 2 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and priv 27 minus line 36)	the cost report e cost reportin <u>minus line 26)</u> servation bed c 8) 33)(see instru	ing period (line g period (line 8 harges) ctions)	0 1, 374, 803 5, 125, 430 0 0 0 0 0 0 0 0 0 0 0 0 0	23 24 25 26 27 28 29 30 31 32 33 34 35 36
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Swing-bed cost applicable to SNF type services after December 31 of t x line 18) Swing-bed cost applicable to NF type services through December 31 of 7 x line 19) Swing-bed cost applicable to NF type services after December 31 of th x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and ob Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 2 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room cost differential (line 32 minus line Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and priv 27 minus line 36) PART 11 - HOSPITAL AND SUBPROVIDERS ONLY	the cost report e cost reportin <u>minus line 26)</u> servation bed c 8) 33)(see instru ate room cost d	ing period (line g period (line 8 harges) ctions)	0 1, 374, 803 5, 125, 430 0 0 0 0 0 0 0 0 0 0 0 0 0	23 24 25 26 27 28 29 30 31 32 33 34 35 36
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Swing-bed cost applicable to SNF type services after December 31 of t x line 18) Swing-bed cost applicable to NF type services through December 31 of 7 x line 19) Swing-bed cost applicable to NF type services after December 31 of th x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and ob Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 + line 2 Average private room per diem charge (line 29 + line 3) Average semi-private room per diem charge (line 30 + line 4) Average per diem private room cost differential (line 32 minus line Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and priv 27 minus line 36) PART 11 - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	the cost report e cost reportin minus line 26) servation bed c 8) 33)(see instru ate room cost d	ing period (line g period (line 8 harges) ctions)	0 1, 374, 803 5, 125, 430 0 0 0 0 0 0 0 0 0 0 0 0 0	23 24 25 26 27 28 29 30 31 32 33 34 35 36 37
3. 00 4. 00 5. 00 5. 00 5. 00 5. 00 5. 00 5. 00 5. 00 5. 00 5. 00 5. 00 5. 00 5. 00 5. 00 5. 00 6. 00 7. 00 3. 00	Swing-bed cost applicable to SNF type services after December 31 of t x line 18) Swing-bed cost applicable to NF type services through December 31 of 7 x line 19) Swing-bed cost applicable to NF type services after December 31 of th x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and ob Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 2 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room cost differential (line 32 minus line Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and priv 27 minus line 36) PART 11 - HOSPITAL AND SUBPROVIDERS ONLY	the cost report e cost reportin minus line 26) servation bed c 8) 33)(see instru ate room cost d	ing period (line g period (line 8 harges) ctions)	0 1, 374, 803 5, 125, 430 0 0 0 0 0 0 0 0 0 0 0 0 0	23 24 25 26 27 30 31 32 33 34 35 36 37 37 38

<u>He</u> al th	Financial Systems	IU HEALTH JAY	HOSPI TAL		In Lie	u of Form CMS-	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-1320	Period: From 01/01/2021	Worksheet D-1	l
					To 12/31/2021		
			Ti tl	e XIX	Hospi tal	5/27/2022 8:0 PPS	JU alli
	Cost Center Description	Total	Total	Average Per		Program Cost	
		Inpatient Cost	Inpatient Days	Diem (col. + col. 2)		(col. 3 x col. 4)	
10.00		1.00	2.00	3.00	4.00	5.00	10.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	(0. (0 0	0	42.00
43.00	INTENSIVE CARE UNIT						43.00
44.00 45.00	CORONARY CARE UNI T BURN I NTENSI VE CARE UNI T						44.00
46.00	SURGI CAL I NTENSI VE CARE UNI T						46.00
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.00
	cost center bescription					1.00	
48.00	Program inpatient ancillary service cost (Wk					45, 181	
49.00	Total Program inpatient costs (sum of lines - PASS THROUGH COST ADJUSTMENTS	41 through 48)(s	see Instructi	ons)		131, 106	49.00
50.00	Pass through costs applicable to Program inpa	atient routine s	services (fro	m Wkst. D, su	m of Parts I and	8, 168	50.00
51.00	<pre>III) Pass through costs applicable to Program inp.</pre>	atient ancillary	, services (f	rom Wkst D	sum of Parts II	2, 323	51.00
51.00	and IV)			rom wkst. D,		2, 525	51.00
52.00 53.00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		ated per ph	velelan anost	botict and	10, 491 120, 615	
55.00	medical education costs (line 49 minus line		ateu, non-pi	ysi ci all'allest	netist, and	120, 015	53.00
54.00	TARGET AMOUNT AND LIMIT COMPUTATION						54.00
54.00 55.00	Program discharges Target amount per discharge					0 0.00	
56.00	Target amount (line 54 x line 55)					0	56.00
57.00 58.00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and tar	rget amount (line 56 minus	line 53)	0	1
58.00 Bonus payment (see instructions) 59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by th							
(0.00	market basket	ant report up	lated by the	markat backat		0.00	40.00
60.00 61.00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line					0.00	1
	which operating costs (line 53) are less that	n expected costs					
62.00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	Instructions)				0	62.00
63.00	Allowable Inpatient cost plus incentive paym	ent (see instruc	ctions)			0	63.00
64.00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Decer	nher 31 of th	e cost report	ing period (See	0	64.00
	instructions)(title XVIII only)	Ū.			0 1 1		
65.00	Medicare swing-bed SNF inpatient routine cos instructions)(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 routin	ne costs (line é	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	o costs through	Docombor 21	of the cost r	oporting ported	0	67.00
67.00	(line 12 x line 19)	e costs through	December 31	of the cost i	eporting period		07.00
68.00	Title V or XIX swing-bed NF inpatient routing	e costs after De	ecember 31 of	the cost rep	orting period	0	68.00
69.00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (I	ine 67 + lin	e 68)		0	69.00
70.00	PART III - SKILLED NURSING FACILITY, OTHER NU				\ \		1 70 00
70.00 71.00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of)		70.00
72.00	Program routine service cost (line 9 x line	71)					72.00
73.00 74.00	Medically necessary private room cost application Total Program general inpatient routine serv	0	•				73.00
75.00	Capital -related cost allocated to inpatient	•		·	Part II, column		75.00
76.00	26, line 45) Per diem capital related costs (line 75 ± li	20 2)					76.00
78.00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						77.00
78.00	Inpatient routine service cost (line 74 minu:	,					78.00
79.00 80.00	Aggregate charges to beneficiaries for excess Total Program routine service costs for comp	• •			nus line 79)		79.00
81.00	Inpatient routine service cost per diem limit	tation		、 / o ///			81.00
82.00 83.00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (82.00 83.00
83.00 84.00	Program inpatient ancillary services (see in:		<i>•)</i>				83.00
85.00	Utilization review - physician compensation	(see instruction					85.00
86.00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		ougn 85)			<u> </u>	86.00
87.00	Total observation bed days (see instructions))				578	
88.00 89.00	Adjusted general inpatient routine cost per observation bed cost (line 87 x line 88) (see	•	line 2)			2, 148. 13 1, 241, 619	
07.00						1 ., 2.1., 017	1 0 / 00

Health Financial Systems	IU HEALTH JA	Y HOSPI TAL		In Lie	2552-10	
COMPUTATION OF INPATIENT OPERATING COST		Provider C		Period: From 01/01/2021	Worksheet D-1	
				To 12/31/2021		pared: 0 am
		Titl	e XIX	Hospi tal	PPS	
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	617, 878	6, 500, 233	0.09505	5 1, 241, 619	118, 022	90.00
91.00 Nursing Program cost	0	6, 500, 233	0.00000	0 1, 241, 619	0	91.00
92.00 Allied health cost	0	6, 500, 233	0.00000	0 1, 241, 619	0	92.00
93.00 All other Medical Education	0	6, 500, 233	0.00000	0 1, 241, 619	0	93.00

	JAY HOSPITAL			u of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1320	Peri od:	Worksheet D-3	
			From 01/01/2021 To 12/31/2021	Date/Time Pre	narod
			10 12/31/2021	5/27/2022 8:0	
	Title	xviii	Hospi tal	Cost	o an
Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
		To Charges	Program	Program Costs	
		_	Charges	(col. 1 x	
				col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS			1, 512, 442		30.00
40. 00 04000 SUBPROVI DER – I PF			0		40.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS		1			
50. 00 05000 OPERATING ROOM		0. 52264			
52.00 05200 DELIVERY ROOM & LABOR ROOM		0.0000		-	52.00
53. 00 05300 ANESTHESI OLOGY		0.0000		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 17718			
60. 00 06000 LABORATORY		0. 35278			
65. 00 06500 RESPI RATORY THERAPY		0. 55535			
66. 00 06600 PHYSI CAL THERAPY		0. 87412			
67.00 06700 OCCUPATI ONAL THERAPY		0. 52602			
68.00 06800 SPEECH PATHOLOGY		1. 15458			
69. 00 06900 ELECTROCARDI OLOGY		0. 00245			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1. 20228			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 23464			
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 30252			
76. 00 03160 CARDI OPULMONARY		0. 22065	66, 208	14, 609	76.00
OUTPATIENT SERVICE COST CENTERS				-	
90. 00 09000 CLINIC		0.0000			90.00
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY		1. 92529			
90. 02 09002 JAY FAMILY MEDICINE		2. 24570		0	90.02
90. 03 09003 WOUND CLINIC		0.0000		-	90.03
90. 04 09004 OP ORTHO CLINIC		0.0000		0	90.04
90. 05 09005 JAY FAMILY FIRST HEALTH CARE		6. 81387		, s	90.05
90. 06 09006 I NFUSI ON CLINIC		0. 18542		-	90.06
90. 07 09007 HEALTH BEGI NNI NGS PROGRAM		5. 21201		0	90.07
91. 00 09100 EMERGENCY		0. 19218			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 40128		-	
93.00 04950 OUTPATIENT PSYCH		0. 78338		0	
200.00 Total (sum of lines 50 through 94 and 96 through 94			1, 991, 363	708, 247	
201.00 Less PBP Clinic Laboratory Services-Program only cl	harges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			1, 991, 363		202.00

Health Financial Systems IU HEALTH J	AY HOSPI TAL		In Li	eu of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1320	Period:	Worksheet D-3	}
	Component	CCN: 15-Z320	From 01/01/202 [°] To 12/31/202 [°]		epared.
				5/27/2022 8:0	
	Title	e XVIII	Swing Beds - SN		
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges		Program Costs	
			Charges	(col. 1 x	
		1.00	2.00	<u>col.2)</u> 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	5.00	
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
40. 00 04000 SUBPROVI DER - I PF					40.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS		•			
50.00 05000 OPERATING ROOM		0. 5226	42 (0 0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0.0000	00 00	o o	52.00
53. 00 05300 ANESTHESI OLOGY		0.0000	00 (0 0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1771	89 48, 82	5 8, 651	54.00
60. 00 06000 LABORATORY		0.3527	89 63, 74 ⁻	1 22, 487	60.00
65. 00 06500 RESPI RATORY THERAPY		0. 5553	50 105, 928	3 58, 827	65.00
66. 00 06600 PHYSI CAL THERAPY		0.8741	24 191, 400	5 167, 313	66.00
67.00 06700 OCCUPATI ONAL THERAPY		0. 5260	22 123, 68 ⁻	1 65, 059	67.00
68.00 06800 SPEECH PATHOLOGY		1. 1545	85 2, 522	2 2, 912	68.00
69. 00 06900 ELECTROCARDI OLOGY		0.0024		2 7	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1. 2022		0 0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 2346			
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 3025			73.00
76.00 03160 CARDI OPULMONARY		0. 2206	57 5, 76	5 1, 272	76.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC		0.0000		0 0	
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY		1.9252		0 0	1
90. 02 09002 JAY FAMILY MEDICINE		2.2457		0 0	
90. 03 09003 WOUND CLINIC		0.0000		0	
90. 04 09004 OP ORTHO CLINIC		0.0000		0 0	
90. 05 09005 JAY FAMILY FIRST HEALTH CARE		6.8138		0 0	
90. 06 09006 INFUSION CLINIC		0. 1854		0	
90. 07 09007 HEALTH BEGI NNI NGS PROGRAM		5.2120		°	
91. 00 09100 EMERGENCY		0. 1921		0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0.4012		0	
93. 00 04950 OUTPATIENT PSYCH		0. 7833			
200.00 Total (sum of lines 50 through 94 and 96 through 98)			845, 05		
201.00 Less PBP Clinic Laboratory Services-Program only cha	irges (Trne 61)				201.00
202.00 Net charges (line 200 minus line 201)		I	845, 05	1	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT Cost Center Description	Provider C	e XIX	Peri od: From 01/01/2021 To 12/31/2021 Hospi tal	Worksheet D-3 Date/Time Pre	
Cost Center Description	Ti tl		To 12/31/2021		
Cost Center Description	Ti tl				nared
Cost Center Description	Ti tl		llooni tol	5/27/2022 8:0	
Cost Center Description			HOSPILAI	PPS	
		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
				col. 2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			05 454		
30. 00 03000 ADULTS & PEDI ATRI CS			95, 151		30.00
40. 00 04000 SUBPROVIDER - IPF			0		40.00
43. 00 04300 NURSERY ANCI LLARY SERVICE COST CENTERS			0		43.00
50. 00 05000 OPERATING ROOM		0. 52264	12 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 00000		0	52.00
53. 00 05300 ANESTHESI OLOGY		0.00000		0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 17718		-	
60. 00 06000 LABORATORY		0. 35278		6, 853	1
65. 00 06500 RESPI RATORY THERAPY		0. 5553		2, 339	
66. 00 06600 PHYSI CAL THERAPY		0. 87412		2, 339 5, 071	
67. 00 06700 0CCUPATI ONAL THERAPY		0. 52602		2, 981	67.00
68. 00 06800 SPEECH PATHOLOGY		1. 15458		2, 701	1
69. 00 06900 ELECTROCARDI OLOGY		0. 00245		4	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1. 20228		7,457	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 23464		0	
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 30252		11, 022	73.00
76. 00 03160 CARDI OPULMONARY		0. 22065		848	
OUTPATI ENT SERVI CE COST CENTERS		0.2200	5,042	040	/0.00
90. 00 09000 CLINIC		0.0000	0 00	0	90.00
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY		1. 92529		739	
90. 02 09002 JAY FAMILY MEDICINE		2.24570		0	1
90. 03 09003 WOUND CLINIC		0.0000		0	90.03
90. 04 09004 OP ORTHO CLINIC		0.0000		0	90.04
90. 05 09005 JAY FAMILY FIRST HEALTH CARE		6.8138		0	90.05
90. 06 09006 I NFUSI ON CLI NI C		0. 18542		0	90.06
90. 07 09007 HEALTH BEGINNINGS PROGRAM		5. 2120		0	90.07
91. 00 09100 EMERGENCY		0. 19218		5, 873	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 40128		0,0,0	
93. 00 04950 OUTPATIENT PSYCH		0. 78338		0	
200.00 Total (sum of lines 50 through 94 and 96 through 98)			125, 431	45, 181	
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)	. ,		125, 431		202.00

	Financial Systems IU HEALTH JAY ATION OF REIMBURSEMENT SETTLEMENT	HOSPITAL Provider CCN: 15-1320	Period: From 01/01/2021	u of Form CMS-2 Worksheet E Part B	
			To 12/31/2021	Date/Time Pre 5/27/2022 8:0	
	· · · · · · · · · · · · · · · · · · ·	Title XVIII	Hospi tal	Cost	
				1.00	
1.00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)			6, 061, 804	1.00
2.00	Medical and other services (see fistilactions) Medical and other services reimbursed under OPPS (see instru	uctions)		0,001,004	
3.00	OPPS payments			0	
4.00 4.01	Outlier payment (see instructions) Outlier reconciliation amount (see instructions)			0	
5.00	Enter the hospital specific payment to cost ratio (see instr	ructions)		0.000	
6.00 7.00	Line 2 times line 5 Sum of lines 3, 4, and 4.01, divided by line 6			0 0.00	
8.00	Transitional corridor payment (see instructions)			0.00	
9.00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 13, line 200		0	
10.00 11.00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			0 6, 061, 804	10.00
	COMPUTATION OF LESSER OF COST OR CHARGES			-,,	
12.00	Reasonable charges Ancillary service charges			0	12.00
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4,	line 69)		0	
14.00	Total reasonable charges (sum of lines 12 and 13)			0	14.00
15.00	Customary charges Aggregate amount actually collected from patients liable for	payment for services on	a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable f	for payment for services		0	
17.00	had such payment been made in accordance with 42 CFR §413.13 Ratio of line 15 to line 16 (not to exceed 1.000000)	3(e)		0.000000	17 00
18.00	Total customary charges (see instructions)			0.000000	
19.00	Excess of customary charges over reasonable cost (complete o	only if line 18 exceeds l	ine 11) (see	0	19.00
20. 00	instructions) Excess of reasonable cost over customary charges (complete o	only if line 11 exceeds l	ine 18) (see	0	20.00
01 00	instructions)	•		(100 100	01.00
21.00	Lesser of cost or charges (see instructions) Interns and residents (see instructions)			6, 122, 422 0	
23.00	Cost of physicians' services in a teaching hospital (see ins			0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	24.00
25.00	Deductibles and coinsurance amounts (for CAH, see instruction	ons)		101, 034	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on li			2, 307, 545	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) instructions)	prus the sum of rifles z		3, 713, 843	27.00
	Direct graduate medical education payments (from Wkst. E-4,			0	
29.00 30.00	ESRD direct medical education costs (from Wkst. E-4, line 36 Subtotal (sum of lines 27 through 29)))		0 3, 713, 843	
31.00	Primary payer payments			1, 208	31.00
32.00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERV	/I CES)		3, 712, 635	32.00
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	1023)		0	33.00
34.00 35.00	Allowable bad debts (see instructions)			482, 689	
36.00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins	structions)		313, 748 296, 838	
37.00	Subtotal (see instructions)			4,026,383	
38.00 39.00	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 50	Pioneer ACO demonstration payment adjustment (see instructio			Ū	39.50
39.97 39.98	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for repl		ctions)	0	
39.99	RECOVERY OF ACCELERATED DEPRECIATION	aced devices (see filsting		0	
40.00	Subtotal (see instructions)			4, 026, 383	
40.01	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			0	
40.03	Sequestration adjustment-PARHM pass-throughs				40.03
41.00 41.01	Interim payments Interim payments-PARHM			4, 467, 527	41.00 41.01
	Tentative settlement (for contractors use only)			0	
42.01	Tentative settlement-PARHM (for contractor use only)			441 144	42.01
43.00	Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions)			-441, 144	43.00 43.01
44.00	Protested amounts (nonallowable cost report items) in accord	dance with CMS Pub. 15-2,	chapter 1,	491, 563	
	§115.2 TO BE COMPLETED BY CONTRACTOR				-
	Original outlier amount (see instructions)			0	
	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0 0.00	
	Time Value of Money (see instructions)			0.00	
	Total (sum of lines 91 and 93)			0	94.00

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC		Period: From 01/01/2021 To 12/31/2021		narodi
				10 12/31/2021	5/27/2022 8:00	
		Title		Hospi tal	Cost	
		Inpatient	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, 922, 52	4	3, 121, 827	1.00
2.00	Interim payments payable on individual bills, either			0	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
3.00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment					3.00
3.00	amount based on subsequent revision of the interim rate					3.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider	L I				
3. 01	ADJUSTMENTS TO PROVIDER	11/16/2021	541, 50	0 11/16/2021	1, 345, 700	3. 01
3. 02				0	0	3.02
3.03				0	0	3.03
3.04				0	0	3.04
3.05				0	0	3.05
0 50	Provider to Program	I			0	0.50
3.50 3.51	ADJUSTMENTS TO PROGRAM			0	0	3.50
3.51				0	0	3.51 3.52
3.52				0	0	3.52
3.54				0	0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		541, 50	-	1, 345, 700	3.99
	3. 50-3. 98)				, ,	
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		2, 464, 02	4	4, 467, 527	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate)					
5.00	TO BE COMPLETED BY CONTRACTOR					E OC
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none,					5.00
	write "NONE" or enter a zero. (1)					
	Program to Provider	I				
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	TENTATI VE TO PROGRAM			0	0	5.50
5.51				0	0	5.51
5.52 5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5.52 5.99
5.99	5. 50-5. 98)			0	0	5.95
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					2. 50
6. 01	SETTLEMENT TO PROVIDER			0	0	6. 01
6. 02	SETTLEMENT TO PROGRAM		534, 50		441, 144	6.02
7.00	Total Medicare program liability (see instructions)		1, 929, 51		4, 026, 383	7.00
				Contractor	NPR Date	
		0		Number 1.00	(Mo/Day/Yr) 2.00	

NALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	N: 15-1320	Period: From 01/01/2021	Worksheet E-1	
		Component C	CN: 15-Z320	To 12/31/2021		
		Title	XVIII	Swing Beds - SN		_
		Inpati en	t Part A	Pa	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		1, 745, 8 [,]	41 O	000	2.0
. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.0
. 01	ADJUSTMENTS TO PROVIDER	11/16/2021	425, 70	00	0	3.0
. 02				0	0	
03				0	0	
04				0	0	
. 05	Dravidar to Dragram			0	0	3.(
50	Provider to Program ADJUSTMENTS TO PROGRAM			0	0	3.
50 51	ADJUSTMENTS TO PROGRAM			0		
52				0	0	
53				0	0	
54				0	0	
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		425, 70	00	0	3.
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)		2, 171, 5 [,]	41	0	4. (
	TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after					5.0
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
01	Program to Provider TENTATIVE TO PROVIDER			0	0	5.
02				0	0	
03				0	0	
	Provider to Program	I				1 .
50	TENTATI VE TO PROGRAM			0	0	
51				0	0	
52				0	0	
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5.
00	Determined net settlement amount (balance due) based on the cost report. (1)					6.
01	SETTLEMENT TO PROVIDER			0	0	6.
02	SETTLEMENT TO PROGRAM		374, 5	78	0	
00	Total Medicare program liability (see instructions)		1, 796, 90		0	
				Contractor Number	NPR Date (Mo/Day/Yr)	
		C		1,00	(-

Heal th	Financial Systems IU HEALTH J	AY HOSPI TAL	In Lie	u of Form CMS-	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provi der CCN: 15-1320	Period: From 01/01/2021 To 12/31/2021		epared:
		Title XVIII	Hospi tal	Cost	
	TO DE CONDUCTED DV CONTRACTOR FOR NONCTANDARD COST REPORT			1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORT: HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULA				-
1.00	Total hospital discharges as defined in AARA §4102 from W		0.14		1.00
2.00	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1,				2.00
2.00	reporting periods beginning on or after 10/01/2013, line		TOI COST		2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	32)			3.00
4.00	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of li	nes 1, and 8 through 12, an	d plus for cost		4.00
	reporting periods beginning on or after 10/01/2013, line		· · · · · · · · ·		
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 20	0			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col.	3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase	of certified HIT technology	Wkst. S-2, Pt. I		7.00
	line 168				
8.00	Calculation of the HIT incentive payment (see instruction	s)			8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestrat	ion (see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
	Initial/interim HIT payment adjustment (see instructions)				30.00
	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 a	nd line 31) (see instructio	ns)		32.00

ALCULATION OF REIMBURSEMENT SE	TTLEMENT - SWING BEDS	Provider CCN: 15-1320	Period:	Worksheet E-2	2552-
			From 01/01/2021 To 12/31/2021	Date/Time Pre 5/27/2022 8:0	
		Title XVIII S	Swing Beds - SNF		Jaii
			Part A	Part B	
COMPLITATION OF NET COST			1.00	2.00	<u> </u>
00 COMPUTATION OF NET COST	es - swing bed-SNF (see instru	ctions)	1, 388, 551	0	1.0
	es - swing bed-NF (see instruc		1, 300, 331	0	2.0
1 1		for Part A, and sum of Wkst. D,	421, 567	0	3.0
		and swing-bed pass-through, see	121,007	0	
instructions)					
5	h payment-PARHM (see instruction				3.
	s and residents not in approve	d teaching program (see		0.00	4.
instructions) 00 Program days			640	0	5.
5 5	t in approved teaching program	(see instructions)	040	0	6.
	sician compensation - SNF opti		0	-	7.
00 Subtotal (sum of lines 1	through 3 plus lines 6 and 7)	5	1, 810, 118	0	8.
00 Primary payer payments (0	0	9.
0.00 Subtotal (line 8 minus l			1, 810, 118	0	10.
	ogram patients (exclude amounts	s applicable to physician	0	0	11.
2.00 Subtotal (line 10 minus	line 11)		1, 810, 118	0	12.
	ogram patients (from provider)	records) (exclude coinsurance	13, 727	0	
for physician profession	ö			-	
4.00 80% of Part B costs (lin				0	14.
5.00 Subtotal (see instructio			1, 796, 391	0	15.
6.00 OTHER ADJUSTMENTS (SEE I	, , , ,		0	0	16.
	n payment adjustment (see inst		0		16.
6.55 Rural community hospital adjustment (see instruct	demonstration project (§410A	Demonstration) payment	0		16.
	justment amount before sequest	ration	0	0	16.
7.00 Allowable bad debts (see			880	0	17.
7.01 Adjusted reimbursable ba	d debts (see instructions)		572	0	17.
	dual eligible beneficiaries (s	ee instructions)	880	0	-
9.00 Total (see instructions)			1, 796, 963	0	19.
9.01 Sequestration adjustment	. ,		0	0	19.
9.02 Demonstration payment ad 9.03 Sequestration adjustment	justment amount after sequestra	ation)	0	0	19. 19.
	aims based amounts (see instru	ctions)	0	0	19.
0.00 Interim payments			2, 171, 541	0	
0.01 Interim payments-PARHM					20.
.00 Tentative settlement (fo	r contractor use only)		0	0	21.
	HM (for contractor use only)				21.
	gram (line 19 minus lines 19.0	1, 19.02, 19.25, 20, and 21)	-374, 578	0	
	gram-PARHM (see instructions) lowable cost report items) in a	accordance with CMS Dub 15 2	140 014	0	22. 23.
chapter 1, §115.2	Towable cost report rtems) in a	accoluance with two Pub. 15-2,	140, 814	0	23.
	Demonstration Project (§410A [Demonstration) Adjustment			
00.00 Is this the first year o	f the current 5-year demonstra	tion period under the 21st			200.
	"Y" for yes or "N" for no.				1
Cost Reimbursement					0.01
66 (title XVIII hospital	npatient routine service costs	(Trom WKST. D-I, Pt. II, line			201.
		ts (from Wkst. D-3, col. 3, lin	_		202.
200 (title XVIII swing-b					202.
03.00 Total (sum of lines 201					203.
04.00 Medicare swing-bed SNF d					204.
	tion Target Amount Limitation	(N/A in first year of the curre	nt 5-year demons	trati on	
period) 15.00 Medicare swing-bed SNF t	argat amount				205
	npatient routine cost cap (line	e 205 times line 204)			205. 206.
	art A Swing-Bed SNF Inpatient F				200.
	der the §410A Demonstration (se				207.
08.00 Medicare swing-bed SNF i	npatient service costs (from W	kst. E-2, col. 1, sum of lines	1		208.
and 3)					1.
3	wing-bed SNF PPS payments (see	instructions)			209.
10.00 Reserved for future use	Coot Doimhumocrat				210.
Comparision of PPS versu	s Cost Reimbursement care swing-bed SNF PPS payment	(line 200 plus line 210) (see			215.
instructions)	care swing bed sive Frs payillent	(1110 207 prus 1110 210) (See			<u>د ان</u>

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1320	Period: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part V Date/Time Pre	epare
			lleen: tel	5/27/2022 8:0	00 ar
		Title XVIII	Hospi tal	Cost	
				1.00	-
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICA	ARE PART A SERVICES - COS	ST_RELMBURSEMENT	1.00	
. 00	Inpatient services			2, 108, 828	1 1
00	Nursing and Allied Health Managed Care payment (see instruc	ctions)		0	
00	Organ acquisition	,		0	3
00	Subtotal (sum of lines 1 through 3)			2, 108, 828	
00	Primary payer payments			0	5
. 00	Total cost (line 4 less line 5). For CAH (see instructions))		2, 129, 916	6
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable charges				
00	Routine service charges			0	
00	Ancillary service charges			0	
00	Organ acquisition charges, net of revenue			0	
0. 00	Total reasonable charges			0	10
~~	Customary charges			0	1 11
. 00	Aggregate amount actually collected from patients liable for			0	
. 00	Amounts that would have been realized from patients liable had such payment been made in accordance with 42 CFR 413.13	1 3	on a charge basis	0	12
8. 00	Ratio of line 11 to line 12 (not to exceed 1.000000)	3(e)		0.000000	13
. 00	Total customary charges (see instructions)			0.000000	
. 00	Excess of customary charges over reasonable cost (complete	only if line 14 exceeds 1	ine 6) (see	0	
. 00	instructions)			0	
5.00	Excess of reasonable cost over customary charges (complete	only if line 6 exceeds li	ne 14) (see	0	16
	instructions)	5			
7.00	Cost of physicians' services in a teaching hospital (see in	nstructions)		0	17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
3.00	Direct graduate medical education payments (from Worksheet	E-4, line 49)		0	
9.00	Cost of covered services (sum of lines 6, 17 and 18)			2, 129, 916	
0.00	Deductibles (exclude professional component)			215, 104	
. 00	Excess reasonable cost (from line 16)			0	
2.00	Subtotal (line 19 minus line 20 and 21) Coinsurance			1, 914, 812 0	
. 00 . 00	Subtotal (line 22 minus line 23)			1, 914, 812	
. 00	Allowable bad debts (exclude bad debts for professional ser	rvicas) (see instructions)		22, 626	
5.00	Adjusted reimbursable bad debts (see instructions))	14, 707	
. 00	Allowable bad debts for dual eligible beneficiaries (see in	nstructions)		7, 420	
. 00	Subtotal (sum of lines 24 and 25, or line 26)			1, 929, 519	
0.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
. 50	Pioneer ACO demonstration payment adjustment (see instructi	i ons)		0	
. 98	Recovery of accelerated depreciation.			0	
. 99	Demonstration payment adjustment amount before sequestration	on		0	29
00	Subtotal (see instructions)			1, 929, 519	30
. 00	Sequestration adjustment (see instructions)			0	
	Demonstration payment adjustment amount after sequestration	n		0	30
. 01					30
. 01 . 02				2, 464, 024	
). 01). 02). 03 . 00	Interim payments				31
). 00). 01). 02). 03 . 00 . 01	Interim payments Interim payments-PARHM				
). 01). 02). 03 . 00 . 01 2. 00	Interim payments Interim payments-PARHM Tentative settlement (for contractor use only)			0	32
0. 01 0. 02 0. 03 0. 00 0. 01 0. 01 0. 00 0. 01	Interim payments Interim payments-PARHM Tentative settlement (for contractor use only) Tentative settlement-PARHM (for contractor use only)				32 32
 0. 01 0. 02 0. 03 00 01 01 00 01 00 01 00 01 00 	Interim payments Interim payments-PARHM Tentative settlement (for contractor use only) Tentative settlement-PARHM (for contractor use only) Balance due provider/program (line 30 minus lines 30.01, 30			0 -534, 505	32 32 33
0. 01 0. 02 0. 03 1. 00 1. 01 2. 00 2. 01	Interim payments Interim payments-PARHM Tentative settlement (for contractor use only) Tentative settlement-PARHM (for contractor use only)	, minus lines 30.03, 31.01			32 32 33 33

	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider CC		eriod: com 01/01/2021 o 12/31/2021	Worksheet G Date/Time Pre 5/27/2022 8:0	
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
. 00	Cash on hand in banks	-3, 250, 998	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00 4.00	Notes receivable Accounts receivable	0 5, 227, 469	0	0	0	3.00
5.00	Other receivable	5, 227, 409	0	0	0	5.00
o. 00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	638, 564	0	0	0	7.00
3.00 9.00	Prepaid expenses Other current assets	154, 898 0	0	0	0	8.00 9.00
	Due from other funds	0	0	0	0	10.00
	Total current assets (sum of lines 1-10)	3, 270, 497	0	0	0	11.00
	FIXED ASSETS	000.440				1.0.0
	Land Land improvements	989, 148 0	0	0	0	12.00
	Accumulated depreciation	0	0	0	0	14.00
	Buildings	18, 977, 852	0	0	0	15.00
	Accumulated depreciation	-4, 883, 151	0	0	0	16.0
	Leasehold improvements	0	0	0	0	17.0
	Accumulated depreciation Fixed equipment	0	0	0	0	18.0 19.0
	Accumulated depreciation	0	0	0	0	20.0
	Automobiles and trucks	42, 146	0	0	0	21.0
	Accumulated depreciation	-18, 439	0	0	0	22.0
	Major movable equipment Accumulated depreciation	9, 816, 480 -5, 984, 935	0	0	0	23.0 24.0
	Minor equipment depreciable	-5, 764, 755	0	0	0	24.0
	Accumulated depreciation	0	0	0	0	26.0
	HIT designated Assets	0	0	0	0	27.0
	Accumulated depreciation	0	0	0	0	28.0
	Minor equipment-nondepreciable Total fixed assets (sum of lines 12-29)	18, 939, 101	0	0	0	29.00 30.00
	OTHER ASSETS		-	-1		
	Investments	0	0	0	0	31.00
	Deposits on Leases	0	0	0	0	32.0
	Due from owners/officers Other assets	1, 905, 223	0	0	0	33.0 34.0
35.00	Total other assets (sum of lines 31-34)	1, 905, 223	0	0	0	35.0
86.00	Total assets (sum of lines 11, 30, and 35)	24, 114, 821	0	0	0	36.00
	CURRENT_LIABILITIES	4 0/7 040				1 07 0/
	Accounts payable Salaries, wages, and fees payable	1, 967, 942 1, 050, 039	0	0	0	37.00 38.00
	Payrol I taxes payable	60, 278	0	0	0	39.00
	Notes and Loans payable (short term)	0	0	0	0	40.0
	Deferred income	0	0	0	0	41.0
	Accelerated payments Due to other funds	1, 109, 535	0	0	0	42.0 43.0
	Other current liabilities	9, 187, 336	0	0	0	
	Total current liabilities (sum of lines 37 thru 44)	13, 375, 130	0	0	0	45.0
	LONG TERM LIABILITIES					1
	Mortgage payable Notes payable	0	0	0	0	46.0
	Unsecured Loans	0	0	0	0	47.0
	Other long term liabilities	0	0	0	0	49.0
	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.0
51.00	Total liabilities (sum of lines 45 and 50)	13, 375, 130	0	0	0	51.0
52.00	CAPI TAL ACCOUNTS General fund balance	10, 739, 691		I		52.0
	Specific purpose fund	. 5, . 6 , 6 , 1	0			53.0
	Donor created - endowment fund balance - restricted			0		54.0
	Donor created - endowment fund balance - unrestricted			0		55.0
	Governing body created - endowment fund balance Plant fund balance - invested in plant			0	0	56.0 57.0
	Plant fund balance - reserve for plant improvement,				0	58.0
	replacement, and expansion				Ū	
9.00	Total fund balances (sum of lines 52 thru 58)	10, 739, 691	0	0	0	59.0
0.00	Total liabilities and fund balances (sum of lines 51 and	24, 114, 821	0	0	0	60.0

	Financial Systems	IU HEALTH JAY				u of Form CMS-	
STATEN	IENT OF CHANGES IN FUND BALANCES		Provider CO	CN: 15-1320	Period: From 01/01/2021 To 12/31/2021	Worksheet G-1 Date/Time Pre 5/27/2022 8:0	epared:
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance		11, 377, 869 -638, 178 10, 739, 691 10, 739, 691 10, 739, 691 10, 739, 691				$\begin{array}{c} 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund			
		6.00	7.00	8.00		-	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0 0	000000000000000000000000000000000000000		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		00		7.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00
	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		18.00 19.00

	Financial Systems IU HEALTH JAY				u of Form CMS-2	
STATEN	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CO	CN: 15-1320	Period: From 01/01/2021 To 12/31/2021		pared:
	Cost Center Description		I npati ent		Total	
			1.00	2.00	3.00	
	PART I - PATIENT REVENUES					-
1 00	General Inpatient Routine Services		4 511 4	24	4 511 404	1 1 00
1.00 2.00	Hospital SUBPROVIDER - IPF		4, 511, 4	0	4, 511, 424	
2.00	SUBPROVIDER - IRF			0	0	3.00
4.00	SUBPROVI DER					4.00
5.00	Swing bed - SNF		1, 084, 2	97	1, 084, 297	5.00
6.00	Swing bed - NF		1,001,2	0	0	•
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)		5, 595, 7	21	5, 595, 721	10.00
	Intensive Care Type Inpatient Hospital Services				-	
11.00	I NTENSI VE CARE UNI T					11.00
12.00	CORONARY CARE UNIT					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)	<u> </u>				15.00
16.00	Total intensive care type inpatient hospital services (sum	oflines		0	0	16.00
17.00	11-15) Total inpatient routine care services (sum of lines 10 and	1()	5, 595, 7	21	5, 595, 721	17.00
18.00	Ancillary services	10)	8, 026, 4			•
19.00	Outpatient services		932, 4			
20.00	RURAL HEALTH CLINIC		752,4	0 27, 333, 474		•
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0		•
22.00	HOME HEALTH AGENCY			0		22.00
23.00	AMBULANCE SERVICES					23.00
24.00	СМНС					24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)					25.00
26.00	HOSPICE					26.00
27.00	OTHER (SPECIFY)			0 0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column	3 to Wkst.	14, 554, 6	81 67, 815, 822	82, 370, 503	28.00
	G-3, line 1)					
~~ ~~	PART II - OPERATING EXPENSES			00 701 01/		1 00 00
29.00	Operating expenses (per Wkst. A, column 3, line 200)			39, 701, 916		29.00
30.00 31.00	ADD (SPECIFY)			0		30.00
31.00				0		31.00
32.00				0		32.00
34.00				0		34.00
35.00				0		35.00
36.00	Total additions (sum of lines 30–35)			0		36.00
37.00	DEDUCT (SPECIFY)			0		37.00
38.00				0		38.00
39.00				0		39.00
40.00				0		40.00
41.00				0		41.00
42.00	Total deductions (sum of lines 37-41)			0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line	42)(transfer		39, 701, 916		43.00
	to Wkst. G-3, line 4)					1

		TH JAY HOSPITAL		u of Form CMS-2	
STATEM	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-1320	Peri od:	Worksheet G-3	
			From 01/01/2021 To 12/31/2021	Date/Time Pre	nared
			10 12/31/2021	5/27/2022 8:0	
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column			82, 370, 503	
2.00	Less contractual allowances and discounts on patients'	accounts		43, 665, 767	
3.00	Net patient revenues (line 1 minus line 2)			38, 704, 736	
4.00	Less total operating expenses (from Wkst. G-2, Part II			39, 701, 916	
5.00	Net income from service to patients (line 3 minus line	4)		-997, 180	5.00
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			0	
7.00	Income from investments			0	
8.00	Revenues from telephone and other miscellaneous commun	ication services		0	
9.00	Revenue from television and radio service			0	
10.00	Purchase di scounts			0	
	Rebates and refunds of expenses			0	
	Parking lot receipts			-	12.00
	Revenue from laundry and linen service			-	13.0
	Revenue from meals sold to employees and guests			0	14.0
	Revenue from rental of living quarters			0	
	Revenue from sale of medical and surgical supplies to	other than patients		0	1 .0.0
	Revenue from sale of drugs to other than patients				17.0
	Revenue from sale of medical records and abstracts			-	18.0
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.0
	Revenue from gifts, flowers, coffee shops, and canteen			0	
21.00	Rental of vending machines			0	
22.00	Rental of hospital space			0	22.0
23.00	Governmental appropriations			0	23.00
24.00	MI SCELLANEOUS I NCOME			-1, 148, 087	24.0
24.50	COVI D-19 PHE Fundi ng			1, 507, 089	24.5
25.00	Total other income (sum of lines 6-24)			359, 002	
26.00	Total (line 5 plus line 25)			-638, 178	26.00
27.00	OTHER EXPENSES (SPECIFY)			0	27.0
28.00	Total other expenses (sum of line 27 and subscripts)			0	28.00
29 00	Net income (or loss) for the period (line 26 minus lin	e 28)		-638, 178	29 00