Heal th Financia	al Systems	JAY COUNTY HOSP	I TAL	In Lieu	u of Form CMS-2552-10
This report is	required by law (42 USC 1395	g; 42 CFR 413.20(b)). Failu	re to report can re	esult in all interim	FORM APPROVED
payments made	since the beginning of the cos	st reporting period being d	eemed overpayments	(42 USC 1395g).	OMB NO. 0938-0050
HOSPI TAL AND H AND SETTLEMENT	IOSPITAL HEALTH CARE COMPLEX CO SUMMARY	OST REPORT CERTIFICATION	Provider CCN: 1513	20 Period: From 10/01/2014 To 09/30/2015	Worksheet S Parts I-III Date/Time Prepared: 2/17/2016 10:11 am
PART I - COST	REPORT STATUS				
Provi der	1. [X] Electronically filed	cost report		Date: 2/17/20	16 Time: 10:11 am
use only	2. [] Manually submitted co	st report			
	3. [0] If this is an amended 4. [F] Medicare Utilization.	report enter the number of Enter "F" for full or "L"		r resubmitted this co	ost report
Contractor use only	(1) As Submitted(2) Settled without Audit	6. Date Received: 7. Contractor No. 8. [N] Initial Report for 9. [N] Final Report for th	this Provider CCN		
PART II - CERT	I FI CATI ON				
MI SREPRESENTAT	ION OR FALSIFICATION OF ANY I	NFORMATION CONTAINED IN THI	S COST REPORT MAY I	BE PUNISHABLE BY CRIM	INAL, CIVIL AND

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by JAY COUNTY HOSPITAL (151320) for the cost reporting period beginning 10/01/2014 and ending 09/30/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.



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Officer or Administrator of Provider(s)
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Title

Date

			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	-13, 201	-71, 131	0	29, 117	1.00
2.00	Subprovider - IPF	0	0	0		23, 556	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVI DER I	0	0	0		0	4.00
5.00	Swing bed - SNF	0	-931	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00	Total	0	-14, 132	-71, 131	0	52, 673	200.00

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

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX I		COUNTY HOSP TA	I TAL Provi der	- CCN: 1	151320	Peri od:		Workshe		2552-10
							From 10/01/ To 09/30/	/2014	Part I Date/Ti		
	1.00		20						2/17/20		
	<u> </u>		00	3. C)0			4.00			
1.00	Street: 500 W. VOTAW	P0 Box:									1.00
2.00	City: PORTLAND	State: I Component Na		CODE: 4		Provi der	zy: JAY Date	Payme	nt Syst	em (P,	2.00
				mber Nu	mber	Туре	Certi fi ed	Τ,	0, or	N)	-
		1.00	2	. 00 3	3. 00	4.00	5.00	V 6.00	-	XIX 8.00	-
	Hospital and Hospital-Based Componen				0045	4	01 (01 (000 1				
3.00 4.00	Hospital Subprovider – IPF	JAY COUNTY HOSPIT JAY COUNTY			9915 9915	1 4	01/01/2004	1	0 P	0	3.00 4.00
- 00		HOSPITAL-PSYCH UN									
5.00 5.00	Subprovider - IRF Subprovider - (Other)										5.00 6.00
7.00	Swing Beds - SNF	JAY COUNTY HOSPI	TAL 152	Z320 9	9915		01/01/2004	N	0	0	7.00
8.00 9.00	Swing Beds - NF Hospital-Based SNF										8.00 9.00
10.00	Hospi tal -Based NF										10.00
11.00	Hospi tal -Based OLTC										11.00
12.00 13.00	Hospital-Based HHA Separately Certified ASC										12.00 13.00
14.00	Hospi tal -Based Hospi ce										14.00
	Hospital-Based Health Clinic - RHC Hospital-Based Health Clinic - FQHC										15.00 16.00
17.00	Hospi tal -Based (CMHC) I										17.00
17. 10 18. 00	Hospital-Based (CORF) I Renal Dialysis										17.10
	Other										18.00 19.00
			·	·			From:		To		-
20.00	Cost Reporting Period (mm/dd/yyyy)						1.00		2.0 09/30/		20.00
	Type of Control (see instructions)							9			21.00
22.00	Inpatient PPS Information Does this facility qualify and is it	currently receiv	ing payment	s for di	spropor	rti onate	N				22.00
	share hospital adjustment, in accord										
	for yes or "N" for no. Is this facil amendment hospital?) In column 2, en				6(C)(2)) (РГСКГЕ					
22. 01	Did this hospital receive interim un	compensated care	payments fo	or this c			N		N		22. 01
	period? Enter in column 1, "Y" for y reporting period occurring prior to										
	for no for the portion of the cost r										
22. 02	(see instructions) Is this a newly merged hospital that	requires final u	ncomponsate	d care n	avmonte	to be	N		N		22.02
22.02	determined at cost report settlement				2						22.02
	or "N" for no, for the portion of th										
	in column 2, "Y" for yes or "N" for or after October 1.	no, for the porti	on or the c	ost repo	rting p						
22. 03	Did this hospital receive a geograph						t N		Ν		22. 03
	of the OMB standards for delineating in column 1, "Y" for yes or "N" for										
	prior to October 1. Enter in column	2, "Y" for yes or	"N" for no	for the	portic	on of the	e				
	cost reporting period occurring on o hospital contain at least 100 but no						h				
	42 CFR 412.105)? Enter in column 3,	"Y" for yes or "N	" for no.								
23.00	Which method is used to determine Me 1, enter 1 if date of admission, 2 i							3	N		23.00
	method of identifying the days in th	is cost reporting	period dif	ferent f	rom the	e method					
	used in the prior cost reporting per	iod? In column 2	<u>, enter "Y"</u> In-State	for yes In-State		<u>'forno</u> . t-of		ledi cai	d 0	ther	
			Medi cai d	Medi cai d	3 St	ate	State H	iMO day	ys Mec	li cai d	
			paid days	el i gi bl e unpai d			Medicaid eligible		C	lays	
				days	paru		unpai d				
24.00	If the provider is an IDDO is the	optor the	1.00	2.00		. 00	4.00	5.00		. 00	24.00
24.00	If this provider is an IPPS hospital in-state Medicaid paid days in colum		0		0	0	0		0	0	24.00
	Medicaid eligible unpaid days in col	umn 2,									
	out-of-state Medicaid paid days in c out-of-state Medicaid eligible unpai										
	4, Medicaid HMO paid and eligible bu	t unpaid days in									
	column 5, and other Medicaid days in		~		0	0	0		0		25.00
25 00	If this provider is an IRF, enter th		0		4	U	U U		9		∠0. UU
25.00	Medicaid paid days in column 1, the	in-state	1								
25. 00	Medicaid eligible unpaid days in col	umn 2,									
25. 00		umn 2, 3, out-of-state									

Heal th	Financial Systems JAY	COUNTY	HOSPI TAL		l i	n Lieu	u of For	m CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D	ATA	Provi der		eriod: rom 10/01/ p 09/30/		Workshe Part I Date/Ti 2/17/20	me Pre	pared:
					Urban/Rur 1.00			Geogr	
26.00	Enter your standard geographic classification (not w cost reporting period. Enter "1" for urban or "2" fo			jinning of the	1.00	2	2.0		26.00
27.00	Enter your standard geographic classification (not w reporting period. Enter in column 1, "1" for urban o	age) sta r "2" fe	atus at the enc or rural. If ap			2			27.00
35.00	enter the effective date of the geographic reclassif If this is a sole community hospital (SCH), enter th effect in the cost reporting period.			CH status in		0			35.00
					Begi nni 1. 00		Endi 2. (-
36.00	Enter applicable beginning and ending dates of SCH s		Subscript line	36 for number				-	36.00
37.00	of periods in excess of one and enter subsequent dat If this is a Medicare dependent hospital (MDH), ente is in effect in the cost reporting period.		umber of perioc	ls MDH status		0			37.00
38.00	If line 37 is 1, enter the beginning and ending date greater than 1, subscript this line for the number o enter subsequent dates.								38.00
					Y/N 1.00		Y/ 2. (-
39.00	Does this facility qualify for the inpatient hospita hospitals in accordance with 42 CFR §412.101(b)(2)(i				N		N		39.00
40. 00	or "N" for no. Does the facility meet the mileage re CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes Is this hospital subject to the HAC program reductio	qui remen or "N" n adjus ⁻	nts in accordar for no. (see i tment? Enter "Y	nce with 42 nstructions) (" for yes or	N		N		40.00
	"N" for no in column 1, for discharges prior to Octo no in column 2, for discharges on or after October 1			es or "N" for					
						V 1.00	XVIII 2.00	XI X 3. 00	
45.00	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payme	nt for (di sproporti onat	e share in acc	ordance	N	N	N	45.00
46.00	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III.					N	N	N	46.00
47. 00 48. 00	Is this a new hospital under 42 CFR §412.300 PPS cap Is the facility electing full federal capital paymen Teaching Hospitals				10.	N N	N N	N N	47.00 48.00
56.00	Is this a hospital involved in training residents in	approv	ed GME programs	s? Enter "Y" f	or yes	N			56.00
57.00	or "N" for no. If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" fo								57.00
	is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is " "N", complete Wkst. D, Parts III & IV and D-2, Pt. I	th of tl Y", com	his cost report plete Worksheet	ing period? E	nter "Y"				
58.00	defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	bursemei	nt for physicia	ans' services a	IS	N			58.00
	Are costs claimed on line 100 of Worksheet A? If ye	s, comp	lete Wkst. D-2,			N			59.00
60.00	Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y"				tions)	N			60.00
		Y/N	IME	Direct GME	IME		Di rect	GME	
61 00	Did your hospital receive FTE slots under ACA	1.00 N	2.00	3.00	4.00	0.00	5.0		61.00
01.00	section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N				0.00		0.00	01.00
61. 01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see		0.00	0.00					61.01
61. 02	instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs,		0. 00	0.00					61. 02
61. 03	and primary care FTEs added under section 5503 of ACA). (see instructions) Enter the base line FTE count for primary care		0.00	0.00					61.03
	and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)								
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the		0.00	0.00					61.04
61.05	current cost reporting period. (see instructions). 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		0.00	0.00					61.05
61.06	61.04 minus line 61.03). (see instructions) 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)		0.00	0.00					61.06

HOSPI TAL AND HOSPI TAI	- HEALTH CARE COMPI	_EX IDENTIFICATION DA		F		2/17/2016 10:	pared:
			Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
1			1.00	2.00	3.00	4.00	
specialty, if for each new p column 1, the program code, unweighted cou FTE unweighted 51.20 Of the FTEs in program specia residents for instructions) enter in colum 3, the IME FTE	any, and the numbe rogram. (see instr program name, ente enter in column 3, nt and enter in co count. line 61.05, speci lty, if any, and t each expanded prog Enter in column 1, n 2, the program c	r in column 2, the the IME FTE lumn 4, direct GME fy each expanded he number of FTE ram. (see the program name, ode, enter in column and enter in column			0.00		61. 10
						1.00	
ACA Provisions	Affecting the Hea	Ith Resources and Ser	rvices Administration	(HRSA)		1.00	
		s that your hospital			od for which	0.00	62.00
52.01 Enter the numb during in this	er of FTE resident _cost reporting pe	funding (see instruc s that rotated from a <u>riod of HRSA THC proc</u>	a Teaching Health Cer gram. (see instructio		your hospital	0.00	62. 0 ⁴
3.00 Has your facil	ity trained reside	<u>sidents in Nonprovide</u> nts in nonprovider se umn 1. If yes, comple	ettings during this c	instructions)	period? Enter	N	63.0
				Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
		r FTE Residents in No uly 1, 2009 and befor		This base year	is your cost r	reporting	
4.00 Enter in colum in the base ye resident FTEs settings. Ent resident FTEs	n 1, if line 63 is ar period, the num attributable to ro er in column 2 the that trained in yo	yes, or your facilit ber of unweighted nor tations occurring in number of unweighted ur hospital. Enter ir 1 + column 2)). (see Program Name	ty trained residents n-primary care all nonprovider d non-primary care n column 3 the ratio	0.00		0.000000 Ratio (col. 3/	64.0
			Fi ograni Code	FTEs Nonprovi der Si te	FTEs in Hospital	(col. 3 + col. 4))	
F 00 F 1 1	4 16 11 15	1.00	2.00	3.00	4.00	5.00 0.000000	15.5
year period, t associated wit FTEs for each program in whi residents. Ent the program co col umn 3, the unweighted pri residents attr rotations occu non-provider s col umn 4, the unweighted pri resident FTEs	r facility nts in the base he program name h primary care primary care ch you trained er in column 2, de, enter in number of mary care FTE ibutable to rring in all ettings. Enter in number of mary care that trained in Enter in column			0. 00	0.00		

Heal th	Financial Systems		COUNTY HOSP	I TAL		I	n Lie	u of For	m CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPI	EX IDENTIFICATION DA	ATA	Provi der	F	eriod: rom 10/01, o 09/30,		Workshe Part I Date/Ti 2/17/20	me Pre	
					Unweighted FTEs Nonprovider Site	Unwei gh FTEs Hospi t	in al	Ratio (c (col. 1 2)	:ol. 1/ + col.)	
	Section 5504 of the ACA Current	Year FTE Residents i	n Nonprovide	er Setting	1.00 sEffective f	2.00 2.00		3.C ng perio		
66.00	beginning on or after July 1, 20 Enter in column 1 the number of FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	10 unweighted non-prima ccurring in all nonpu unweighted non-prima al. Enter in column 3	ry care resi rovider sett ry care resi 3 the ratio	dent i ngs. dent	0. 00		0.00	<u> </u>	000000	66.00
		Program Name	Program	n Code	Unwei ghted FTEs Nonprovi der Si te	Unwei gh FTEs Hospi t	in	Ratio (c (col. 3 4))	+ col.	
(7.00		1.00	2.0	00	3.00	4.00		5.0		(7.00
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)				0.00)	0.00	0.	000000	67.00
							1.00	2 00	2.00	
	Inpatient Psychiatric Facility P	PS					1.00	0 2.00	3.00	
70.00	Is this facility an Inpatient Ps	ychiatric Facility (I	IPF), or doe	s it cont	ain an IPF subp	provi der?	Y			70.00
	Enter "Y" for yes or "N" for no If line 70 yes: Column 1: Did th recent cost report filed on or b 42 CFR 412.424(d)(1)(iii)(c)) Co program in accordance with 42 CF Column 3: If column 2 is Y, indi (see instructions) Inpatient Rehabilitation Facilit	e facility have an ap efore November 15, 20 lumn 2: Did this faci R 412.424 (d)(1)(iii) cate which program yo y PPS	004? Enter ility train)(D)? Enter ear began du	"Y" for y residents "Y" for y ring this	es or "N" for r in a new teach es or "N" for r cost reporting	no. (see ni ng no.	N	N	0	71.00
75.00	Is this facility an Inpatient Re		y (IRF), or	does it c	ontain an IRF		N			75.00
	subprovider? Enter "Y" for yes If line 75 yes: Column 1: Did th recent cost reporting period end no. Column 2: Did this facility CFR 412.424 (d)(1)(iii)(D)? Ente indicate which program year bega	e facility have an ap ing on or before Nove train residents in a r "Y" for yes or "N"	ember 15, 20 new teachin for no. Col	04? Enter g program umn 3: If	"Y" for yes or in accordance column 2 is Y,	"N" for with 42			0	76.00
								1. C	0	
	Long Term Care Hospital PPS Is this a long term care hospita Is this a LTCH co-located within "Y" for yes and "N" for no. TEFRA Providers					period? E	nter	N		80. 00 81. 00
	Is this a new hospital under 42 Did this facility establish a ne \$413.40(f)(1)(ii)? Enter "Y" fo	w Other subprovider	(excluded un				no.	Ν		85. 00 86. 00
87.00	Is this hospital a "subclause (I for yes or "N" for no.			n 1886(d)	(1)(B)(iv)(II)	? Enter "Y		N		87.00
						V		XL		
	Title V and XIX Services					1.00)	2.0	0	
90.00	Does this facility have title V		hospital se	rvi ces? E	nter "Y" for	N		Y		90.00
91.00	yes or "N" for no in the applica Is this hospital reimbursed for	title V and/or XIX tH				N		Y		91.00
	full or in part? Enter "Y" for y Are title XIX NF patients occupy	es or "N" for no in t	the applicab	le column				N		92.00
	instructions) Enter "Y" for yes	or "N" for no in the	appl i cabl e	column.	, .					
93.00	Does this facility operate an IC "Y" for yes or "N" for no in the		urposes of t	itle V an	d XIX? Enter	N		N		93.00
94.00	Does title V or XIX reduce capit applicable column.		or yes, and	"N" for n	o in the	N		N		94.00

Health Financial Systems JAY COUNTY HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA			eri od:		Workshe		<u>2552-10</u> 2
			rom 10/01/ p 09/30/		Part I Date/Ti 2/17/20		
			V 1.00		XI 2 2. 0	x	
95.00 If line 94 is "Y", enter the reduction percentage in the app 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.			N	0.00	N	0.00	0 95.00 96.00
97.00 If line 96 is "Y", enter the reduction percentage in the app	licable column	ı.		0. 00		0.00	97.00
Rural Providers 105.00 Does this hospital qualify as a critical access hospital (CA 106.00 on this facility qualifies as a CAH, has it elected the all-		nod of payment	Y N				105. 00 106. 00
for outpatient services? (see instructions) 107.00 f this facility qualifies as a CAH, is it eligible for cost training programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, col. reimbursed. If yes complete Wkst. D-2, Pt. II.	1. (see inst	ructions) lf	N				107.00
108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N				108.00
	Physi cal 1.00	Occupational 2.00	Speech 3.00		Respira 4. C		-
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.	Y	Y	Y		Y		109.00
					1.0		
110.00 Did this hospital participate in the Rural Community Hospita the current cost reporting period? Enter "Y" for yes or "N"		on project (410	A Demo)for		N		110.00
				1.00	2.00	3.00	-
Miscellaneous Cost Reporting Information 115.00(s this an all-inclusive rate provider? Enter "Y" for yes or	"N" for no in	n column 1 lf	column 1	N		0	115.00
is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percen psychiatric, rehabilitation and long term hospitals provider Pub. 15-1, chapter 22, §2208.1.	lf column 2 i t for long ter	is "E", enter i rm care (includ	n column es			Ū	
116.00 Is this facility classified as a referral center? Enter "Y" 117.00 Is this facility legally-required to carry malpractice insur			N" for	N Y			116. 00 117. 00
no. 118.00 s the mal practice insurance a claims-made or occurrence pol	icy? Enter 1 i	f the policy i	s	1			118.00
claim-made. Enter 2 if the policy is occurrence.		Premi ums	Losses	5	Insura	ance	
		1.00	2.00		3.0	0	-
118.01 List amounts of malpractice premiums and paid losses:		254, 584		0			0 118. 01
			1.00		2.0	0	110.00
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein.			N				118.02
119.00 D0 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 amendmen Enter in column 2, "Y" for yes or "N" for no.	column 1, "Y alifies for th	' for yes or ne Outpatient	N		N		119.00 120.00
121.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no. Transplant Center Information	ntable devices	s charged to	N				121.00
125.00 Does this facility operate a transplant center? Enter "Y" fo	r yes and "N"	for no. If	N				125.00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 f this is a Medicare certified kidney transplant center, en		fication date					126.00
in column 1 and termination date, if applicable, in column 2 127.00 If this is a Medicare certified heart transplant center, ent		cation 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		cation date					128.00
in column 1 and termination date, if applicable, in column 2 129.00 f this is a Medicare certified lung transplant center, ente		cation date in					129.00
column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center,							130.00
date in column 1 and termination date, if applicable, in col 131.00 f this is a Medicare certified intestinal transplant center	umn 2.						131.00
date in column 1 and termination date, if applicable, in col 132.00 If this is a Medicare certified islet transplant center, ent	umn 2.						132.00
in column 1 and termination date, if applicable, in column 2 133.00 f this is a Medicare certified other transplant center, ent							133.00
in column 1 and termination date, if applicable, in column 2							
134.00 If this is an organ procurement organization (OPO), enter th							134.00

Health Financial Systems	JAY COUN	NTY HOSPI TAL	-				In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	EX IDENTIFICATION DATA	Pro	ovider CCN	: 15132	20 Pe Fr Tc)/01/2014)/30/2015	Worksheet S-2 Part I Date/Time Pre 2/17/2016 10:	pared:
							1.00	2.00	
All Providers 140.00 Are there any related organizatio chapter 10? Enter "Y" for yes or	"N" for no in column 1.	If yes, and	d home off	rice co			Y		140. 00
are claimed, enter in column 2 th		ber. (see in 2.00	nstructior	<u>15)</u>			3.00		
If this facility is part of a cha			1 through	143 tl	he nam	ne and		of the	
home office and enter the home of			r number.						
141.00Name: 142.00Street:	Contractor's Name: PO Box:	:		Contr	actor'	's Nur	nber:		141.00
143. 00 Ci ty:	State:			Zip C	ode:				142.00
	H								
144 00 Are provider based physicians' co	sta included in Werkshe	ot 42						1.00 Y	144.00
144.00 Are provider based physicians' co	Sts Included In workshee	elA?						Y	144.00
							1.00	2.00	-
145.00 If costs for renal services are c inpatient services only? Enter "Y no, does the dialysis facility in period? Enter "Y" for yes or "N" 146.00 Has the cost allocation methodolo	" for yes or "N" for no clude Medicare utilizati for no in column 2.	in column ion for this	1. If colu s cost rep	umn 1 i porting			N		145.00
Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/		b. 15-2, cha	apter 40,	§4020)	lf				
								1.00	
147.00 Was there a change in the statist								N	147.00
148.00 Was there a change in the order o 149.00 Was there a change to the simplif		2			for n	~		N	148.00 149.00
	red cost finding method	Part		Part			tle V	Title XIX	149.00
		1. (00	2.00)		3.00	4.00	
Does this facility contain a prov	ider that qualifies for	an exempti	on from th	he_appl	licati	on of	the lowe	r of costs	
or charges? Enter "Y" for yes or 155.00Hospital	"N" for no for each com	ponent for N		<u>d Part</u> N	<u>B. (S</u>	see 42	CFR §413 N	. 13) N	155.00
156.00 Subprovi der – IPF		N		N			N	N	156.00
157.00 Subprovider – IRF		N		N			Ν	Ν	157.00
158. 00 SUBPROVI DER 159. 00 SNF		N		Ν			N	Ν	158.00 159.00
160.00 HOME HEALTH AGENCY		N	1	N			N	N	160.00
161.00 CMHC				Ν			N	Ν	161.00
161. 10 CORF				N			N	N	161.10
Multicampus								1.00	-
165.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no.								N	165.00
	Name 0	<u>Count</u> 1.00		<u>State</u> 2.00	Zip 3.		CBSA 4.00	FTE/Campus 5.00	-
166.00 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)				2.00					166.00
					1				
								1.00	
Health Information Technology (HI 167.00 Is this provider a meaningful use 168.00 If this provider is a CAH (line 1 reasonable cost incurred for the	r under §1886(n)? Enter 05 is "Y") and is a mear	r "Y" for ye ningful use	es or "N"	for no).		the	N	167. 00 168. 00
168.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii)	not a meaningful user, (? Enter "Y" for yes or '	does this p "N" for no.	(see inst	tructic	ons)				168. 01
169.00 If this provider is a meaningful transition factor. (see instruction		and is not a	a CAH (lir	ne 105	is "N	"), e	nter the	0.00	169.00
	,						ji nni ng	Endi ng	
	boging data 1 "	na data C	the	.+1			1.00	2.00	170.00
170.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)	beginning date and endii	ng date for	the repor	ting		10/	01/2014	09/30/2015	170. 00

Health Financial Systems	JAY COUNTY HOSP	1 TAL	In Lie	u of Form CMS	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA	Provider CCN: 151320	From 10/01/2014	Worksheet S-: Part I Date/Time Pro	
			10 097 307 2015	2/17/2016 10	
					_
				1.00	
171.00 If line 167 is "Y", does this provid	der have any days for individ	duals enrolled in sec	tion 1876	N	171.00
Medicare cost plans reported on Wks (see instructions)	t. S-3, Pt. I, line 2, col. 6	5? Enter "Y" for yes	and "N" for no.		

SPI T.	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE	Provi der	CCN: 151320	Period: From 10/01/2014 To 09/30/2015	Date/Time Pr	repare
					Y/N	2/17/2016 10 Date): 07 ar
					1.00	2.00	+
	General Instruction: Enter Y for all YES resp mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	oonses. Enter N for	all NO re	sponses. Ente	r all dates in ⁻		
00	Provider Organization and Operation Has the provider changed ownership immediatel reporting period? If yes, enter the date of t				N		1.
	reporting period: IT yes, enter the date of t	the change in cordi	11 2. (300	Y/N	Date	V/I	
-				1.00	2.00	3.00	-
00	Has the provider terminated participation in yes, enter in column 2 the date of terminatic voluntary or "I" for involuntary.			N			2.
00	Is the provider involved in business transact contracts, with individuals or entities (e.g. or medical supply companies) that are related officers, medical staff, management personnel of directors through ownership, control, or f	, chain home offic d to the provider c , or members of th	es, drug r its e board	N			3.
	relationships? (see instructions))/ /N	Tuno	Data	_
				Y/N 1.00	Type 2.00	Date 3.00	
	Financial Data and Reports						
00	Column 1: Were the financial statements prep Accountant? Column 2: If yes, enter "A" for or "R" for Reviewed. Submit complete copy or column 3. (see instructions) If no, see instr	Audited, "C" for C enter date availab ructions.	ompiled, le in	N	C		4
00	Are the cost report total expenses and total			N			5
	those on the filed financial statements? If y	<u>es, submit reconci</u>	Tration.		Y/N	Legal Oper.	
					1.00	2.00	
0	Approved Educational Activities Column 1: Are costs claimed for nursing scho	ol? Colump 2: If	voc ic th	o providor i c	N	1	6
0	the legal operator of the program?		yes, is th				0.
0	Are costs claimed for Allied Health Programs? Were nursing school and/or allied health prog	grams approved and/		l during the	N N		7
0	cost reporting period? If yes, see instructic Are costs claimed for Interns and Residents i		uate medic	al education	N		9
	program in the current cost report? If yes, s	see instructions.					
00	Was an approved Intern and Resident GME progr cost reporting period? If yes, see instruction		newed in t	he current	N		10.
00	Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see	rs other than I & R	in an App	proved	Ν		11.
						Y/N	_
	Bad Debts					1.00	
00	Is the provider seeking reimbursement for bac					Y	12.
00	If line 12 is yes, did the provider's bad deb	ot collection polic	y change d	luring this co	st reporting	N	13
00	period? If yes, submit copy. If line 12 is yes, were patient deductibles a	and/or co-payments	waived? If	yes, see ins	tructions.	N	14.
	Bed Complement					1	
00	Did total beds available change from the pric	or cost reporting p	eriod?lf	r'	<u>ructions.</u> art A	N Part B	15.
		Descriptio	n	Y/N	Date	Y/N	
		0		1.00	2.00	3.00	
00	<u>PS&R Data</u> 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			Y	01/21/2016	Y	16
	Report used in columns 2 and 4 . (see						
00	instructions)			N		N	17.
00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns			N		N	
00	2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional			N		N	18.
	claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.						
00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			N		N	19.
00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe			N		N	20.

provider's records? If yes, see instructions. 1.00 CoupleTED by COST REINBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) CoupleTED by COST REINBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) CoupleTer and the Wedicare purposes? If yes, see instructions Reveal bases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions Reveal bases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions. Reveal bases and/or amendments to existing leases entered into during the cost reporting period? If yes, see instructions. Reveal bases and/or amendments to existing leases entered into during the cost reporting period? If yes, see instructions. Reveal bases and/or amendments to existing leases entered into during the cost reporting period? If yes, see instructions. Reveal bases and/or amendments or letters of credit entered into during the cost reporting period? If yes, see instructions. Reveal bases and/or amendments or letters of credit entered into during the cost reporting period? If yes, see instructions. Instructions. Reveal base and depreciation account and/or bond funds (bebt Service Reserve Fund) Tradeted base funded depreciation account and/or bond funds (bebt Service Reserve Fund) Tradeted beare realized into account and/or bond funds (bebt? If yes, see instructions. Reveal base and funded depreciation account in yes see instructions. Reveal base and privates Reveal base are funded depreciation account if yes, see instructions. Reveal base are set of the provider facility under an arrangement with provider-based physicians? Reveal base are set of the provider facility under an arrangement with provider-based physicians? Reveal base are set of the cost report? Reveal base are set of the provider facility under an arrangement with provider-based physicians? Reveal base are tone set of t	Heal th	Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS-	2552-10
To Operation Part A Part A </td <td>HOSPI T</td> <td>AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE</td> <td>STI ONNAI RE</td> <td>Provi der</td> <td></td> <td></td> <td></td> <td>2</td>	HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE	Provi der				2
Description Part A 0 Part B 0 Part B 0 21.00 Was the cost report prepared only using the provider's records? If yes, see N N N 21.00 21.00 Was the cost report prepared only using the provider's records? If yes, see N N N 2.00 3.00 2.00 3.00 2.00 3.00 2.00 3.00 2.00 3.00 2.00 3.00 2.00 3.00 2.00 3.00 2.00 3.00 2.00 3.00 2.00 3.00 2.00 3.00 2.00 3.00 2.00 3.00 2.00 3.00 2.00 3.00 2.00 3.00 2.00 3.00 2.01 3.00 3.00 2.01 3.00 3.00 3.00 2.01 3.00								epared:
Description V/N Date V/N 21.00 Nas the cost report prepared only using the provider's records? If yes, see N 2.00 3.00 2.00 21.01 Instructions. N N 2.00 N 21.0 21.02 Mas the cost report prepared only using the provider is records? If yes, see N N 21.0 22.00 Mase changes occurred in the Madicare purposes? If yes, see instructions N 22.0 22.00 Have changes occurred in the Madicare purposes? If yes, see instructions N 22.0 22.00 Have changes occurred in the Madicare purposes? If yes, see instructions N 22.0 22.00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see N 22.0 1.00 Here assists bloct to Sc.2314 of DEFRA acquired during the cost reporting period? If yes, see N 22.0 1.00 Here assists added as acquitation policy changed during the cost reporting period? If yes, see N 20.0 1.01 Here new loans, mertgage agreements or letters of credit entered into during the cost reporting period? If yes, see N 20.0 20								07 am
0 1.00 2.00 3.00 2.00 3.00 21.00 Was the cost report prepared only using the provider's records? If yes, see N 21.0 N 22.0			Docori	inti on				
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Completies 1.00 Completies								
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22.00 Have assets been relifed for Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions. N 22.1 23.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? N 22.1 24.00 Were henges occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? N 22.1 25.00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see N 22.1 26.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, submit N 22.1 27.00 Has the provider have a funded depreciation account and/or bond funds (Dett Service Reserve Fund) N 22.1 27.00 Have then recalled before scheduled maturity without issuance of new debt? If yes, see N 30.1 30.00 Have tanges during the cost report ons. N 30.1 31.00 Have tanges during the cost report on the during? If yes, see N 30.1 31.00 Have stifting debt depreciation account? If yes, see instructions. N 30.1 31.00 Have a funded depreciation account? If yes, see instructions. N 30.1 <		COMPLETED BY COST REIMBURSED AND TEFRA HOSPIT	ALS ONLY (EXCE	EPT CHILDRENS H	IOSPI TALS)		1.00	
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reporting period? If yes, see instructions. 24.0 Were new leases and/or amendments to existing leases entered into during this cost reporting period? N 24.1 17 yes, see Instructions 25.0 Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions. 26.0 Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see N 27.1 27.0 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit N 27.1 28.0 Were new leases, mortgage agreements or letters of credit entered into during the cost reporting 28.0 Were new leases, mortgage agreements or letters of credit entered into during the cost reporting 28.0 Were new leases, and depreciation account? If yes, see instructions 29.0 Did the provider have a funded depreciation account? If yes, see instructions 30.0 Were accelled before scheduled maturity with new debt? If yes, see N 31.0 Has the there cost energiated prior to its scheduled maturity without issuance of new debt? If yes, see N 31.0 Have changes or new agreements of Sec. 2135.2 applied pertaining to competitive bidding? If N 32.0 Have changes or new agreements of Sec. 2135.2 applied pertaining to competitive bidding? If N 33.0 If filme 34 is yes, were there new agreements or amended existing agreements with the provider-based Physicians? 34.0 If yes, see instructions. 35.0 If filme 34 is yes, were there new agreements or amended existing agreements with the provider-based Y 35.0 If yes, see instructions. 36.0 If filme 36 is yes, did the provider readire services to ther chan components? If yes, 37.1 Do 38.0 If filme 36 is yes, did the provider readires envices to there office? 37.2 38.0 If filme 36 is yes, did the provider reader services to the home office? 37.3 38.0 If filme 36 is yes, did the provider reader services to the home office? 39.0 If ilme 36 is yes, did the provider reader services to there office? 39.0 If ilme 36 is yes, did the provider reader services to there office? 30.0 If					ale mada duri n	a the cost		22.00
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25:00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see N 25:0 26:00 Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see N 26:0 27:00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit N 27:0 27:00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit N 27:0 28:00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions. N 28:0 20:00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) Y 29:0 20:00 Have thave a funded depreciation account? If yes, see instructions. N 30:0 30:01 Has debt been replaced prior to its scheduled maturity without issuance of new debt? If yes, see N 31:1 31:00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. N 33:1 32:00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. N 32:1 <tr< td=""><td>24.00</td><td></td><td>g Leases entere</td><td>ed into during</td><td>this cost repo</td><td>orting period?</td><td>Ν</td><td>24.00</td></tr<>	24.00		g Leases entere	ed into during	this cost repo	orting period?	Ν	24.00
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27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit N 27.10 1nterest Expense 27.00 N 28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting in period? If yes, see instructions. 28.00 N 28.00 N 28.01 N 29.01 N 28.01 N 28.01 N 29.01 N 20.01 N 20.01 N	26.00		uired during th	ne cost reporti	ng period? If	yes, see	Ν	26.00
copy. 1.1.5 to 3.1.5	27 00		and during the	a cost reportin	na neriod2 lf v	ves submit	Ν	27.00
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43. OF LETTER THE LETERIONE HUMBER AND HIGH AUDIESS OF THE COST (317-713-7940 TEREBURGENDUC, COM (43.)	12 00		of the cost	217 712 7044				12 00
report preparer in columns 1 and 2, respectively.	+5.00			517-713-7740			500. OUW	↓ 4 5.00

	Financial Systems	JAY COUNTY H	OSPI TAL		In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE	Provi der	CCN: 151320	Period: From 10/01/2014 To 09/30/2015	Worksheet S-2 Part II Date/Time Pre 2/17/2016 10:	pared:
		Part B					
		Date					
		4.00					
	PS&R Data						
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions)	01/21/2016					16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)						17.00
18. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.						18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.						19.00
	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:						20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.						21.00
			3.	00			
	Cost Report Preparer Contact Information						
	Enter the first name, last name and the title held by the cost report preparer in columns ' respectively.		ANAGER				41.00
42.00	Enter the employer/company name of the cost i preparer.	report					42.00
43.00	Enter the telephone number and email address report preparer in columns 1 and 2, respectiv						43.00

	Financial Systems	JAY COUNTY	позр		CON. 151220			u of Form CMS-2	
HUSPII	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA		Provi der	CCN: 151320		eriod: com 10/01/2014	Worksheet S-3	
						Tc		Date/Time Pre	pared:
								2/17/2016 10:	07 am
								I/P Days / O/P	
								Visits / Trips	
	Component	Worksheet A	No.	of Beds	Bed Days		CAH Hours	Title V	
		Line Number			Avai I abl e				
		1.00		2.00	3.00		4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00		25	9, 1	25	49, 008. 00	0	1.00
	8 exclude Swing Bed, Observation Bed and								
	Hospice days) (see instructions for col. 2								
2.00	for the portion of LDP room available beds) HMO and other (see instructions)								2.00
2.00	HMO IPF Subprovider								3.00
4.00	HMO IRF Subprovider								4.00
4.00 5.00	Hospital Adults & Peds. Swing Bed SNF							0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF Hospital Adults & Peds. Swing Bed NF							0	6.00
7.00	Total Adults and Peds. (exclude observation			25	9, 1	າະ	49,008.00	0	7.00
7.00	beds) (see instructions)			20	9, 1.	20	49,006.00	0	/.00
8.00	INTENSIVE CARE UNIT	31.00		0		0	0.00	0	8.00
9.00	CORONARY CARE UNI T	51.00		0		0	0.00	0	9.00
10.00	BURN INTENSIVE CARE UNIT								10.00
11.00	SURGI CAL I NTENSI VE CARE UNI T								11.00
12.00	OTHER SPECIAL CARE (SPECIFY)								12.00
13.00	NURSERY	43.00						0	13.00
14.00	Total (see instructions)	43.00		25	9, 1	25	49,008.00	0	14.00
15.00	CAH visits			20	2, 1.	25	47,000.00	0	15.00
16.00	SUBPROVIDER - IPF	40.00		10	3, 6	50		0	16.00
17.00	SUBPROVIDER - IRF	41.00		0		0		0	17.00
18.00	SUBPROVI DER	42.00		0		0		0	18.00
19.00	SKILLED NURSING FACILITY	121 00		U		Ŭ		Ū	19.00
20.00	NURSING FACILITY								20.00
21.00	OTHER LONG TERM CARE								21.00
22.00	HOME HEALTH AGENCY								22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)								23.00
24.00	HOSPI CE								24.00
24.10	HOSPICE (non-distinct part)	30.00							24.10
25.00	CMHC - CMHC								25.00
25. 10	CMHC - CORF	99. 10						0	25.10
26.00	RURAL HEALTH CLINIC	88.00						0	26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89.00						0	26. 25
27.00	Total (sum of lines 14-26)			35					27.00
28.00	Observation Bed Days							0	28.00
29.00	Ambul ance Tri ps								29.00
30. 00	Employee discount days (see instruction)								30.00
31.00	Employee discount days - IRF								31.00
32.00	Labor & delivery days (see instructions)			0		0			32.00
32. 01	Total ancillary labor & delivery room								32.01
	outpatient days (see instructions)								
33.00	LTCH non-covered days								33.00

IOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provi der	CCN: 151320	Period: From 10/01/201 To 09/30/201		pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
. 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)	839	38				1.00
. 00	HMO and other (see instructions)	96	0				2.00
. 00	HMO I PF Subprovider	22	0				3.00
. 00	HMO I RF Subprovi der	0	0				4.00
. 00	Hospital Adults & Peds. Swing Bed SNF	276	0	48	34		5.00
. 00	Hospital Adults & Peds. Swing Bed NF		0		30		6.00
. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	1, 115	38				7.00
8.00	INTENSIVE CARE UNIT	0	0		0		8.00
. 00	CORONARY CARE UNIT						9.0
0.00	BURN INTENSIVE CARE UNIT						10.0
1.00	SURGICAL INTENSIVE CARE UNIT						11.0
2.00	OTHER SPECIAL CARE (SPECIFY)						12.0
3.00	NURSERY		0	15	53		13.0
4.00	Total (see instructions)	1, 115	38			275.27	
5.00	CAH visits	1, 113	0		0.0	213.21	15.0
6.00	SUBPROVIDER - IPF	1, 415	40		-	15.03	
7.00	SUBPROVIDER - IRF	1, 415	40		0.0		
8.00	SUBPROVI DER	0	0		0 0.0		
9.00 9.00		U	0		0.0	0.00	19. (
	SKILLED NURSING FACILITY						20.0
0.00	NURSING FACILITY						
1.00	OTHER LONG TERM CARE						21.0
2.00	HOME HEALTH AGENCY						22.0
3.00	AMBULATORY SURGICAL CENTER (D. P.)						23.0
4.00	HOSPICE		0		0		24.0
4.10	HOSPICE (non-distinct part)	0	0		0		24.
5.00	CMHC - CMHC		0				25.0
5.10	CMHC - CORF	0	0		0 0.0		
6.00	RURAL HEALTH CLINIC	0	0		0 0.0		
6. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.0		
7.00	Total (sum of lines 14-26)				0.0	0 290.30	
8.00	Observation Bed Days		0	8	35		28.0
9.00	Ambul ance Trips	0					29.0
0. 00	Employee discount days (see instruction)				0		30. (
1.00	Employee discount days - IRF				0		31.0
2.00	Labor & delivery days (see instructions)	0	0		0		32. (
2. 01	Total ancillary labor & delivery room				0		32.0
	outpatient days (see instructions)						
3.00	LTCH non-covered days	0					33.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICA	AL DATA	Provi der	CCN: 151320	Period: From 10/01/2014 To 09/30/2015	Worksheet S-3 Part I Date/Time Pre 2/17/2016 10:	pared:
	Full Time Equivalents		Di s	charges	12, 17, 2010 101	
Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
	Workers				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) OH HMO and other (see instructions) OH HMO IPF Subprovider OH HMO IRF Subprovider OH HMO IRF Subprovider OH HAUITS & Peds. Swing Bed SNF OH HAUITS & Peds. Swing Bed NF OT Total Adults & Peds. (exclude observation beds) (see instructions) ON TOTAI Adults and Peds. (exclude observation beds) (see instructions) ON CORONARY CARE UNIT ON CORONARY CARE UNIT ON GURGI CAL INTENSI VE CARE UNIT ON UNESRY ON OTAI (see instructions) ON CAH visits ON SUBPROVIDER - IPF ON SUBPROVIDER - IRF ON SUBPROVIDER - IRF ON ONURSI NG FACILITY ON ONE HEALTH AGENCY 	0. 00 0. 00 0. 00 0. 00 0. 00	0 0 0 0 0 0 0	2	79 11 28 0 0 0 79 11 95 0 0 0 0 0 0 0 0	667 667 155 0 0	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 15.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00
 23.00 AMBULATORY SURGICAL CENTER (D. P.) 24.00 HOSPICE 24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 25.10 CMHC - CORF 26.00 RURAL HEALTH CLINIC 26.25 FEDERALLY QUALIFIED HEALTH CENTER 27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 	0.00 0.00 0.00 0.00					23. 0 24. 0 24. 1 25. 0 25. 1 26. 0 26. 0 27. 0 28. 0 29. 0 30. 0 31. 0 32. 0 32. 0 33. 0

Heal th	Financial Systems	JAY COUNTY HOSP	I TAL		In Lie	eu of Form CMS-:	2552-10
	AL UNCOMPENSATED AND INDIGENT CARE DATA		Provider (CCN: 151320	Peri od:	Worksheet S-1	
					From 10/01/2014		
					To 09/30/2015	Date/Time Pre 2/17/2016 10:	pared: 07 am
				I		27172010 101	
						1.00	
	Uncompensated and indigent care cost computat						
1.00	Cost to charge ratio (Worksheet C, Part I lin	e 202 column 3 divi	ded by lir	ne 202 columr	8)	0. 341147	1.00
2 00	Medicaid (see instructions for each line) Net revenue from Medicaid					0	2.00
2.00 3.00	Did you receive DSH or supplemental payments	from Modicaid2				0	3.00
4.00	If line 3 is "yes", does line 2 include all D		payments f	From Medicaic	2		4.00
5.00	If line 4 is "no", then enter DSH or suppleme					0	5.00
6.00	Medi cai d charges					0	6.00
7.00	Medicaid cost (line 1 times line 6)					0	
8.00	Difference between net revenue and costs for	Medicaid program (I	ine 7 minu	us sum of lir	es 2 and 5; if	0	8.00
	< zero then enter zero)		C C				
9.00	State Children's Health Insurance Program (SC	HIP) (see Instructi	ons tor ea	ich line)		0	9.00
	Net revenue from stand-alone SCHIP Stand-alone SCHIP charges					0	
	Stand-alone SCHIP cost (line 1 times line 10)					0	
	Difference between net revenue and costs for		(line 11 mi	nus line 9;	if < zero then	0	
	enter zero)						
	Other state or local government indigent care					I	
13.00	Net revenue from state or local indigent care					0	
14.00	Charges for patients covered under state or I	ocal indigent care	program (N	lot included	in lines 6 or	0	14.00
15.00	10) State or local indigent care program cost (li	ng 1 timos ling 1/	,			0	15.00
	Difference between net revenue and costs for			program (lir	e 15 minus line	0	
	13; if < zero then enter zero)		9	p g (-	
	Uncompensated care (see instructions for each						
	Private grants, donations, or endowment incom						17.00
	Government grants, appropriations or transfer				(G.).	0	
19.00	Total unreimbursed cost for Medicaid, SCHIP 8, 12 and 16)	and state and local	i ndi gent	care program	is (sum of lines	0	19.00
				Uni nsured	Insured	Total (col. 1	
				patients	pati ents	+ col. 2)	
				1.00	2.00	3.00	
20.00	Total initial obligation of patients approved			693, 43	6 0	693, 436	20.00
21.00	charges excluding non-reimbursable cost cente Cost of initial obligation of patients approv			236, 56	4 O	236, 564	21.00
21.00	times line 20)			230, 50	04	230, 304	21.00
22.00	Partial payment by patients approved for char	itv care			0 0	0	22.00
	Cost of charity care (line 21 minus line 22)	, 		236, 56	o4 0	236, 564	23.00
						1.00	
24.00	Does the amount in line 20 column 2 include c			nd a length c	f stay limit		24.00
25.00	imposed on patients covered by Medicaid or ot If line 24 is "yes," charges for patient day			aram's Lonat	h of stav limit	0	25.00
	Total bad debt expense for the entire hospita			gram s rengt	ii or stay i i illit	0	
	Medicare bad debts for the entire hospital co					289, 804	
28.00	Non-Medicare and non-reimbursable Medicare ba			sline 27)		-289, 804	
29.00	Cost of non-Medicare and non-reimbursable Med				28)	-98, 866	29.00
	Cost of uncompensated care (line 23 column 3					137, 698	
31.00	Total unreimbursed and uncompensated care cos	t (line 19 plus lir	ne 30)			137, 698	31.00

	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	JAY COUNTY H			<u>In Lie</u> Period: From 10/01/2014	u of Form CMS-2 Worksheet A	2552-10
					To 09/30/2015		
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	2/17/2016 10: Recl assi fi ed	
				+ col. 2)	ons (See A-6)	Trial Balance	
						(col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
2.00	GENERAL SERVICE COST CENTERS 00200 NEW CAP REL COSTS-MVBLE EQUIP	1	1, 809, 945	1, 809, 94	5 0	1, 809, 945	2.00
2.00	00201 NEW CAP REL COSTS-MVBLE EQUIP MOB		1, 809, 943			1, 809, 945	2.00
2.02	00202 NEW CAP REL COSTS-MVBLE EQUIP-POB		119, 979			119, 979	2. 02
2.03 4.00	00203 NEW CAP REL COSTS-MVBLE EQUIP- WJ 00400 EMPLOYEE BENEFITS DEPARTMENT	0	31, 142 5, 880, 570			31, 142 5, 880, 570	2.03 4.00
4.00 5.00	00500 ADMINI STRATI VE & GENERAL	2, 346, 972	3, 549, 963			5, 896, 935	5.00
7.00	00700 OPERATION OF PLANT	332, 052	889, 973	1, 222, 02	5 -15, 008	1, 207, 017	7.00
7.01	00701 OPERATION OF PLANT-MOB 00702 OPERATION OF PLANT-POB	0	33, 974			38, 961	7.01 7.02
7.02 7.03	00703 OPERATION OF PLANT-POB	0	74, 708 32			81, 940 2, 821	7.02
8.00	00800 LAUNDRY & LINEN SERVICE	35, 288	29, 430	64, 71		64, 718	8.00
9.00	00900 HOUSEKEEPING	343,074	60, 960			404, 034	9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	330, 170	286, 722 0	616, 89	2 -286, 287 0 286, 287	330, 605 286, 287	10.00 11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	960, 092	8, 515	968, 60		968, 607	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	67,669	16, 606			84, 275	14.00
16.00	01600 MEDICAL RECORDS & LIBRARY	348, 435	57, 999	406, 43	4 0	406, 434	16.00
30.00	03000 ADULTS & PEDIATRICS	1, 354, 308	115, 896	1, 470, 20	4 -240, 284	1, 229, 920	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	0		0 0	0	31.00
40.00	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF	651, 976	246, 500		6 0 0 0	898, 476	40.00
41.00 42.00	04200 SUBPROVIDER	0	0		0 0	0	41.00 42.00
43.00	04300 NURSERY	0	0		0 221, 796	221, 796	
F0 00	ANCI LLARY SERVICE COST CENTERS	045 575	(02.127	1 500 71		1 500 710	
50.00 52.00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	845, 575	683, 137 0		2 0 0 18, 488	1, 528, 712 18, 488	
53.00	05300 ANESTHESI OLOGY	0	854, 907	854, 90		854, 907	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	813, 052	570, 490	1, 383, 54	2 0	1, 383, 542	54.00
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0			0	57.00 58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
60.00	06000 LABORATORY	629, 639	1, 170, 217	1, 799, 85	6 0	1, 799, 856	
60. 01 65. 00	06001 BLOOD LABORATORY 06500 RESPI RATORY THERAPY	0	0 354, 136	354, 13	0 0 6 0	0 354, 136	60. 01 65. 00
66.00	06600 PHYSI CAL THERAPY	0	793, 060			657, 688	
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 108, 738	108, 738	67.00
68.00		0	0	254.02	0 26, 634	26, 634	68.00
69.00 71.00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	191, 374 0	163, 454 0	354, 82	0 0	354, 828 0	69.00 71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	394, 065	1, 114, 270	1, 508, 33	5 0	1, 508, 335	73.00
88.00	OUTPATIENT SERVICE COST CENTERS	0	0		0 0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	
90.00	09000 CLINIC	451, 939	240, 009			691, 948	
90. 01 90. 02	09001 FAMILY PRACTICE OF JAY COUNTY 09002 JAY FAMILY MEDICINE	1, 473, 060 1, 024, 837	264, 152 342, 592			1, 737, 212 1, 367, 429	
91.00	09100 EMERGENCY	2, 131, 895	471, 267			2, 603, 162	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	93.00
99.10	09910 CORF	0	0		0 0	0	99.10
	SPECIAL PURPOSE COST CENTERS	1		1			
	10600 HEART ACQUISITION 10900 PANCREAS ACQUISITION	0	0		0 0		106. 00 109. 00
	11000 INTESTINAL ACQUISITION	0	0		0 0		1109.00
	11100 I SLET ACQUI SI TI ON	0	0		0 0		111.00
	11300 INTEREST EXPENSE	44 305 430	0		0 0		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	14, 725, 472	20, 244, 890	34, 970, 36	2 0	34, 970, 362	118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0		0 0		192.00
	19300 NONPAID WORKERS 07950 MOB	0	0 13	1			193.00 194.00
	07950 MOB	0	0		0 0		194.00 194.01
194.02	07952 WEST JAY CLINIC	452, 947	107, 355	560, 30	2 0	560, 302	194. 02
	07953 OTHER NONREI MBURSABLE COST CENTERS 07954 OTHER NONREI MBURSABLE COST CENTERS	0	0		0 0		194. 03 194. 04
	07954 OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0		194.04 194.05
	07956 TRI COUNTY	180, 777	1, 305, 891	1, 486, 66	8 0	1, 486, 668	
		· ·					

Health Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der		Period:	Worksheet A	
				From 10/01/2014 To 09/30/2015	Date/Time Pre 2/17/2016 10:	
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
			+ col. 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col. 4)	
	1.00	2.00	3.00	4.00	5.00	
194. 07 07957 H0SPI TALI ST	66, 300	535	66, 83	5 0	66, 835	194. 07
200.00 TOTAL (SUM OF LINES 118-199)	15, 425, 496	21, 658, 684	37, 084, 18	0 0	37, 084, 180	200. 00

CLASSIIIC	ATION AND ADJUSTMENTS OF TRIAL BALANCE (JF EXPENSES		Provi der	CCN: 151320	From 10/01/2014		
		_				To 09/30/201	5 Date/Time 2/17/2016	Prepare 10:07 a
	Cost Center Description	Adjustments		Expenses Ilocation				
		(See A-8) 6.00		7.00				
	RAL SERVICE COST CENTERS							
	NEW CAP REL COSTS-MVBLE EQUIP	-477, 863		1, 332, 082				2
	NEW CAP REL COSTS-MVBLE EQUIP MOB	C		10, 285				2
	2 NEW CAP REL COSTS-MVBLE EQUIP-POB 3 NEW CAP REL COSTS-MVBLE EQUIP- WJ			119, 979 31, 142				2
	DEMPLOYEE BENEFITS DEPARTMENT	-292, 875		5, 587, 695				4
	ADMINISTRATIVE & GENERAL	-1, 071, 420		4,825,515				5
1	OPERATION OF PLANT	C		1, 207, 017				7
0070 ²	OPERATION OF PLANT-MOB	C	þ	38, 961				7
	2 OPERATION OF PLANT-POB	C)	81, 940				7
	3 OPERATION OF PLANT-WJ	C		2, 821				7
	LAUNDRY & LINEN SERVICE			64, 718				8
	D HOUSEKEEPI NG D DI ETARY	-58, 657		345, 377 330, 605				9
	D CAFETERI A	-166, 730		119, 557				11
	NURSING ADMINISTRATION	-8, 726		959, 881				13
	CENTRAL SERVICES & SUPPLY	C		84, 275				14
	MEDICAL RECORDS & LIBRARY	-13, 534	ļ	392, 900				16
	TIENT ROUTINE SERVICE COST CENTERS			4 000				_
	ADULTS & PEDIATRICS	0		1, 229, 920				30
	DINTENSIVE CARE UNIT DISUBPROVIDER – IPF			0 898, 476				31
	SUBPROVIDER - IRF			070,470				40
	SUBPROVI DER	Ċ		0				42
	NURSERY	C		221, 796				43
	LARY SERVICE COST CENTERS	1						
	OPERATING ROOM	C		1, 528, 712				50
	D DELIVERY ROOM & LABOR ROOM	054 007		18, 488				52
	D ANESTHESI OLOGY D RADI OLOGY-DI AGNOSTI C	-854, 907 -856		1, 382, 686				53 54
	CT SCAN	-050		1, 302, 000				57
	MAGNETIC RESONANCE IMAGING (MRI)			0				58
	CARDI AC CATHETERI ZATI ON	C	b	0				59
. 00 06000	LABORATORY	-55,000		1, 744, 856				60
	1 BLOOD LABORATORY	C		0				60
	RESPIRATORY THERAPY	0	1	354, 136				65
	D PHYSI CAL THERAPY D OCCUPATI ONAL THERAPY	-21, 659		636, 029				66
	SPEECH PATHOLOGY			108, 738 26, 634				67
	DELECTROCARDIOLOGY	-20, 857		333, 971				69
	MEDICAL SUPPLIES CHARGED TO PATIENTS	C		0				71
. 00 07200	IMPL. DEV. CHARGED TO PATIENTS	C		0				72
	D DRUGS CHARGED TO PATIENTS	-86, 323	8	1, 422, 012				73
	ATLENT SERVICE COST CENTERS		1	0	1			
	D RURAL HEALTH CLINIC D FEDERALLY QUALIFIED HEALTH CENTER			0 0				88
	CLINIC	-427, 441		264, 507				90
	FAMILY PRACTICE OF JAY COUNTY	-1, 289, 083	1	448, 129				90
02 09002	2 JAY FAMILY MEDICINE	-882, 210		485, 219				90
	DEMERGENCY	-1, 678, 951		924, 211				91
	OBSERVATION BEDS (NON-DISTINCT PART)	-		~				92
	DOTHER OUTPATIENT SERVICE COST CENTER R REIMBURSABLE COST CENTERS	C	יי	0				93
. 10 09910		C		0				99
	AL PURPOSE COST CENTERS		.1	0				-1
5. 00 10600	D HEART ACQUI SI TI ON	C)	0				106
	PANCREAS ACQUISITION	C	0	0				109
	DINTESTINAL ACQUISITION	C	2	0				110
	DISLET ACQUISITION		2	0				111
3.0011300 3.00	UINTEREST EXPENSE SUBTOTALS (SUM OF LINES 1-117)	-7, 407, 092	/))	0 7, 563, 270				113 118
	EIMBURSABLE COST CENTERS	7, 407, 092	- <u> </u>	., 333, 270				
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	C		0				190
	PHYSICIANS' PRIVATE OFFICES	C		0				192
3.00 19300	NONPAID WORKERS	C)	0				193
. 00 07950		C	0	13				194
1.010795 ⁻		C	2	0				194
	2 WEST JAY CLINIC 3 OTHER NONREIMBURSABLE COST CENTERS			560, 302				194 194
1	OTHER NONREIMBURSABLE COST CENTERS		Ś	0				194
	5 OTHER NONREI MBURSABLE COST CENTERS			0				194
	5 TRI COUNTY	0		1, 486, 668				194
	HOSPI TALI ST	C		66, 835				194
	TOTAL (SUM OF LINES 118-199)	-7, 407, 092	1 0	9, 677, 088	1			200

Heal th	Financial Systems		JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS-	-2552-10
RECLAS	SIFICATIONS			Provi der	CCN: 151320	Peri od:	Worksheet A-	6
						From 10/01/2014 To 09/30/2015	Date/Time Pr 2/17/2016 10	epared: :07 am
		Increases						
	Cost Center	Line #	Sal ary	Other				
	2. 00	3.00	4.00	5.00				
	A – NURSERY RECLASS							
1.00	NURSERY	43.00	<u>137, 1</u> 38	8 <u>4, 6</u> 58				1.00
	TOTALS		137, 138	84, 658				
	B - LABOR & DELIVERY RECLASS							
1.00	DELIVERY ROOM & LABOR ROOM	52.00	<u> </u>	<u> </u>				1.00
	TOTALS		17, 453	1, 035				
	C – CAFETERIA RECLASS							_
1.00	CAFETERI A	<u> </u>	153, 225	13 <u>3, 0</u> 62				1.00
	TOTALS		153, 225	133, 062				
	D - MOB, POB, WEST JAY MAINT							_
1.00	OPERATION OF PLANT-MOB	7.01	4, 987	0				1.00
2.00	OPERATION OF PLANT-POB	7.02	7, 232	0				2.00
3.00	OPERATION OF PLANT-WJ		<u> </u>	0				3.00
	TOTALS		15, 008	0				
	F - OCCUPATIONAL AND SPEECH 1							_
1.00	OCCUPATI ONAL THERAPY	67.00	0	108, 738				1.00
2.00	SPEECH PATHOLOGY		0	26, 634				2.00
	TOTALS		0	135, 372				
500.00	Grand Total: Increases		322, 824	354, 127				500.00

Heal th	Financial Systems		JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS-	-2552-10
RECLASS	SEFECATIONS			Provi der	CCN: 151320	Peri od:	Worksheet A-	6
						From 10/01/2014 To 09/30/2015	Date/Time Pro 2/17/2016 10	epared: :07 am
		Decreases		·				
	Cost Center	Line #	Sal ary	Other	Wkst. A-7 Ref	· .		
	6. 00	7.00	8.00	9.00	10.00			
	A – NURSERY RECLASS				1			
1.00	ADULTS & PEDIATRICS		<u>137, 1</u> 38	<u> </u>		<u>o</u>		1.00
	TOTALS		137, 138	84, 658				
	B - LABOR & DELIVERY RECLASS	· · · · · ·			1			_
1.00	ADULTS & PEDIATRICS		1 <u>7, 4</u> 53	<u> </u>		0		1.00
	TOTALS		17, 453	1, 035				
	C - CAFETERIA RECLASS	I I			1			-
1.00	<u>DI ETARY</u>	10.00	15 <u>3, 2</u> 25	13 <u>3, 0</u> 62		0		1.00
	TOTALS		153, 225	133, 062				_
	D - MOB, POB, WEST JAY MAINT				1	-1		
1.00	OPERATION OF PLANT	7.00	15, 008	0		0		1.00
2.00		0.00	0	0		0		2.00
3.00		0.00		0		0		3.00
	TOTALS		15, 008	0				-
	F - OCCUPATIONAL AND SPEECH T		a	105 070				1
1.00	PHYSI CAL THERAPY	66.00	0	135, 372		0		1.00
2.00			0	0	<u>├──</u> ── ──	<u>u</u>		2.00
	TOTALS		0	135, 372		_		
500.00	Grand Total: Decreases		322, 824	354, 127				500.00

Health Fina	ncial Systems	JAY COUNTY	HOSPI TAL			In Lie	u of Form CMS-2	2552-10
RECONCI LI AT	FION OF CAPITAL COSTS CENTERS		Provi der	CCN: 151320	Frc To	riod: om 10/01/2014 09/30/2015		oared:
			Acqui si ti on					
		Begi nni ng Bal ances	Purchases	Donati on		Total	Disposals and Retirements	
		1.00	2.00	3.00		4.00	5.00	
PART								
1.00 Land		220, 245	127, 488		0	127, 488		1.00
	Improvements	936, 209	16, 123		0	16, 123		2.00
	dings and Fixtures	23, 337, 569	0		0	0	11, 312	3.00
	ding Improvements	0	0		0	0	0	4.00
5.00 Fixe	d Equipment	3, 105, 733	554, 134		0	554, 134	0	5.00
6.00 Mova	ble Equipment	11, 458, 040	1, 030, 395		0	1, 030, 395	0	6.00
7.00 HIT	designated Assets	0	0		0	0	0	7.00
8.00 Subt	otal (sum of lines 1-7)	39, 057, 796	1, 728, 140		0	1, 728, 140	11, 312	8.00
9.00 Reco	nciling Items	0	0		0	0	0	9.00
10.00 Tota	l (line 8 minus line 9)	39, 057, 796	1, 728, 140		0	1, 728, 140	11, 312	10.00
		Endi ng Bal ance	Fully					
		_	Depreciated					
			Assets					
		6.00	7.00					
	I - ANALYSIS OF CHANGES IN CAPITAL							
1.00 Land		347, 733	0					1.00
	Improvements	952, 332	0					2.00
	dings and Fixtures	23, 326, 257	0					3.00
4.00 Buil	ding Improvements	0	0					4.00
	d Equipment	3, 659, 867	0					5.00
	ble Equipment	12, 488, 435	0					6.00
	designated Assets	0	0					7. OC
8.00 Subt	otal (sum of lines 1-7)	40, 774, 624	0					8.00
9.00 Reco	nciling Items	0	0					9.00
10.00 Tota	I (line 8 minus line 9)	40, 774, 624	0					10.00

Heal th	n Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 151320	Peri od:	Worksheet A-7	
					From 10/01/2014 To 09/30/2015		arod
					10 09/30/2013	2/17/2016 10:0	
			SL	JMMARY OF CAP	PI TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
					instructions)		
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK			nd 2			
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1, 809, 945			0 0	0	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP MOB	10, 285			0 0	0	2.01
2.02	NEW CAP REL COSTS-MVBLE EQUIP-POB	119, 979			0 0	0	2.02
2.03	NEW CAP REL COSTS-MVBLE EQUIP- WJ	31, 142			0 0	0	2.03
3.00	Total (sum of lines 1-2)	1,971,351 SUMMARY 0			0 0	0	3.00
		SUMMARY U	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
	bost benter beschiption	Capi tal -Rel ate					
		d Costs (see					
		instructions)					
		14.00	15.00	1			
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	1, 809, 945				2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP MOB	0	10, 285				2.01
2.02	NEW CAP REL COSTS-MVBLE EQUIP-POB	0	119, 979				2.02
2.03	NEW CAP REL COSTS-MVBLE EQUIP- WJ	0	31, 142				2.03
3.00	Total (sum of lines 1-2)	0	1, 971, 351				3.00

Heal th	Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS			CCN: 151320	Period: From 10/01/2014 To 09/30/2015	Date/Time Prep 2/17/2016 10:0	pared:
		COMF	PUTATION OF RA	TIOS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col 2)	instructions)	Insurance	
	1	1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE			-			
2.00	NEW CAP REL COSTS-MVBLE EQUIP	11, 458, 040	(0 11, 458, 04		0	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP MOB	0	(0 0.000000	0	2.01
2.02	NEW CAP REL COSTS-MVBLE EQUIP-POB	0			0 0.00000	0	2.02
2.03 3.00	NEW CAP REL COSTS-MVBLE EQUIP- WJ Total (sum of lines 1-2)	0 11, 458, 040) 11, 458, 04	0 0.000000 1.000000	Ű	2.03 3.00
3.00			TION OF OTHER			F CAPITAL	3.00
		ALLUCA	ITON OF OTHER	CAFTIAL	JUNIMART		
	Cost Center Description	Taxes	Other	Total (sum o	f Depreciation	Lease	
			Capi tal -Rel ate				
			d Costs	through 7)			
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	INTERS					
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0		כ	0 1, 332, 082	0	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP MOB	0	(C	0 10, 285	0	2.01
2.02	NEW CAP REL COSTS-MVBLE EQUIP-POB	0	(D	0 119, 979		2.02
2.03	NEW CAP REL COSTS-MVBLE EQUIP- WJ	0	(D	0 31, 142		2.03
3.00	Total (sum of lines 1-2)	0			0 1, 493, 488	0	3.00
			S	UMMARY OF CAP	IAL		
	Cost Center Description	Interest	Insurance (see	e Taxes (see	Other	Total (2) (sum	
	·		instructions)	i nstructi ons) Capi tal -Rel ate		
					d Costs (see	through 14)	
					instructions)		
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE			1		1 000 000	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0			0 0	1, 332, 082	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP MOB	0			0 0	10, 285	2.01
2.02	NEW CAP REL COSTS-MVBLE EQUIP-POB	0	(2	0	119, 979	2.02
2.03	NEW CAP REL COSTS-MVBLE EQUIP- WJ	0				31, 142	2.03
3.00	Total (sum of lines 1-2)	I U	l (ין	0	1, 493, 488	3.00

	IENTS TO EXPENSES				eriod: rom 10/01/2014	Worksheet A-8	
				Т	o 09/30/2015		
				Expense Classification on To/From Which the Amount is			
					<i>"</i>		
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Line # 4.00	Wkst. A-7 Ref. 5.00	
00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		()*** Cost Center Deleted ***	1.00	0	1.0
00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		C	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.0
01	Investment income - NEW CAP REL COSTS-MVBLE EQUIP MOB (chapter 2)		C	NEW CAP REL COSTS-MVBLE EQUIP MOB	2.01	0	2.0
02	Investment income - NEW CAP REL COSTS-MVBLE EQUIP-POB (chapter 2)		C	NEW CAP REL COSTS-MVBLE EQUIP-POB	2.02	0	2. (
03	Investment income - NEW CAP REL COSTS-MVBLE EQUIP- WJ (chapter 2)		C	NEW CAP REL COSTS-MVBLE EQUIP- WJ	2.03	0	2. (
00	Investment income - other		C		0.00	0	3. (
00	(chapter 2) Trade, quantity, and time		(0.00	0	4.0
00	discounts (chapter 8) Refunds and rebates of		C		0.00	0	5.0
00	expenses (chapter 8) Rental of provider space by		(0.00	0	6. (
00	suppliers (chapter 8) Telephone services (pay stations excluded) (chapter		C		0.00	О	7.
00	21) Television and radio service (chapter 21)		C		0.00	0	8.
00 . 00	Parking lot (chapter 21) Provider-based physician adjustment	A-8-2	(-4, 332, 685	5	0.00	0 0	
. 00	Sale of scrap, waste, etc. (chapter 23)		(0.00	0	11.
. 00	Related organization transactions (chapter 10) Laundry and linen service	A-8-1	-21, 659		0.00	0	
. 00 . 00	Cafeteria-employees and guests	В	-167, 708	CAFETERI A	0.00 11.00	0	14.
. 00	Rental of quarters to employee and others		(D	0.00	0	15.
00	Sale of medical and surgical supplies to other than patients		C		0.00	0	16.
. 00	Sale of drugs to other than patients		(D	0.00	0	17.
. 00	Sale of medical records and	В	-13, 534	MEDICAL RECORDS & LIBRARY	16.00	о	18.
. 00	abstracts Nursing school (tuition, fees,		(0.00	о	19.
. 00	books, etc.) Vending machines		()	0.00	0	20.
. 00	Income from imposition of interest, finance or penalty charges (chapter 21)		C		0.00	0	21.
. 00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		C		0.00	0	22.
00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	C	RESPI RATORY THERAPY	65.00		23.
00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	C	PHYSICAL THERAPY	66.00		24.
00	Utilization review - physicians' compensation (chapter 21)		C	*** Cost Center Deleted ***	114.00		25.
00	Depreciation - CAP REL COSTS-BLDG & FIXT		(*** Cost Center Deleted ***	1.00	0	26.
00	Depreciation - NEW CAP REL		C	NEW CAP REL COSTS-MVBLE	2.00	0	27.
. 01	COSTS-MVBLE EQUIP Depreciation - NEW CAP REL		C	EQUIP NEW CAP REL COSTS-MVBLE	2.01	0	27.
	COSTS-MVBLE EQUIP MOB			EQUIP MOB	1	1	(

	Financial Systems		JAY COUNTY			u of Form CMS-2	
ADJUST	MENTS TO EXPENSES			Provider CCN: 151320	Period: From 10/01/2014	Worksheet A-8	
					To 09/30/2015	Date/Time Pre 2/17/2016 10:	pared:
				Expense Classification o	n Worksheet A	2/11/2010 10.	
				To/From Which the Amount is	s to be Adjusted		
	Cost Center Description	Basis/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Line # 4.00	Wkst. A-7 Ref. 5.00	
27.03	Depreciation - NEW CAP REL	1.00		NEW CAP REL COSTS-MVBLE	2.03	5.00	27.0
	COSTS-MVBLE EQUIP- WJ			EQUIP- WJ			
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***			28.0
9.00	Physicians' assistant		0		0.00		
30. 00	Adjustment for occupational therapy costs in excess of	A-8-3	00	OCCUPATIONAL THERAPY	67.00		30.0
	limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30.9
	instructions)						
31.00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68.00		31.0
	pathology costs in excess of limitation (chapter 14)						
32.00	CAH HIT Adjustment for		0		0.00	0	32.0
2.00	Depreciation and Interest		0		0100		
3.00	JEMS RENTAL	В		ADMINISTRATIVE & GENERAL	5.00		33. C
3. 01	SUPPLY REBATES AND DI SCOUNTS	В		ADMINISTRATIVE & GENERAL	5.00		
33.02	OTHER REVENUE	В		ADMI NI STRATI VE & GENERAL	5.00		
33. 03	OTHER REVENUE-DIABETIC COUNSELING	В	-8, 726	NURSING ADMINISTRATION	13.00	0	33.0
33. 04	CRNA OFFSET	А	-854, 907	ANESTHESI OLOGY	53.00	0	33.0
33.05	PHYSI CI AN RECRUI TMENT	A		ADMINISTRATIVE & GENERAL	5.00		
33.06	ADVERTI SI NG EXPENSE	А		ADMINISTRATIVE & GENERAL	5.00	0	33.0
33.07	SENI OR PROGRAM	А		ADMINISTRATIVE & GENERAL	5.00		
33.08	SWI TCHBOARD SALARY	A		ADMI NI STRATI VE & GENERAL	5.00		
3. 09 3. 10	SWITCHBOARD EH&W PATIENT TELEPHONE EXPENSE	A A		EMPLOYEE BENEFITS DEPARTMEN ADMINISTRATIVE & GENERAL	IT 4.00 5.00		
3. 10	PATIENT TELEPHONE DEPRECIATION	A		NEW CAP REL COSTS-MVBLE	2.00	9	
5. 11	TATIENT TEEETIONE DELKEGRATION	~		EQUIP	2.00	,	00.1
3. 12	HEALTH EDUCATION	В		ADMINISTRATIVE & GENERAL	5.00		
3. 13	VENDING MACHINE REVENUE	В		CAFETERI A	11.00	0	
3.14	PHARMACY EMPLOYEE SALES	В		DRUGS CHARGED TO PATIENTS	73.00		
3. 15 3. 16	PENSI ON EXPENSE HOUSEKEEPI NG WAGES	A A		EMPLOYEE BENEFITS DEPARTMEN HOUSEKEEPING	IT 4.00 9.00	0	
3.10	THA DUES	A		ADMINISTRATIVE & GENERAL	5.00		
3. 18		В		ADMINISTRATIVE & GENERAL	5.00		
3. 19	CLINIC RENTAL	В	-20, 857	ELECTROCARDI OLOGY	69.00	0	33.1
3. 20	CONFERENCE ROOM RENTAL	В		ADMINISTRATIVE & GENERAL	5.00		
3.21	VENDOR/CONTRACT REV	В		ADMI NI STRATI VE & GENERAL	5.00		
3. 22	EHR DEPRECIATION	В		NEW CAP REL COSTS-MVBLE	2.00	9	33. 2
33. 23	HOSPITAL ASSESSMENT FEE	А		ADMINISTRATIVE & GENERAL	5.00	0	33.2
33. 24	OTHER REVENUE	В		RADI OLOGY-DI AGNOSTI C	54.00		
33. 25	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 2
-0.00	(3)		7 .07 0				-
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A,		-7, 407, 092				50.0
	column 6, line 200.)						

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

Heal th	Financial Systems	JAY COUNT	In Lieu of Form CMS-2552-10			
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM	ME Provider CCN: 151320	Period: From 10/01/2014	Worksheet A-8	3-1
OFFICE	COSTS			To 09/30/2015		
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTM HOME OFFICE COSTS:	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED	ORGANI ZATI ONS OR	CLAIMED	
1.00	66.00	PHYSI CAL THERAPY	RENT/LEASE EXPENSE	28, 341	50, 000	1.00
2.00	0.00			0	0	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4).			28, 341	50, 000	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

na	5 1101	been posted to worksheet A,				FOI this part.	
					Related Organization(s) and/	or Home Office	
		Symbol (1)	Nama	Democratore of	Nama	Democrateria of	<u> </u>
		Symbol (1)	Name	Percentage of	Name	Percentage of	
				Ownershi p		Ownershi p	
		1.00	2.00	3.00	4.00	5.00	
		B INTERPRIATIONSHIP TO REL	TED OPCANIZATION(S) AND/OP I	OME DEELCE			

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	С	JAY CO MED FAC	65.00	1	0.00	6.00
7.00			0.00	1	0.00	7.00
8.00			0.00	1	0.00	8.00
9.00			0.00	1	0.00	9.00
10.00			0.00	1	0.00	10.00
100.00	G. Other (financial or					100.00
	non-financial) specify:					1

(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.

Health Financial Systems JAY CO	DUNTY HOSPITAL	In Lieu	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND		Period: From 10/01/2014	Worksheet A-8-1
OFFICE COSTS			Date/Time Prepared:

						ite/fille frepareu.
					2/	<u>17/2016 10:07 am</u>
	Net	Wkst. A-7 Ref.				
	Adjustments					
	(col. 4 minus					
	col. 5)*					
	6.00	7.00				
	A. COSTS INCUR	RED AND ADJUSTN	ENTS REQUIRED AS A RESULT	OF TRANSACTIONS WITH RE	LATED ORGANIZATIONS OR CLA	IMED
	HOME OFFICE CO	STS:				
1.00	-21, 659	0				1.00
2.00	0	0				2.00
3.00	0	0				3.00
4.00	0	0				4.00
5.00	-21,659					5.00

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

nas no	Di been posteu to worksneet A,		Z, the	e alliount	arrowabre	should be	i nui cateu	this part.	
	Rel ated Organi zati on(s)								
	and/or Home Office								
	Type of Business								
	Type of Busiliess								
		-							
	6. 00								
	B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATI ON	(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 7.00	6.00
7.00	7.00
8.00	8.00
9.00	9.00
10.00	10.00
8. 00 9. 00 10. 00 <u>100. 00</u>	100.00

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

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

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

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

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

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

	Financial Syste		JAY COUNT	Y HOSPI TAL			eu of Form CMS-	
PROVI DE	ER BASED PHYSICI	AN ADJUSTMENT		Provi dei	- CCN: 151320	Period: From 10/01/2014 To 09/30/2015		epared:
	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component		Physician/Prov ider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		LABORATORY	55, 000			0 0	0	
2.00		CLINIC	427, 441	427, 441		0 0	0	2.00
3.00		FAMILY PRACTICE OF JAY COUNTY	1, 289, 083		3	0 0	0	3.00
4.00	90. 02	JAY FAMILY MEDICINE	882, 210	882, 210)	0 0	0	4.00
5.00	91.00	EMERGENCY	2, 022, 833		343, 88	2 0	0	5.00
6.00	0.00		0	0)	0 0	0	6.00
7.00	0.00		0	0)	0 0	0	7.00
8.00	0.00		0)	o o	0	8.00
9.00	0.00		0	0)	o o	0	9.00
10.00	0, 00		0	0)	0 0	0	10.00
200.00			4, 676, 567	4, 332, 685	343,88	2	0	
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE			of Malpractice	
			2	Limit	Conti nui ng	Share of col.	Insurance	
				211111	Educati on	12	r nour anoo	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	60.00	LABORATORY	0	()	0 0	0	1.00
2.00	90, 00	CLINIC	0)	ol o	0	2.00
3.00	90. 01	FAMILY PRACTICE OF JAY COUNTY	0	C)	0 0	0	3. 00
4.00	90.02	JAY FAMILY MEDICINE	0	0)	0 0	0	4.00
5.00		EMERGENCY	0			0 0	0	
6.00	0.00	Emertoenton	0			0 0	0	6.00
7.00	0.00						0	7.00
8.00	0.00				·	0 0	0	
9.00	0.00		0				0	9,00
10.00	0.00		0			0 0	0	
200.00	0.00						0	
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	0	200.00
	into a	I denti fi er	Component Share of col.	Limit	Di sal I owance			
	1.00	2.00	14 15.00	16.00	17.00	18.00		
1.00		LABORATORY	15.00			0 55,000		1.00
2.00		CLINIC				0 55,000		2.00
2.00		FAMILY PRACTICE OF JAY				0 1, 289, 083		3.00
		COUNTY				.,,		
4.00		JAY FAMILY MEDICINE	0	0		0 882, 210		4.00
5.00		EMERGENCY	0	0		0 1, 678, 951		5.00
6.00	0.00		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
	1							1 40 00
10.00	0.00		0			0 0		10.00

	IABLE COST DETERMINATION FOR THERAPY SERVICES DE SUPPLIERS	FURNI SHED BY	Provi der	CCN: 151320	Period: From 10/01/2014 To 09/30/2015	Worksheet A-8- Parts I-VI Date/Time Prep 2/17/2016 10:0	oared:				
					Physical Therapy						
						1.00					
	PART I – GENERAL INFORMATION	<u> </u>				1.00					
. 00	Total number of weeks worked (excluding aides	s) (see instruc	tions)			52	1.00				
. 00	Line 1 multiplied by 15 hours per week				- :	780	2.00				
. 00 . 00	Number of unduplicated days in which supervis Number of unduplicated days in which therapy					0	3.00 4.00				
. 00	nor therapist was on provider site (see inst		on provider si		er supervisor	0	4.00				
. 00	Number of unduplicated offsite visits - super					0	5.00				
. 00	Number of unduplicated offsite visits - thera assistant and on which supervisor and/or the					0	6.00				
	instructions)	apist was not j	present during	the visit(s)) (see						
. 00	Standard travel expense rate					0.00	7.00				
. 00	Optional travel expense rate per mile		T I I I		A: 1	0.00	8.00				
		Supervi sors 1.00	Therapists 2.00	Assistants 3.00	Ai des 4.00	Trai nees 5.00					
. 00	Total hours worked	2, 155. 00	3, 907.00	2,053.		0.00	9.00				
0.00	AHSEA (see instructions)	89.53	77.86	50.							
1.00	Standard travel allowance (columns 1 and 2,	38. 93	38. 93	25.	31		11. OC				
	one-half of column 2, line 10; column 3, one-half of column 3, line 10)										
2.00	Number of travel hours (provider site)	0	0		0		12.00				
2.01	Number of travel hours (offsite)	0	0		0		12.0				
3.00	Number of miles driven (provider site)	0	0		0		13.00				
3.01	Number of miles driven (offsite)	0	0		0		13.0				
						1.00					
	Part II - SALARY EQUIVALENCY COMPUTATION										
4.00	Supervisors (column 1, line 9 times column 1,					192, 937					
5.00 5.00	Therapists (column 2, line 9 times column 2, Assistants (column 3, line 9 times column 3,					304, 199 103, 902	15. 0 16. 0				
7.00	Subtotal allowance amount (sum of lines 14 a		ratory therapy	or lines 14	-16 for all	601, 038	17.0				
	others)										
3. 00	Aides (column 4, line 9 times column 4, line					0	18. 0				
9.00	Trainees (column 5, line 9 times column 5, li		*h	- 17 10	for all athenal	0	19.0				
0. 00	Total allowance amount (sum of lines 17-19 for If the sum of columns 1 and 2 for respiratory					601, 038	20.00				
	occupational therapy, line 9, is greater than			2		0.5					
	the amount from line 20. Otherwise complete										
1.00	Weighted average rate excluding aides and tra			n of columns	1 and 2, line 9	0.00	21.0				
2.00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and trained					0	22. 0				
3.00	Total salary equivalency (see instructions)		00 11110 21)			601, 038					
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW	ANCE AND TRAVE	L EXPENSE COMPL	JTATION - PR	OVIDER SITE						
1 00	Standard Travel Allowance					0	24.0				
4.00 5.00	Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11)					0	24.0 25.0				
6.00	Subtotal (line 24 for respiratory therapy or	sum of lines 24	4 and 25 for a	I others)		0	26.0				
7.00	Standard travel expense (line 7 times line 3				3 and 4 for all	0	27.0				
	others)	trougl avrages	at the provid	ar aita (aum	of Linco 24 and	0	20.0				
8.00	Total standard travel allowance and standard 27)	travel expense	at the provide	er site (sum	or times 26 and	0	28.00				
	Optional Travel Allowance and Optional Travel	Expense									
~ ~~	Therapists (column 2, line 10 times the sum of		d 2, line 12)			0	29.0				
9.00	Assistants (column 3, line 10 times column 3,					0	30. 0 31. 0				
0. 00	0 Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)										
). 00 . 00											
). 00 1. 00					y or sum of	0	32.0				
0.00 0.00 2.00	Optional travel expense (line 8 times columns	s 1 and 2, line	13 for respira		y or sum of	0					
0.00 1.00 2.00 3.00 4.00	Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel	s 1 and 2, line expense (line expense (sum o	13 for respira 28) of lines 27 and	atory therap d 31)	y or sum of	0 0	33. 0 34. 0				
0.00 .00 2.00 3.00 4.00	Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel	s 1 and 2, line expense (line expense (sum expense (sum	13 for respira 28) of lines 27 and of lines 31 and	atory therap d 31) d 32)	-	0 0 0	33. 0 34. 0				
0.00 1.00 2.00 3.00 4.00	Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/	s 1 and 2, line expense (line expense (sum expense (sum	13 for respira 28) of lines 27 and of lines 31 and	atory therap d 31) d 32)	-	0 0 0	33. 0 34. 0				
0.00 1.00 2.00 3.00 4.00 5.00	Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel	s 1 and 2, line expense (line expense (sum expense (sum	13 for respira 28) of lines 27 and of lines 31 and	atory therap d 31) d 32)	-	0 0 0	33. 00 34. 00 35. 00				
 a) 00 b) 00 c) 00 	Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11)	s 1 and 2, line expense (line expense (sum expense (sum	13 for respira 28) of lines 27 and of lines 31 and	atory therap d 31) d 32)	-	0 0 0 0 0 0 0 0 0 0 0	33. 00 34. 00 35. 00 36. 00 37. 00				
 a. 00 b. 00 c. 00 c. 00 d. 00 <lid. 00<="" li=""> d. 00 d. 00 d. 00 <l< td=""><td>Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37)</td><td>s 1 and 2, line expense (line expense (sum expense (sum NCE AND TRAVEL</td><td>13 for respira 28) of Lines 27 and of Lines 31 and EXPENSE COMPU</td><td>atory therap d 31) d 32)</td><td>-</td><td>0 0 0 0 0 0 0 0 0 0 0 0</td><td>33. 00 34. 00 35. 00 36. 00 37. 00 38. 00</td></l<></lid.>	Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37)	s 1 and 2, line expense (line expense (sum expense (sum NCE AND TRAVEL	13 for respira 28) of Lines 27 and of Lines 31 and EXPENSE COMPU	atory therap d 31) d 32)	-	0 0 0 0 0 0 0 0 0 0 0 0	33. 00 34. 00 35. 00 36. 00 37. 00 38. 00				
 a. 00 b. 00 c. 00 c. 00 d. 00 <lid. 00<="" li=""> d. 00 d. 00 d. 00 <l< td=""><td>Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum</td><td>s 1 and 2, line expense (line expense (sum of NNCE AND TRAVEL</td><td>13 for respira 28) of Lines 27 and of Lines 31 and EXPENSE COMPU</td><td>atory therap d 31) d 32)</td><td>-</td><td>0 0 0 0 0 0 0 0 0 0 0</td><td>33. 00 34. 00 35. 00 36. 00 37. 00 38. 00</td></l<></lid.>	Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum	s 1 and 2, line expense (line expense (sum of NNCE AND TRAVEL	13 for respira 28) of Lines 27 and of Lines 31 and EXPENSE COMPU	atory therap d 31) d 32)	-	0 0 0 0 0 0 0 0 0 0 0	33. 00 34. 00 35. 00 36. 00 37. 00 38. 00				
 0.00 00 00	Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel	s 1 and 2, line expense (line expense (sum of expense (sum of NCE AND TRAVEL	13 for respira 28) of lines 27 and of lines 31 and EXPENSE COMPU d 6)	atory therap d 31) d 32)	-	0 0 0 0 0 0 0 0 0 0 0 0	33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00				
0.00 .00	Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum	s 1 and 2, line expense (line expense (sum expense (sum NNCE AND TRAVEL m of lines 5 and Expense D1 times column	13 for respira 28) of lines 27 and of lines 31 and EXPENSE COMPU d 6)	atory therap d 31) d 32)	-	0 0 0 0 0 0 0 0 0 0 0 0 0	33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00				
0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 3.00 9.00 0.00 1.00 2.00	Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0 Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41)	s 1 and 2, line expense (line expense (sum NACE AND TRAVEL m of lines 5 and Expense D1 times column n 3, line 10)	13 for respira 28) of lines 27 and of lines 31 and EXPENSE COMPU d 6) 2, line 10)	atory therap d 31) d 32)	-	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00				
0.00 1.00 2.00	Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0 Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the sum	s 1 and 2, line expense (line expense (sum of expense (sum of NNCE AND TRAVEL n of lines 5 and Expense D1 times column n 3, line 10) n of columns 1-2	13 for respira 28) of lines 27 and of lines 31 and EXPENSE COMPU d 6) 2, line 10) 3, line 13.01)	atory therap d 31) d 32) FATION - SER	VI CES OUTSI DE PRO	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00				
0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 3.00 9.00 0.00 1.00 2.00	Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sur Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0 Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the sur Total Travel Allowance and Travel Expense - (s 1 and 2, line expense (line expense (sum of expense (sum of NNCE AND TRAVEL n of lines 5 and Expense D1 times column n 3, line 10) n of columns 1-2	13 for respira 28) of lines 27 and of lines 31 and EXPENSE COMPU d 6) 2, line 10) 3, line 13.01)	atory therap d 31) d 32) FATION - SER	VI CES OUTSI DE PRO	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00				
0.00 1.00 2.00 3.00 4.00 5.00 5.00 6.00 7.00 8.00 9.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00	Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0 Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the sum	s 1 and 2, line expense (line expense (sum of expense (sum of NACE AND TRAVEL n of lines 5 and Expense D1 times column h 3, line 10) n of columns 1- Dffsite Services	13 for respira 28) of lines 27 and of lines 31 and EXPENSE COMPU d 6) 2, line 10) 3, line 13.01) s; Complete ond	atory therap d 31) d 32) TATION - SER	VICES OUTSIDE PRO	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	33. 0 34. 0 35. 0 36. 0 37. 0 38. 0 39. 0 40. 0 41. 0 42. 0				

Health Financial Systems	Financial Systems JAY COUNTY HOSPITAL In Lieu				
REASONABLE COST DETERMINATION FOR THERAPY OUTSIDE SUPPLIERS	SERVI CES FURNI SHED BY	Provider CCN: 151320	From 10/01/2014	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/17/2016 10:07 am	

				Pł	ysical Therapy	Cost	
			1				
						1.00	
46.00	Optional travel allowance and optional travel			d 43 - see ins			46.00
		Therapists	Assistants	Aides	Trai nees	Total	
	PART V - OVERTIME COMPUTATION	1.00	2.00	3.00	4.00	5.00	
47.00	Overtime hours worked during reporting	0.00	0.00	0.00	0.00	0.00	47.00
	period (if column 5, line 47, is zero or	01 00	0.00	0100	0100	0100	
	equal to or greater than 2,080, do not						
	complete lines 48-55 and enter zero in each						
40.00	column of line 56)	0.00	0.00	0.00	0.00		40.00
48.00 49.00	Overtime rate (see instructions) Total overtime (including base and overtime	0. 00 0. 00	0.00 0.00		0. 00 0. 00		48.00 49.00
47.00	allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category	0.00	0.00	0.00	0.00	0.00	50.00
	(divide the hours in each column on line 47						
	by the total overtime worked - column 5, line 47)						
51.00	Allocation of provider's standard work year	0.00	0.00	0.00	0.00	0.00	51.00
01.00	for one full-time employee times the	0.00	0.00	0.00	0.00	0.00	
	percentages on line 50) (see instructions)						
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount	77.86	50. 61	0.00	0.00		52.00
53.00	(see instructions) Overtime cost limitation (line 51 times line	0	0	0	0		53.00
55.00	52)	0	0	0	0		33.00
54.00	Maximum overtime cost (enter the lesser of	0	0	0	0		54.00
	line 49 or line 53)						
55.00	Portion of overtime already included in	0	0	0	0		55.00
	hourly computation at the AHSEA (multiply line 47 times line 52)						
56.00	Overtime allowance (line 54 minus line 55 -	0	0	0	0	0	56.00
00.00	if negative enter zero) (Enter in column 5	Ū	Ū		Ū	0	
	the sum of columns 1, 3, and 4 for						
	respiratory therapy and columns 1 through 3						
	for all others.)						
						1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST	ADJUSTMENT				
57.00	Salary equivalency amount (from line 23)					601, 038	
58.00	Travel allowance and expense - provider site					0	
59.00	Travel allowance and expense - Offsite servic	es (from lines	44, 45, or 46)		0	
60.00 61.00	Overtime allowance (from column 5, line 56) Equipment cost (see instructions)					0	
62.00	Supplies (see instructions)					0	
63.00	Total allowance (sum of lines 57-62)					601, 038	•
64.00	Total cost of outside supplier services (from					585, 856	64.00
65.00	Excess over limitation (line 64 minus line 63	8 - if negative	, enter zero)			0	65.00
100.00	LINE 33 CALCULATION	<u> </u>	4 1 05 0				100.00
	Line 26 = line 24 for respiratory therapy or Line 27 = line 7 times line 3 for respiratory				thore		100. 00 100. 01
	Line 33 = line 28 = sum of lines 26 and 27	the apy of su	III OF TITLES 3 a		LITELS		100.01
100.02	LINE 34 CALCULATION						100.02
101.00	Line 27 = line 7 times line 3 for respiratory	therapy or su	m of lines 3 a	nd 4 for all o	thers	0	101.00
101.01	Line 31 = line 29 for respiratory therapy or	sum of lines 2	9 and 30 for a	II others			101.01
101.02	Line 34 = sum of lines 27 and 31					0	101. 02
100.00	LINE 35 CALCULATION	oum of Lines O	0 and 20 fri	ll othor-			102.00
	Line 31 = line 29 for respiratory therapy or Line 32 = line 8 times columns 1 and 2, line				ns 1-3 line		102. 00 102. 01
102.01	13 for all others	is is respire	tory therapy 0			0	102.01
102.02	Line 35 = sum of lines 31 and 32					0	102. 02

	Financial Systems WABLE COST DETERMINATION FOR THERAPY SERVICES DE SUPPLIERS	JAY COUNTY HO	SPITAL Provider CCN:	F	In Lie eri od: rom 10/01/2014 o 09/30/2015 Respi ratory Therapy	u of Form CMS-2 Worksheet A-8 Parts I-VI Date/Time Prep 2/17/2016 10: (Cost	-3 pared:
					-	1.00	
4 00	PART I - GENERAL INFORMATION	<u> </u>				50	1 00
1.00 2.00	Total number of weeks worked (excluding aide Line 1 multiplied by 15 hours per week	s) (see instructi	ons)			52 780	1.00 2.00
3.00 4.00	Number of unduplicated days in which supervi Number of unduplicated days in which therapy					0	•
E 00	nor therapist was on provider site (see inst	,	icto (coo instru	ations)		0	E 00
5.00 6.00	Number of unduplicated offsite visits - supe Number of unduplicated offsite visits - ther assistant and on which supervisor and/or the instructions)	apy assistants (i	nclude only visi	ts made by		0	5.00 6.00
7.00	Standard travel expense rate					0.00	
8.00	Optional travel expense rate per mile	Supervi sors	Therapists As	sistants	Ai des	0.00 Trai nees	8.00
		1.00	2.00	3.00	4.00	5.00	
9.00 10.00	Total hours worked AHSEA (see instructions)	1, 863. 00 70. 38	5, 949. 00 61. 20	0. 00 0. 00		0.00	9.00 10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	30. 60	30. 60	0.00		0.00	11.00
12.00	Number of travel hours (provider site)	0	О	0			12.00
12. 01 13. 00	Number of travel hours (offsite) Number of miles driven (provider site)	o	0	0			12.01 13.00
13.00	Number of miles driven (provider site)	0	0	0			13.00
		· · · ·			-	1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION					1.00	
14.00	Supervisors (column 1, line 9 times column 1					131, 118	
15.00 16.00	Therapists (column 2, line 9 times column 2,					364, 079 0	
17.00	Assistants (column 3, line 9 times column 3, Subtotal allowance amount (sum of lines 14 a		tory therapy or I	lines 14-1	6 for all	495, 197	
	others)		5 15				
18.00 19.00	Aides (column 4, line 9 times column 4, line Trainees (column 5, line 9 times column 5, l					82, 620 0	18.00
20.00	Total allowance amount (sum of lines 17-19 f	or respiratory th				577, 817	
	If the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater that the amount from line 20. Otherwise complete	n line 2, make no					
21.00	Weighted average rate excluding aides and tra		ivided by sum of	columns 1	and 2, line 9	0.00	21.00
22.00	for respiratory therapy or columns 1 thru 3,					0	22.00
22.00 23.00	Weighted allowance excluding aides and train Total salary equivalency (see instructions)	ees (TTHE 2 TTHES	TThe 21)			0 577, 817	
	PART III - STANDARD AND OPTIONAL TRAVEL ALLO	VANCE AND TRAVEL	EXPENSE COMPUTATI	ON - PROV	I DER SI TE		
24.00	Standard Travel Allowance Therapists (line 3 times column 2, line 11)					0	24.00
24.00	Assistants (line 4 times column 3, line 11)					0	
26.00	Subtotal (line 24 for respiratory therapy or					0	
27.00	Standard travel expense (line 7 times line 3 others)	for respiratory	therapy or sum of	flines 3 a	and 4 for all	0	27.00
28.00	Total standard travel allowance and standard 27)	·	t the provider si	ite (sum o	flines 26 and	0	28.00
29 00	Optional Travel Allowance and Optional Travel Therapists (column 2 line 10 times the sum		2 line 12)			0	29 00
29. 00 30. 00	Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3	of columns 1 and	2, line 12)			0	29.00 30.00
30. 00 31. 00	Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or	of columns 1 and , line 12) sum of lines 29	and 30 for all o [.]			0	30. 00 31. 00
30.00	Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column	of columns 1 and , line 12) sum of lines 29	and 30 for all o [.]		or sum of	0	30. 00 31. 00
30. 00 31. 00 32. 00 33. 00	Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave	of columns 1 and , line 12) sum of lines 29 s 1 and 2, line 1 l expense (line 2	and 30 for all o 3 for respiratory 8)	y therapy	or sum of	0	30. 00 31. 00 32. 00 33. 00
30. 00 31. 00 32. 00 33. 00 34. 00	Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave	of columns 1 and , line 12) sum of lines 29 s 1 and 2, line 1 l expense (line 2 l expense (sum of	and 30 for all o 3 for respiratory 8) lines 27 and 31	y therapy (or sum of	0 0 0 0 0	30. 00 31. 00 32. 00 33. 00 34. 00
30. 00 31. 00 32. 00 33. 00	Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW	of columns 1 and , line 12) sum of lines 29 s 1 and 2, line 1 l expense (line 2 l expense (sum of l expense (sum of	and 30 for all o 3 for respiratory 8) lines 27 and 31 lines 31 and 32	y therapy ()		0 0 0 0 0 0	30. 00 31. 00 32. 00 33. 00 34. 00
30. 00 31. 00 32. 00 33. 00 34. 00	Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave	of columns 1 and , line 12) sum of lines 29 s 1 and 2, line 1 l expense (line 2 l expense (sum of l expense (sum of	and 30 for all o 3 for respiratory 8) lines 27 and 31 lines 31 and 32	y therapy ()		0 0 0 0 0 VI DER SI TE	30. 00 31. 00 32. 00 33. 00 34. 00
30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00	Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11)	of columns 1 and , line 12) sum of lines 29 s 1 and 2, line 1 l expense (line 2 l expense (sum of l expense (sum of	and 30 for all o 3 for respiratory 8) lines 27 and 31 lines 31 and 32	y therapy ()		0 0 0 0 0 0 0 VI DER SI TE 0 0	30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00
30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00	Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37)	of columns 1 and , line 12) sum of lines 29 s 1 and 2, line 1 l expense (line 2 l expense (sum of expense (sum of ANCE AND TRAVEL E	and 30 for all o 3 for respiratory 8) lines 27 and 31 lines 31 and 32 XPENSE COMPUTATIO	y therapy ()		0 0 0 0 0 <u>0</u> <u>0</u> <u>0</u> <u>0</u> <u>0</u> <u>0</u> 0	30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00
30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00	Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the su Optional Travel Allowance and Optional Travel	of columns 1 and , line 12) sum of lines 29 s 1 and 2, line 1 l expense (line 2 l expense (sum of l expense (sum of LANCE AND TRAVEL E m of lines 5 and Expense	and 30 for all or 3 for respiratory 8) lines 27 and 31 lines 31 and 32 XPENSE COMPUTATIO	y therapy ()		0 0 0 0 0 0 0 0 0 0 0 0 0 0	30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00
30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00	Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the su Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.	of columns 1 and , line 12) sum of lines 29 s 1 and 2, line 1 l expense (line 2 l expense (sum of L expense (sum of ANCE AND TRAVEL E m of lines 5 and Expense D1 times column 2	and 30 for all or 3 for respiratory 8) lines 27 and 31 lines 31 and 32 XPENSE COMPUTATIO	y therapy ()		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00
30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00	Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12. Assistants (column 3, line 12.01 times colum	of columns 1 and , line 12) sum of lines 29 s 1 and 2, line 1 l expense (line 2 l expense (sum of L expense (sum of ANCE AND TRAVEL E m of lines 5 and Expense D1 times column 2	and 30 for all or 3 for respiratory 8) lines 27 and 31 lines 31 and 32 XPENSE COMPUTATIO	y therapy ()		0 0 0 0 0 0 0 0 0 0 0 0 0 0	30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00
30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 35. 00 37. 00 38. 00 39. 00 40. 00 41. 00	Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12. Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the sum	of columns 1 and , line 12) sum of lines 29 s 1 and 2, line 1 l expense (line 2 l expense (sum of expense (sum of ANCE AND TRAVEL E m of lines 5 and Expense D1 times column 2 n 3, line 10) m of columns 1-3,	and 30 for all or 3 for respiratory 8) lines 27 and 31 lines 31 and 32 XPENSE COMPUTATIO 6) , line 10) line 13.01)	y therapy ())))N - SERVI(CES OUTSI DE PRO	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00
30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00	Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Expense Therapists (line 5 times column 3, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12. Assistants (column 3, line 12. 01 times colum Subtotal (sum of lines 40 and 41)	of columns 1 and , line 12) sum of lines 29 s 1 and 2, line 1 l expense (line 2 l expense (sum of expense (sum of ANCE AND TRAVEL E m of lines 5 and Expense D1 times column 2 n 3, line 10) m of columns 1-3,	and 30 for all or 3 for respiratory 8) lines 27 and 31 lines 31 and 32 XPENSE COMPUTATIO 6) , line 10) line 13.01)	y therapy ())))N - SERVI(CES OUTSI DE PRO	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00

	ABLE COST DETERMINATION FOR THERAPY SERVICES I E SUPPLIERS	-URNI SHED BY	Provider	CCN: 151320	Period: From 10/01/2014 To 09/30/2015	Worksheet A-8 Parts I-VI Date/Time Pre 2/17/2016 10:	pared
					Respi ratory Therapy	Cost	
						1.00	
5.00	Optional travel allowance and standard travel	expense (sum o	of lines 39 an	d 42 - see ir	nstructions)	0	45. C
5.00	Optional travel allowance and optional travel	expense (sum o	of lines 42 an	d 43 - see ir	nstructions)	0	46.0
		Therapists 1.00	Assistants 2.00	Ai des 3.00	Trai nees 4. 00	<u> </u>	
	PART V - OVERTIME COMPUTATION	1.00	2.00	3.00	4.00	5.00	
7.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	113. 00	0.00	45.0	0. 00	158.00	47.(
. 00	Overtime rate (see instructions)	91. 80	0.00				48.
. 00	Total overtime (including base and overtime	10, 373. 40	0.00	3, 098. 2	25 0.00		49. (
	allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT						
. 00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	71. 52	0.00	28.4	48 0.00	100.00	50. (
. 00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	1, 487. 62	0.00	592. 3	38 0.00	2, 080. 00	51.
~~	DETERMINATION OF OVERTIME ALLOWANCE	(4.00		45.4			1 50
00	Adjusted hourly salary equivalency amount (see instructions) Overtime cost limitation (line 51 times line	61. 20 91, 042	0.00				52. 53.
. 00	52) Maximum overtime cost (enter the lesser of	10, 373	0				54.
. 00	line 49 or line 53) Portion of overtime already included in hourly computation at the AHSEA (multiply	6, 916	0	2, 00	66 0		55.
00	line 47 times line 52) Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	3, 457	0	1, 03	32 0	4, 489	56.
	tor an others.)						
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST	AD JUSTMENT			1.00	
00	Salary equivalency amount (from line 23)					577, 817	57.
00	Travel allowance and expense - provider site			_		0	
00 00	Travel allowance and expense - Offsite servic Overtime allowance (from column 5, line 56)	es (from lines	44, 45, or 46)		0 4, 489	
	Equipment cost (see instructions)						61.
	Supplies (see instructions)						62.
00	Total allowance (sum of lines 57-62)					583, 106	
00	Total cost of outside supplier services (from	•				346, 046	
00	Excess over limitation (line 64 minus line 63	- if negative,	, enter zero)			0	65.
	LINE 33 CALCULATION Line 26 = line 24 for respiratory therapy or	sum of lines 24	4 and 25 for a	ll others		0	100.
00	Line 27 = line 7 times line 3 for respiratory				others		100.
							100.
). 01	Line 33 = line 28 = sum of lines 26 and 27						
). 01). 02	LINE 34 CALCULATION						1
). 01). 02 I. 00	LINE 34 CALCULATION Line 27 = line 7 times line 3 for respiratory				others		101.
). 01). 02 . 00 . 01	LINE 34 CALCULATION Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or				others	0	101.
0. 01 0. 02 . 00 . 01	LINE 34 CALCULATION Line 27 = line 7 times line 3 for respiratory				others	0	101.
). 01). 02 I. 00 I. 01 I. 02 2. 00	LINE 34 CALCULATION Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31	sum of lines 29	9 and 30 for a 9 and 30 for a	II others		00	

	Financial Systems IABLE COST DETERMINATION FOR THERAPY SERVICES DE SUPPLIERS	JAY COUNTY HO FURNI SHED BY	SPI TAL Provi der CCN: 15	From 10 To 00 Occup		u of Form CMS-2 Worksheet A-8- Parts I-VI Date/Time Prep 2/17/2016 10:0 Cost	-3 pared:
					-	1.00	
4 00	PART I - GENERAL INFORMATION					50	1 00
1.00 2.00	Total number of weeks worked (excluding aide Line 1 multiplied by 15 hours per week	s) (see instruction	ons)			52 780	1.00 2.00
3.00	Number of unduplicated days in which supervis	sor or therapist v	was on provider sit	e (see instru	uctions)	0	3.00
4.00	Number of unduplicated days in which therapy		provider site but	neither super	rvi sor	0	4.00
5.00	nor therapist was on provider site (see inst Number of unduplicated offsite visits - supe	,	sts (see instructi	ons)		0	5.00
6.00	Number of unduplicated offsite visits - ther assistant and on which supervisor and/or the	apy assistants (ii	nclude only visits	made by thera	ару	0	6.00
7.00	instructions) Standard travel expense rate					0.00	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors 1 1.00			Aides 4.00	Trai nees 5. 00	
9.00	Total hours worked	15. 00	1, 833. 00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	81.19	73.81	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, column 3, line 10)	36. 91	36.91	0.00			11.00
12.00	one-half of column 3, line 10) Number of travel hours (provider site)	0	o	o			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00 13.01	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	U	0			13.01
						1.00	
14.00	Part II - SALARY EQUIVALENCY COMPUTATION Supervisors (column 1, line 9 times column 1	line 10)				1 218	14.00
15.00	Therapists (column 2, line 9 times column 2,					135, 294	
16.00	Assistants (column 3, line 9 times column 3,					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 a others)	nd 15 for respira	tory therapy or lir	nes 14-16 for	all	136, 512	17.00
18.00	Aides (column 4, line 9 times column 4, line					0	18.00
19.00	Trainees (column 5, line 9 times column 5, l		arany or lines 17 a	and 10 fear all	othere	0 136, 512	19.00
20. 00	Total allowance amount (sum of lines 17-19 f If the sum of columns 1 and 2 for respiratory						20.00
	occupational therapy, line 9, is greater that the amount from line 20. Otherwise complete		entries on lines 2	1 and 22 and	enter on	line 23	
21.00	Weighted average rate excluding aides and tra		vided by sum of co	Jumns 1 and 2	2, line 9	0.00	21.00
	for respiratory therapy or columns 1 thru 3,	line 9 for all o	thers)				
22.00 23.00	Weighted allowance excluding aides and train Total salary equivalency (see instructions)	ees (line 2 times	line 21)			0 136, 512	
	PART III - STANDARD AND OPTIONAL TRAVEL ALLO	VANCE AND TRAVEL E	EXPENSE COMPUTATION	I - PROVIDER S	SI TE		
24.00	Standard Travel Allowance					0	24 00
24.00	Assistants (line 3 times column 2, line 11)					0	24.00 25.00
26.00	Subtotal (line 24 for respiratory therapy or					0	26.00
27.00	Standard travel expense (line 7 times line 3 others)	for respiratory	therapy or sum of I	ines 3 and 4	for all	0	27.00
28. 00	Total standard travel allowance and standard 27)	travel expense a	t the provider site	e (sum of line	es 26 and	0	28.00
	Optional Travel Allowance and Optional Travel						
20 00	Therapists (column 2, line 10 times the sum	or corumns 1 and 2	z, iine 12)			0	20 22
29.00 30.00		line 12)				ol	
29.00 30.00 31.00	Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or		and 30 for all othe	ers)		0 0	29.00 30.00 31.00
30.00	Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column	sum of lines 29 a			n of		30.00
30. 00 31. 00 32. 00	Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others)	sum of lines 29 a s 1 and 2, line 13	3 for respiratory t		n of	0 0	30. 00 31. 00 32. 00
30. 00 31. 00	Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave	sum of lines 29 a s 1 and 2, line 13 l expense (line 20 l expense (sum of	3 for respiratory t 3) lines 27 and 31)		n of	0	30. 00 31. 00
30. 00 31. 00 32. 00 33. 00	Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and optional trave	sum of lines 29 a s 1 and 2, line 13 l expense (line 20 l expense (sum of l expense (sum of	3 for respiratory t 3) lines 27 and 31) lines 31 and 32)	herapy or sur		0 0 0 0 0	30. 00 31. 00 32. 00 33. 00
30. 00 31. 00 32. 00 33. 00 34. 00	Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW	sum of lines 29 a s 1 and 2, line 13 l expense (line 20 l expense (sum of l expense (sum of	3 for respiratory t 3) lines 27 and 31) lines 31 and 32)	herapy or sur		0 0 0 0 0	30. 00 31. 00 32. 00 33. 00 34. 00
30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00	Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Expense Therapists (line 5 times column 2, line 11)	sum of lines 29 a s 1 and 2, line 13 l expense (line 20 l expense (sum of l expense (sum of	3 for respiratory t 3) lines 27 and 31) lines 31 and 32)	herapy or sur		0 0 0 0 <u>VI DER SI TE</u> 0	30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00
30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00	Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11)	sum of lines 29 a s 1 and 2, line 13 l expense (line 20 l expense (sum of l expense (sum of	3 for respiratory t 3) lines 27 and 31) lines 31 and 32)	herapy or sur		0 0 0 0 <u>0</u> <u>0</u> 0 <u>0</u> 0 0	30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00
30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00	Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Expense Therapists (line 5 times column 2, line 11)	sum of lines 29 a s 1 and 2, line 1: l expense (line 24 l expense (sum of l expense (sum of ANCE AND TRAVEL EX	3 for respiratory t 3) lines 27 and 31) <u>lines 31 and 32)</u> KPENSE COMPUTATION	herapy or sur		0 0 0 0 <u>VI DER SI TE</u> 0	30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00
30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00	Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the su Optional Travel Allowance and Optional Travel	sum of lines 29 a s 1 and 2, line 1: l expense (line 20 l expense (sum of expense (sum of NACE AND TRAVEL EX m of lines 5 and of Expense	3 for respiratory t 3) lines 27 and 31) lines 31 and 32) (PENSE COMPUTATION 5)	herapy or sur		0 0 0 0 0 0 0 0 0 0 0 0 0	30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00 39.00
30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00	Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the su Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.)	sum of lines 29 a s 1 and 2, line 1: l expense (line 21 expense (sum of expense (sum of ANCE AND TRAVEL EX m of lines 5 and (Expense D1 times column 2,	3 for respiratory t 3) lines 27 and 31) lines 31 and 32) (PENSE COMPUTATION 5)	herapy or sur		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00
30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00	Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the su Optional Travel Allowance and Optional Travel	sum of lines 29 a s 1 and 2, line 1: l expense (line 21 expense (sum of expense (sum of ANCE AND TRAVEL EX m of lines 5 and (Expense D1 times column 2,	3 for respiratory t 3) lines 27 and 31) lines 31 and 32) (PENSE COMPUTATION 5)	herapy or sur		0 0 0 0 0 0 0 0 0 0 0 0 0	30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00 39.00
30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 35. 00 37. 00 38. 00 39. 00 40. 00 41. 00	Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the su Optional Travel Allowance and Optional Travel Therapists (column 3, line 12.01 times colum Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the su	sum of lines 29 a s 1 and 2, line 1: l expense (line 24 l expense (sum of l expense (sum of NNCE AND TRAVEL E) m of lines 5 and of Expense D1 times column 2, n 3, line 10) m of columns 1-3,	3 for respiratory t 3) lines 27 and 31) lines 31 and 32) (PENSE COMPUTATION 5) Line 10) line 13.01)	herapy or sur	JTSI DE PRO	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00
30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00	Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the su Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.) Assistants (column 3, line 12.01 times colum Subtotal (sum of lines 40 and 41)	sum of lines 29 a s 1 and 2, line 1: l expense (line 24 l expense (sum of l expense (sum of NNCE AND TRAVEL E) m of lines 5 and of Expense D1 times column 2, n 3, line 10) m of columns 1-3,	3 for respiratory t 3) lines 27 and 31) lines 31 and 32) (PENSE COMPUTATION 5) Line 10) line 13.01)	herapy or sur	JTSI DE PRO	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00

	ABLE COST DETERMINATION FOR THERAPY SERVICES F E SUPPLIERS	FURNI SHED BY	Provi der	CCN: 151320	Period: From 10/01/2014 To 09/30/2015	Worksheet A-8 Parts I-VI Date/Time Pre 2/17/2016 10:0	pared
					Occupational Therapy	Cost	
						1.00	
5.00	Optional travel allowance and standard travel	expense (sum	oflines 39 an	d 42 - see ir	structions)	0	45.0
	Optional travel allowance and optional travel		of lines 42 an			0	
		Therapi sts	Assistants	Aides	Trai nees	Total	
	PART V - OVERTIME COMPUTATION	1.00	2.00	3.00	4.00	5.00	
	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each	0. 00	0.00	0.0	00 0.00	0.00	47.0
	column of line 56)	0.00	0.00				10
	Overtime rate (see instructions) Total overtime (including base and overtime	0. 00 0. 00	0.00 0.00				48. (49. (
	allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT						
0. 00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0. 00	0.00	0.0	0.00	0.00	50.
1.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0. 00	0.00	0.0	00 0.00	0.00	51.0
00	DETERMINATION OF OVERTIME ALLOWANCE	72.01	0.00	0.0			1 5 2
	Adjusted hourly salary equivalency amount (see instructions)	73. 81	0.00	0.0			52.
. 00	Overtime cost limitation (line 51 times line 52)	0	0		0 0		53.
. 00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0		0 0		54.
5. 00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0		0 0		55.
o. 00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for	0	0		0 0	0	56.
	respiratory therapy and columns 1 through 3 for all others.)						
						1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST	ADJUSTMENT			1.00	
	Salary equivalency amount (from line 23)					136, 512	57.
	Travel allowance and expense - provider site					0	
	Travel allowance and expense - Offsite servic Overtime allowance (from column 5, line 56)	es (from lines	44, 45, OF 46)		0	
	Equipment cost (see instructions)					0	
	Supplies (see instructions)					0	
	Total allowance (sum of lines 57-62)					136, 512	
. 00	Total cost of outside supplier services (from	your records)				108, 738	64.
. 00	Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION	- if negative	, enter zero)			0	65.
0.00	Line 26 = line 24 for respiratory therapy or	sum of lines 2	4 and 25 for a	others		0	100.
0. 01	Line 27 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27				others		100. 100.
1.00	LINE 34 CALCULATION Line 27 = line 7 times line 3 for respiratory	therapy or su	m of lines 3 a	nd 4 for all	others	0	101.
1.01	Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31					0	101. 101.
1.02							1
	LINE 35 CALCULATION Line 31 = line 29 for respiratory therapy or	sum of lines 2	9 and 30 for a	II others		0	102.
2.00					ımns 1-3, line		102 102

	DE SUPPLIERS	FURNI SHED BY	Provider CC	CN: 151320	Period: From 10/01/2014 To 09/30/2015	Worksheet A-8 Parts I-VI Date/Time Pre 2/17/2016 10:0	pared:
					Speech Pathology		
						1.00	
	PART I - GENERAL INFORMATION						
1.00 2.00	Total number of weeks worked (excluding aide Line 1 multiplied by 15 hours per week	s) (see instructi	ons)			52 780	•
3.00	Number of unduplicated days in which supervis	sor or therapist	was on provide	r site (see	e instructions)	0	
4.00	Number of unduplicated days in which therapy		n provider site	but neithe	er supervisor	0	4.00
5.00	nor therapist was on provider site (see inst Number of unduplicated offsite visits - supe		viete (soo inst	ructions)		0	5.00
6.00	Number of unduplicated offsite visits - super Number of unduplicated offsite visits - there				y therapy	0	6.00
	assistant and on which supervisor and/or the						
7.00	instructions) Standard travel expense rate					0.00	7.00
8.00	Optional travel expense rate per mile					0.00	
		Supervi sors		Assi stants	Ai des	Trai nees	
9.00	Total hours worked	1.00	2.00	3.00	4.00 00 0.00	5.00	9.00
9.00 10.00	AHSEA (see instructions)	0.00	70.94	0.0			•
11.00	Standard travel allowance (columns 1 and 2,	35. 47	35.47	0.0			11.00
	one-half of column 2, line 10; column 3,						
12.00	one-half of column 3, line 10) Number of travel hours (provider site)	0	o		0		12.00
12.01	Number of travel hours (offsite)	0	0		0		12.01
13.00	Number of miles driven (provider site)	0	0		0		13.00
13.01	Number of miles driven (offsite)	0	0		0		13.01
						1.00	
14 00	Part II - SALARY EQUIVALENCY COMPUTATION	line 10)					1 1 4 00
14.00 15.00	Supervisors (column 1, line 9 times column 1 Therapists (column 2, line 9 times column 2,					0 13, 053	
16.00	Assistants (column 3, line 9 times column 3,					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 a	nd 15 for respira	tory therapy o	r lines 14-	16 for all	13, 053	17.00
18.00	others) Aides (column 4, line 9 times column 4, line	10)				0	18.00
19.00	Trainees (column 5, line 9 times column 5, l					0	
20. 00	Total allowance amount (sum of lines 17-19 f					13, 053	20.00
	If the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than						
	the amount from line 20. Otherwise complete		entries on m		22 and enter on	TTHE 25	
21.00	Weighted average rate excluding aides and tra	•	2	of columns	1 and 2, line 9	70. 94	21.00
22.00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and train					55, 333	22.00
23.00	Total salary equivalency (see instructions)		5 1110 21)			55, 333	
	PART III - STANDARD AND OPTIONAL TRAVEL ALLO	WANCE AND TRAVEL	EXPENSE COMPUT	ATION - PRO	IVI DER SI TE		1
24 00	Standard Travel Allowance Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	
26. 00	Subtotal (line 24 for respiratory therapy or					0	
27.00	Standard travel expense (line 7 times line 3 others)	for respiratory	therapy or sum	of lines 3	3 and 4 for all	0	27.00
	· ·					۱	
28.00	Total standard travel allowance and standard	travel expense a	it the provider	site (sum	of lines 26 and	0	28.00
28. 00	27)	•	it the provider	site (sum	of lines 26 and	0	28.00
	27) Optional Travel Allowance and Optional Travel	Expense	•	site (sum	of lines 26 and		
28.00 29.00 30.00	27)	Expense of columns 1 and	•	site (sum	of lines 26 and	0	29.00
29. 00	27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or	Expense of columns 1 and , line 12) sum of lines 29	2, line 12) and 30 for all	others)		0	29.00 30.00 31.00
29. 00 30. 00	27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column	Expense of columns 1 and , line 12) sum of lines 29	2, line 12) and 30 for all	others)		0	29.00 30.00 31.00
29.00 30.00 31.00 32.00	27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others)	Expense of columns 1 and , line 12) sum of lines 29 s 1 and 2, line 1	2, line 12) and 30 for all 3 for respirat	others)		000000000000000000000000000000000000000	29.00 30.00 31.00 32.00
29. 00 30. 00 31. 00	27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column	Expense of columns 1 and , line 12) sum of lines 29 s 1 and 2, line 1 l expense (line 2	2, line 12) and 30 for all 3 for respirat 28)	others) ory therapy		0 0 0 0	29.00 30.00 31.00 32.00 33.00
29.00 30.00 31.00 32.00 33.00	27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave	Expense of columns 1 and , line 12) sum of lines 29 s 1 and 2, line 1 l expense (line 2 l expense (sum of l expense (sum of	2, line 12) and 30 for all 3 for respirat 28) 5 lines 27 and 5 lines 31 and	others) ory therapy 31) 32)	or sum of	0 0 0 0 0 0 0 0	29.00 30.00 31.00 32.00 33.00 34.00
29.00 30.00 31.00 32.00 33.00 34.00	27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW	Expense of columns 1 and , line 12) sum of lines 29 s 1 and 2, line 1 l expense (line 2 l expense (sum of l expense (sum of	2, line 12) and 30 for all 3 for respirat 28) 5 lines 27 and 5 lines 31 and	others) ory therapy 31) 32)	or sum of	0 0 0 0 0 0 0 0	29.00 30.00 31.00 32.00 33.00 34.00
29.00 30.00 31.00 32.00 33.00 34.00	27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave	Expense of columns 1 and , line 12) sum of lines 29 s 1 and 2, line 1 l expense (line 2 l expense (sum of l expense (sum of	2, line 12) and 30 for all 3 for respirat 28) 5 lines 27 and 5 lines 31 and	others) ory therapy 31) 32)	or sum of	0 0 0 0 0 0 0 0	29.00 30.00 31.00 32.00 33.00 34.00 35.00
29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00	27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11)	Expense of columns 1 and , line 12) sum of lines 29 s 1 and 2, line 1 l expense (line 2 l expense (sum of l expense (sum of	2, line 12) and 30 for all 3 for respirat 28) 5 lines 27 and 5 lines 31 and	others) ory therapy 31) 32)	or sum of	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00
29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00	27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times 36 and 37)	Expense of columns 1 and , line 12) sum of lines 29 s 1 and 2, line 1 l expense (line 2 l expense (sum of l expense (sum of ANCE AND TRAVEL E	2, line 12) and 30 for all 3 for respirat 28) 7 lines 27 and 7 lines 31 and XPENSE COMPUTA	others) ory therapy 31) 32)	or sum of	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00
29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00	27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11)	Expense of columns 1 and , line 12) sum of lines 29 s 1 and 2, line 1 l expense (line 2 l expense (sum of l expense (sum of l expense (sum of ANCE AND TRAVEL E	2, line 12) and 30 for all 3 for respirat 28) 7 lines 27 and 7 lines 31 and XPENSE COMPUTA	others) ory therapy 31) 32)	or sum of	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00
29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00	27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum	Expense of columns 1 and , line 12) sum of lines 29 s 1 and 2, line 1 l expense (line 2 l expense (sum of l expense (sum of ANCE AND TRAVEL E m of lines 5 and Expense	2, line 12) and 30 for all 3 for respirat (8) F lines 27 and T lines 31 and XPENSE COMPUTA 6)	others) ory therapy 31) 32)	or sum of	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00 39.00
29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00	27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Optional travel allowance and optional trave Optional travel allowance and optional trave Data travel allowance and optional trave Data travel allowance and optional trave Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the su Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12. Assistants (column 3, line 12.01 times colum	Expense of columns 1 and , line 12) sum of lines 29 s 1 and 2, line 1 l expense (line 2 l expense (sum of l expense (sum of ANCE AND TRAVEL E m of lines 5 and Expense 01 times column 2	2, line 12) and 30 for all 3 for respirat (8) F lines 27 and T lines 31 and XPENSE COMPUTA 6)	others) ory therapy 31) 32)	or sum of	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00 39.00 40.00 41.00
29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00	27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12. Assistants (column 3, line 12.01 times colum Subtotal (sum of lines 40 and 41)	Expense of columns 1 and , line 12) sum of lines 29 s 1 and 2, line 1 l expense (line 2 l expense (sum of l expense (sum of ANCE AND TRAVEL E m of lines 5 and Expense 01 times column 2 n 3, line 10)	2, line 12) and 30 for all 3 for respirat (8) 1 lines 27 and 2 lines 27 and 2 lines 27 and 2 lines 27 and 6)	others) ory therapy 31) 32)	or sum of	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00 39.00 40.00 41.00 42.00
29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00	27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Optional travel allowance and optional trave Optional travel allowance and optional trave Data travel allowance and optional trave Data travel allowance and optional trave Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the su Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12. Assistants (column 3, line 12.01 times colum	Expense of columns 1 and , line 12) sum of lines 29 s 1 and 2, line 1 l expense (line 2 l expense (sum of l expense (sum of l expense (sum of l expense 5 and Expense 01 times column 2 n 3, line 10) m of columns 1-3,	2, line 12) and 30 for all 3 for respirat (8) 5 lines 27 and 7 lines 31 and XPENSE COMPUTA 6) 2, line 10) 1 line 13.01)	others) ory therapy 31) 32) TION - SERV	/ or sum of /ICES OUTSIDE PRC	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00 39.00 40.00 41.00 42.00
29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00	27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 3, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the su Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12. Assistants (column 3, line 12.01 times colum Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the su	Expense of columns 1 and , line 12) sum of lines 29 s 1 and 2, line 1 l expense (line 2 l expense (sum of ANCE AND TRAVEL E m of lines 5 and Expense 01 times column 2 n 3, line 10) m of columns 1-3, Dffsite Services;	2, line 12) and 30 for all 3 for respirat (28) F lines 27 and F lines 31 and XPENSE COMPUTA (6) (2, line 10) Line 13.01 Complete one	others) ory therapy 31) 32) TION - SERV	owing three line	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00 39.00 40.00 41.00 42.00

Health Financial Systems	JAY COUNTY HOSP	I TAL	In Lie	u of Form CMS-2552-10
REASONABLE COST DETERMINATION FOR THERAPY OUTSIDE SUPPLIERS	SERVI CES FURNI SHED BY	Provider CCN: 151320	Period: From 10/01/2014 To 09/30/2015	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/17/2016 10:07 am
			Speech Pathol ogy	Cost

				Sp	eech Pathology	Cost	
					-		
46.00	Optional travel allowance and optional travel		of Linco 40 on	d 12 and inc	tructions)	1.00	46.00
40.00	optional travel allowance and optional travel	Therapists	Assi stants	d 43 - see ins Aides	Trai nees	Total	46.00
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION				I		
47.00	Overtime hours worked during reporting	0.00	0.00	0.00	0.00	0.00	47.OC
	period (if column 5, line 47, is zero or						
	equal to or greater than 2,080, do not						
	complete lines 48-55 and enter zero in each column of line 56)						
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime	0.00			0.00		49.00
	allowance) (multiply line 47 times line 48)						
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category	0.00	0.00	0.00	0.00	0.00	50.00
	(divide the hours in each column on line 47						
	by the total overtime worked - column 5, line 47)						
51.00	Allocation of provider's standard work year	0.00	0.00	0.00	0.00	0 00	51.00
01100	for one full-time employee times the	0.00	0.00	0.00	0100	0100	000
	percentages on line 50) (see instructions)						
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount	70. 94	0.00	0.00	0.00		52.00
53.00	(see instructions) Overtime cost limitation (line 51 times line	0	0	0	0		53.00
55.00	52)	0	0	0	0		55.00
54.00	Maximum overtime cost (enter the lesser of	0	0	0	o		54.00
	line 49 or line 53)	_					
55.00	Portion of overtime already included in	0	0	0	0		55.00
	hourly computation at the AHSEA (multiply						
E4 00	line 47 times line 52) Overtime ellewares (line 54 minus line 55	0	0	0	0	0	56.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5	0	0	0	0	0	50.00
	the sum of columns 1, 3, and 4 for						
	respiratory therapy and columns 1 through 3						
	for all others.)						
					-	1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST				1.00	
57.00	Salary equivalency amount (from line 23)		ABS 00 TMENT			55, 333	57.00
58.00	Travel allowance and expense - provider site	(from lines 33	, 34, or 35))			0	58.00
59.00	Travel allowance and expense - Offsite service	es (from lines	44, 45, or 46)		0	59.00
60.00	Overtime allowance (from column 5, line 56)					0	60.0
61.00	Equipment cost (see instructions)					0	61.0
62.00							62.00
	Supplies (see instructions)					0	
63.00	Total allowance (sum of lines 57-62)	vour records)				55, 333	63.00
63. 00 64. 00	Total allowance (sum of lines 57-62) Total cost of outside supplier services (from	J ,				55, 333 26, 634	63. 00 64. 00
63.00	Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63	J ,				55, 333	63. 00 64. 00
63.00 64.00 65.00	Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION	3 - if negative	e, enter zero)	II others		55, 333 26, 634 0	63.00 64.00 65.00
63.00 64.00 65.00	Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63	<u>sum of lines 2</u>	e, enter zero) 4 and 25 for a		thers	55, 333 26, 634 0 0	63.00 64.00
63.00 64.00 65.00 100.00	Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 65 LINE 33 CALCULATION Line 26 = line 24 for respiratory therapy or	<u>sum of lines 2</u>	e, enter zero) 4 and 25 for a		thers	55, 333 26, 634 0 0 0 0	63. 00 64. 00 65. 00
63.00 64.00 65.00 100.01 100.01	Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 65 LINE 33 CALCULATION Line 26 = line 24 for respiratory therapy or Line 27 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION	3 - if negative sum of lines 2 / therapy or su	e, enter zero) 4 and 25 for a m of lines 3 a	nd 4 for all o		55, 333 26, 634 0 0 0 0 0	63.00 64.00 65.00 100.00 100.02
63.00 64.00 65.00 100.01 100.02 101.00	Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION Line 26 = line 24 for respiratory therapy or Line 27 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION Line 27 = line 7 times line 3 for respiratory	<pre>3 - if negative sum of lines 2 / therapy or su / therapy or su</pre>	a, enter zero) 4 and 25 for a m of lines 3 a m of lines 3 a	nd 4 for all o		55, 333 26, 634 0 0 0 0 0 0 0	63. 00 64. 00 65. 00 100. 00 100. 02 100. 02
63.00 64.00 65.00 100.01 100.02 101.00 101.01	Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 65 LINE 33 CALCULATION Line 26 = line 24 for respiratory therapy or Line 37 = line 7 times line 3 for respiratory Line 34 CALCULATION Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or	<pre>3 - if negative sum of lines 2 / therapy or su / therapy or su</pre>	a, enter zero) 4 and 25 for a m of lines 3 a m of lines 3 a	nd 4 for all o		55, 333 26, 634 0 0 0 0 0 0 0 0 0	63. 00 64. 00 65. 00 100. 02 100. 02 101. 00 101. 00
63.00 64.00 65.00 100.01 100.02 101.02	Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION Line 26 = line 24 for respiratory therapy or Line 37 = line 7 times line 3 for respiratory Line 34 CALCULATION Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31	<pre>3 - if negative sum of lines 2 / therapy or su / therapy or su</pre>	a, enter zero) 4 and 25 for a m of lines 3 a m of lines 3 a	nd 4 for all o		55, 333 26, 634 0 0 0 0 0 0 0 0 0	63.00 64.00 65.00 100.00 100.02
63. 00 64. 00 65. 00 100. 00 100. 01 100. 02 101. 00 101. 02	Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 62 LINE 33 CALCULATION Line 26 = line 24 for respiratory therapy or Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION	3 - if negative sum of lines 2 / therapy or su / therapy or su sum of lines 2	e, enter zero) 4 and 25 for a m of lines 3 a m of lines 3 a 9 and 30 for a	nd 4 for all o nd 4 for all o II others		55, 333 26, 634 0 0 0 0 0 0 0 0 0 0 0 0	63.00 64.00 65.00 100.0 100.0 100.0 101.0 101.0
63.00 64.00 65.00 100.01 100.02 101.02 101.02 101.02 102.00	Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION Line 26 = line 24 for respiratory therapy or Line 37 = line 7 times line 3 for respiratory Line 34 CALCULATION Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31	3 - if negative sum of lines 2 / therapy or su / therapy or su sum of lines 2 sum of lines 2	4 and 25 for a m of lines 3 a m of lines 3 a 9 and 30 for a 9 and 30 for a	nd 4 for all o nd 4 for all o II others II others	thers	55, 333 26, 634 0 0 0 0 0 0 0 0 0 0 0 0 0 0	63. 00 64. 00 65. 00 100. 02 100. 02 101. 00 101. 00
63.00 64.00 65.00 100.01 100.02 101.02 101.02 101.02 102.00	Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 62 LINE 33 CALCULATION Line 26 = line 24 for respiratory therapy or Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION D Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION Line 31 = line 29 for respiratory therapy or	3 - if negative sum of lines 2 / therapy or su / therapy or su sum of lines 2 sum of lines 2	4 and 25 for a m of lines 3 a m of lines 3 a 9 and 30 for a 9 and 30 for a	nd 4 for all o nd 4 for all o II others II others	thers	55, 333 26, 634 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	63. 00 64. 00 65. 00 100. 0 100. 0 101. 0 101. 0 101. 0 101. 0

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	JAY COUNTY			eriod: com 10/01/2014	u of Form CMS-2 Worksheet B Part I Date/Time Pre	pared:
				CAPITAL REL	ATED COSTS	2/17/2016 10:	
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	NEW MVBLE EQUI P	NEW MVBLE EQUIP MOB	NEW MVBLE EQUI P-POB	NEW MVBLE EQUIP- WJ	
		0	2.00	2.01	2. 02	2.03	
2.00	GENERAL SERVICE COST CENTERS 00200 NEW CAP REL COSTS-MVBLE EQUIP	1, 332, 082	1, 332, 082				2.00
2.00 2.01 2.02 2.03 4.00 5.00 7.00 7.01	00201 NEW CAP REL COSTS MVBLE EQUIP MOB 00202 NEW CAP REL COSTS MVBLE EQUIP-POB 00203 NEW CAP REL COSTS-MVBLE EQUIP-POB 00203 NEW CAP REL COSTS-MVBLE EQUIP- WJ 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00701 OPERATION OF PLANT-MOB	10, 285 119, 979 31, 142 5, 587, 695 4, 825, 515 1, 207, 017 38, 961	1, 332, 832 0 0 0 0 159, 003 82, 852 0	10, 285 0 0 2, 189 0 0	119, 979 0 0 3, 354 0 0	31, 142 0 0 0 0 0	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 16. 00	00702 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 01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	81, 940 2, 821 64, 718 345, 377 330, 605 119, 557 959, 881 84, 275 392, 900	0 0 8, 961 7, 130 41, 689 40, 033 28, 384 39, 351 27, 565	0 0 373 0 0 0 0	0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	7.02 7.03 8.00 9.00 10.00 11.00 13.00 14.00 16.00
30.00	03000 ADULTS & PEDI ATRI CS	1, 229, 920	260, 751	0	0	0	30.00
31.00 40.00 41.00 42.00	03100 I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF 04200 SUBPROVI DER	0 898, 476 0 0	0 90, 313 0 0	0 0 0 0	0 0 0 0	0 0 0 0	31.00 40.00 41.00 42.00
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	221, 796	20, 124	0	0	0	43.00
50. 00 52. 00 53. 00	05200 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	1, 528, 712 18, 488 0	124, 678 2, 474 0	0 0 0	57, 125 0 0	0 0 0	50. 00 52. 00 53. 00
54.00 57.00 58.00 59.00	05400 RADI OLOGY-DI AGNOSTI C 05700 CT SCAN 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON	1, 382, 686 0 0	121, 853 0 0	0 0 0	0 0 0	0 0 0	54.00 57.00 58.00 59.00
60. 00 60. 01 65. 00	06000 LABORATORY 06001 BLOOD LABORATORY 06500 RESPI RATORY THERAPY	1, 744, 856 0 354, 136	46, 754 0 5, 455	0 0 0	0 0 0	0 0 0	60. 00 60. 01 65. 00
66.00 67.00 68.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	636, 029 108, 738 26, 634 333, 971	0 0 19, 481	0 0 0	0 0 0	0 0 0	66.00 67.00 68.00 69.00
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0 0 1, 422, 012	19, 481 0 0 21, 624	0 0 0 0	0 0 0	0 0 0	71.00 72.00 73.00
88.00	OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	88.00
89. 00 90. 00 90. 01	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09001 FAMILY PRACTICE OF JAY COUNTY 09002 JAY FAMILY MEDICINE 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0 264, 507 448, 129 485, 219 924, 211	0 81, 820 0 90, 586	0 0 0 0 0	0 0 59, 500 0 0	0 0 0 0 0	89.00 90.00 90.01 90.02 91.00 92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS 09910 CORF SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	
109.00 110.00 111.00		0 0 0 27, 563, 270	0 0 0 1, 320, 881	0 0 0 2, 562	0 0 0 119, 979	0 0 0	106. 00 109. 00 110. 00 111. 00 113. 00 118. 00
192.00 193.00 194.00 194.01 194.02	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CLANS' PRI VATE OFFICES 19300 NONPALD WORKERS 07950 MOB 07951 POB 07952 WEST JAY CLINIC 07953 OTHER NONREI MBURSABLE COST CENTERS	0 0 13 0 560, 302	11, 201 0 0 0 0 0	0 0 0 7, 723 0 0	0 0 0 0 0	0 0 0 31, 142	190. 00 192. 00 193. 00 194. 00 194. 01 194. 02 194. 03

Health Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Period: From 10/01/2014	Worksheet B Part I	
				To 09/30/2015	Date/Time Pre	
					2/17/2016 10:	<u>07 am</u>
			CAPITAL R	ELATED COSTS		
Cost Center Description	Net Expenses	NEW MVBLE	NEW MVBLE	NEW MVBLE	NEW MVBLE	
	for Cost	EQUI P	EQUIP MOB	EQUI P-POB	EQUIP- WJ	
	Allocation					
	(from Wkst A					
	col. 7)					
	0	2.00	2.01	2.02	2.03	
194.04 07954 OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0	0	194.04
194.05079550THER NONREIMBURSABLE COST CENTERS	0	0		0 0	0	194.05
194.0607956 TRI COUNTY	1, 486, 668	0		0 0	0	194.06
194. 07 07957 HOSPI TALI ST	66, 835	0		0 0	0	194.07
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers		0		0 0	0	201.00
202.00 TOTAL (sum lines 118-201)	29, 677, 088	1, 332, 082	10, 28	119, 979	31, 142	202.00

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	JAY COUNTY I			<u>In Lie</u> eriod: rom 10/01/2014	u of Form CMS-: Worksheet B Part I	2552-10
				T	09/30/2015	Date/Time Pre 2/17/2016 10:	
	Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT-MOB	
	1	4.00	4A	5.00	7.00	7.01	
2.00	GENERAL SERVICE COST CENTERS 00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.00	00201 NEW CAP REL COSTS MVBLE EQUIP MOB						2.00
2.02	00202 NEW CAP REL COSTS-MVBLE EQUI P-POB						2.02
2.03	00203 NEW CAP REL COSTS-MVBLE EQUIP- WJ	F F07 (05					2.03
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	5, 587, 695 850, 158	5, 840, 219	5, 840, 219			4.00 5.00
7.00	00700 OPERATION OF PLANT	114, 844	1, 404, 713				7.00
7.01	00701 OPERATION OF PLANT-MOB	1, 806	40, 767		0	50, 755	7.01
7.02	00702 OPERATION OF PLANT-POB	2,620	84, 560		0	0	7.02
7.03 8.00	00703 OPERATION OF PLANT-WJ 00800 LAUNDRY & LINEN SERVICE	1, 010 12, 783	3, 831 86, 462		0 14, 375	0	7.03 8.00
9.00	00900 HOUSEKEEPING	124, 273	476, 780		11, 438	0	9.00
10.00	01000 DI ETARY	64, 096	436, 763		66, 875	2, 341	10.00
11.00		55, 503	215, 093		64, 219	0	11.00
13.00 14.00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	347, 779 24, 552	1, 336, 044 148, 178		45, 531 63, 125	0	13.00 14.00
16.00	01600 MEDICAL RECORDS & LIBRARY	126, 215	546, 680		44, 219	0	16.00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	434, 579	1, 925, 250	471, 702	418, 283	0	30.00
31.00 40.00	03100 I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF	236, 169	0 1, 224, 958	0 300, 125	0 144, 875	0	31.00 40.00
41.00	04100 SUBPROVI DER – I RF	0	1, 224, 730	0	0	0	41.00
42.00	04200 SUBPROVI DER	0	0	0	0	0	42.00
43.00		49, 676	291, 596	71, 443	32, 281	0	43.00
50.00	ANCI LLARY SERVICE COST CENTERS	306, 297	2,016,812	494, 135	200, 000	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	6, 322	27, 284		3, 969	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	294, 516	1, 799, 055	440, 783	195, 469	0	54.00
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	57.00 58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59.00
60.00	06000 LABORATORY	228, 077	2, 019, 687	494, 833	75, 000	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0 102	0	0	60.01
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	359, 591 636, 029	88, 103 155, 832	8, 750 0	0	65.00 66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	108, 738		0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	26, 634		0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	69, 322	422, 774	103, 583	31, 250	0	69.00
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	71.00 72.00
	07300 DRUGS CHARGED TO PATIENTS	142, 744	1, 586, 380	388, 676	34, 688	0	
	OUTPATIENT SERVICE COST CENTERS	· · ·		1			
88.00 89.00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	88.00 89.00
89.00 90.00	09000 CLINIC	168, 034	514, 361	126, 023	131, 250	0	90.00
90.01	09001 FAMILY PRACTICE OF JAY COUNTY	533, 594	1, 041, 223		01,200	0	90.01
90.02	09002 JAY FAMILY MEDICINE	366, 906	852, 125		0	0	90. 02
91.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	772, 247	1, 787, 044	437, 840	145, 313	0	91.00 92.00
92.00 93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	
701.00	OTHER REIMBURSABLE COST CENTERS						/0100
99.10	09910 CORF	0	0	0	0	0	99.10
104 00	SPECIAL PURPOSE COST CENTERS			0	0	0	106.00
	10000 PANCREAS ACQUISITION	0	0	0	0		109.00
	11000 INTESTINAL ACQUISITION	0	0	0	0		110.00
	11100 I SLET ACQUI SI TI ON	0	0	0	0	0	111.00
113.00 118.00	11300 INTEREST EXPENSE	F 224 122	27 250 (21	E 047 000	1 700 010	2 241	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	5, 334, 122	27, 259, 631	5, 247, 923	1, 730, 910	2, 341	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11, 201	2, 744	17, 969	0	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192.00
193.00	19300 NONPAID WORKERS 07950 MOB	0	0	0	0		193.00
	07950 MOB 07951 POB	0	7, 736 0	1, 895 0	0	48, 414 0	194.00 194.01
	07952 WEST JAY CLINIC	164, 073	755, 517	185, 108	0		194.02
	07953 OTHER NONREI MBURSABLE COST CENTERS	0	0	0	О		194.03
	07954 OTHER NONREI MBURSABLE COST CENTERS 07955 OTHER NONREI MBURSABLE COST CENTERS	0	0	0	0		194. 04 194. 05
	07955 TRI COUNTY	65, 484	1, 552, 152	380, 290	0		194.05 194.06
	07957 HOSPI TALI ST	24, 016	90, 851				194.07

Health Financial Systems	JAY COUNT	Y HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - GENERAL SERVICE COST	S	Provi der		eriod:	Worksheet B	
				rom 10/01/2014		
				o 09/30/2015		
					2/17/2016 10:	
Cost Center Description	EMPLOYEE	Subtotal	ADMI NI STRATI VE	OPERATION OF	OPERATION OF	
	BENEFITS		& GENERAL	PLANT	PLANT-MOB	
	DEPARTMENT					
	4.00	4A	5.00	7.00	7.01	
200.00 Cross Foot Adjustments		C)			200.00
201.00 Negative Cost Centers		o c	0 0	0 0	0	201.00
202.00 TOTAL (sum lines 118-201)	5, 587, 69	5 29, 677, 088	5, 840, 219	1, 748, 879	50, 755	202.00

Health Financial Systems	JAY COUNTY	HOSPI TAL		In Lieu	ı of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der	Fi	eriod: rom 10/01/2014	Worksheet B Part I	
			To		Date/Time Pre 2/17/2016 10:	
Cost Center Description	OPERATION OF PLANT-POB	OPERATION OF PLANT-WJ	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
GENERAL SERVI CE COST CENTERS	7.02	7.03	8.00	9.00	10.00	
2.00 00200 NEW CAP REL COSTS-MVBLE EQUI P						2.00
2.01 00201 NEW CAP REL COSTS-MVBLE EQUIP MOB						2.01
2. 02 00202 NEW CAP REL COSTS-MVBLE EQUI P-POB 2. 03 00203 NEW CAP REL COSTS-MVBLE EQUI P- WJ						2.02 2.03
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 00500 ADMINI STRATI VE & GENERAL						5.00
7.00 00700 OPERATION OF PLANT 7.01 00701 OPERATION OF PLANT-MOB						7.00 7.01
7.02 00702 OPERATION OF PLANT-MOB	105, 278					7.01
7.03 00703 OPERATION OF PLANT-WJ	0	4, 770				7.03
8.00 00800 LAUNDRY & LINEN SERVICE	0	0	122, 021	(10.007		8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	0	0	14, 264 4, 896	619, 297 16, 343	634, 228	9.00 10.00
11. 00 01100 CAFETERIA	0	0	0	15, 694	001,1220	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	0	0	0	11, 127	0	13.00
14. 00 01400 CENTRAL SERVI CES & SUPPLY 16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	0	0	15, 426 10, 806	0	14.00 16.00
INPATIENT ROUTINE SERVICE COST CENTERS	0	0		10,000		10.00
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	27, 664	102, 218	324, 984	30.00
31. 00 03100 I NTENSI VE CARE UNI T 40. 00 04000 SUBPROVI DER – I PF	0	0	0 8, 145	0 35, 404	0 309, 244	31.00 40.00
41. 00 04100 SUBPROVIDER - IRF	0	0	0, 145	35, 404	309, 244	40.00
42. 00 04200 SUBPROVI DER	0	0	0	0	0	42.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	0	215	7, 889	0	43.00
50. 00 05000 OPERATING ROOM	51, 568	0	27, 320	91, 145	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	970	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 57. 00 05700 CT SCAN	0	0	10, 517	47, 768	0	54.00 57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59.00
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY	0	0	0	18, 328	0	60.00 60.01
65. 00 06500 RESPI RATORY THERAPY	0	0	0	2, 138	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	1, 995	0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0	0	1, 813	7,637	0	68.00 69.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	0	0	8, 477	0	73.00
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 09000 CLINIC 90.01 09001 FAMILY PRACTICE OF JAY COUNTY	53, 710	0	0	32, 074 44, 026	0	90. 00 90. 01
90. 02 09002 JAY FAMILY MEDICINE	0	0	0	0	0	90. 02
91.00 09100 EMERGENCY	0	0	25, 192	35, 511	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	92.00 93.00
OTHER REIMBURSABLE COST CENTERS	-			-	-	
99.10 09910 CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS 106. 00 10600 HEART ACQUI SI TI ON	0	0	0	0	0	106.00
109. 00 10900 PANCREAS ACQUISITION	0	0	0	0		109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0		110.00
111.00 11100 ISLET_ACQUISITION 113.00 11300 INTEREST_EXPENSE	0	0	0	0	0	111. 00 113. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	105, 278	0	122, 021	502, 981	634, 228	
NONREI MBURSABLE COST CENTERS						
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	4, 391		190. 00 192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0		192.00
194. 00 07950 MOB	0	0	0	67, 899	0	194. 00
194. 01 07951 POB	0	0	0	44, 026		194.01
194.0207952WEST JAY CLINIC 194.0307953OTHER NONREIMBURSABLE COST CENTERS	0	4, 770 0	0	0		194. 02 194. 03
194.0407954 OTHER NONREI MBURSABLE COST CENTERS	0	0	o o	o	0	194. 04
194.05 07955 OTHER NONREI MBURSABLE COST CENTERS	0	0	0	0		194.05
194. 06 07956 TRI COUNTY 194. 07 07957 HOSPI TALI ST	0			0		194. 06 194. 07
200.00 Cross Foot Adjustments						200.00

Health Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der	1	Period: From 10/01/2014 Fo 09/30/2015		
Cost Center Description	OPERATI ON OF	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	PLANT-POB	PLANT-WJ	LINEN SERVICE			
	7.02	7.03	8.00	9.00	10.00	
201.00 Negative Cost Centers	0	0	(0 0	0	201.00
202.00 TOTAL (sum lines 118-201)	105, 278	4, 770	122, 02	1 619, 297	634, 228	202.00

Health Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		eriod: com 10/01/2014	Worksheet B Part I	
			Тс	09/30/2015	Date/Time Pre 2/17/2016 10:	pared: 07 am
Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	MEDI CAL RECORDS &	Subtotal	
			SUPPLY	LI BRARY		
GENERAL SERVICE COST CENTERS	11.00	13.00	14.00	16.00	24.00	
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2. 01 00201 NEW CAP REL COSTS-MVBLE EQUIP MOB 2. 02 00202 NEW CAP REL COSTS-MVBLE EQUIP-POB						2.01 2.02
2. 03 00203 NEW CAP REL COSTS-MVBLE EQUI P- WJ						2.03
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL						4.00 5.00
5. 00 00500 ADMI NI STRATI VE & GENERAL 7. 00 00700 OPERATI ON OF PLANT						7.00
7.01 00701 OPERATION OF PLANT-MOB						7.01
7. 02 00702 OPERATION OF PLANT-POB 7. 03 00703 OPERATION OF PLANT-WJ						7.02 7.03
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY						9.00 10.00
11. 00 01100 CAFETERI A	347, 706					11.00
13. 00 01300 NURSING ADMINISTRATION	24, 225					13.00
14.00 01400 CENTRAL SERVICES & SUPPLY 16.00 01600 MEDICAL RECORDS & LIBRARY	4, 038 16, 524		267, 072 271	752, 441		14.00 16.00
INPATIENT ROUTINE SERVICE COST CENTERS		1				
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T	48, 732	602, 458	12, 505	43, 447	3, 977, 243 0	30.00 31.00
40. 00 04000 SUBPROVI DER - I PF	26, 733	330, 472	1, 209	14, 895	2, 396, 060	•
41. 00 04100 SUBPROVI DER – I RF 42. 00 04200 SUBPROVI DER	C	0	0	0	0	
42. 00 04200 SUBPROVI DER 43. 00 04300 NURSERY	5, 354	66, 182	0	0 1, 211	0 476, 171	
ANCI LLARY SERVI CE COST CENTERS	1					
50.00 05000 0PERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	25, 595 516		72, 140 0	124, 385 1, 318	3, 419, 500 47, 118	
53. 00 05300 ANESTHESI OLOGY	C		0	0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	25, 666	1	15, 917	242, 365	2, 777, 540	1
57.00 05700 CT SCAN 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI)		-	0 0	0	0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	C	0	0	0	0	
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY	26, 021		71, 412 0	163, 501 0	2, 868, 782 0	
65. 00 06500 RESPI RATORY THERAPY	C	0	958	7, 549	467, 089	
66.00 06600 PHYSI CAL THERAPY	C	0	1, 057	20, 827	815, 740	•
67.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY		0	0	3, 687 554	139, 067 33, 714	1
69. 00 06900 ELECTROCARDI OLOGY	8, 111		3, 735	15, 184	594, 087	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		-	0	0	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	9, 534	-	2, 299	36, 635	2, 066, 689	
			0	ol	0	88.00
88.00 08800 RURAL HEALTH CLINIC 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	0	88.00
90. 00 09000 CLINIC	18, 640		8, 150	2, 816	833, 314	1
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY 90. 02 09002 JAY FAMILY MEDICINE	44, 715 28, 956		26, 390 25, 973	8, 379 4, 132	1, 473, 551 1, 119, 963	
91.00 09100 EMERGENCY	34, 168	1	13, 627	61, 556	2, 962, 631	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 93.00 04040 OTHER OUTPATIENT SERVICE COST CENTER	C	0	0	o	0	92.00 93.00
OTHER REIMBURSABLE COST CENTERS		<u> </u>	0	U	0	93.00
99. 10 09910 CORF	C	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS 106. 00 10600 HEART ACQUI SI TI ON	0		0	0	0	106.00
109.00 10900 PANCREAS ACQUI SI TI ON	C	0	0	Ō	0	109. 00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON 111. 00 11100 I SLET ACQUI SI TI ON	0	0	0	0		110. 00 111. 00
113. 00 11300 I NTEREST EXPENSE		0	0	0	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	347, 528	1, 744, 268	255, 643	752, 441	26, 468, 259	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	0		0	0	36 305	190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	C	0	0	Ō	0	192.00
193. 00 19300 NONPALD WORKERS 194. 00 07950 MOB		0	0	0	0 125, 944	193.00
194. 00 07950 M0B 194. 01 07951 P0B		0	0	0		194.00 194.01
194.0207952 WEST JAY CLINIC	C	0	7, 303	0	952, 698	194. 02
194. 03 07953 OTHER NONREI MBURSABLE COST CENTERS 194. 04 07954 OTHER NONREI MBURSABLE COST CENTERS		0	0	0		194. 03 194. 04
194.0507955 OTHER NONREIMBURSABLE COST CENTERS	C	0	0	0	0	194.05
194. 06 07956 TRI COUNTY		0	4, 077	0	1, 936, 519	
194. 07 07957 H0SPI TALI ST	178	i Ol	49	0	113, 337	1194.07

Health Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Period:	Worksheet B	
				From 10/01/2014 To 09/30/2015	Part I Date/Time Pre	narod
				10 09/30/2015	2/17/2016 10:	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	MEDI CAL	Subtotal	
		ADMI NI STRATI ON	SERVICES &	RECORDS &		
			SUPPLY	LI BRARY		
	11.00	13.00	14.00	16.00	24.00	
200.00 Cross Foot Adjustments					0	200.00
201.00 Negative Cost Centers	0	0		0 0	0	201.00
202.00 TOTAL (sum lines 118-201)	347, 706	1, 744, 268	267, 07	2 752, 441	29, 677, 088	202.00

	Financial Systems LOCATION - GENERAL SERVICE COSTS	JAY COUNTY H	OSPI TAL Provi der CCN:	
	Cost Center Description	Intern & Residents Cost & Post Stepdown	Total	
		Adjustments 25.00	26.00	
	GENERAL SERVICE COST CENTERS	20100	20100	
	00200 NEW CAP REL COSTS-MVBLE EQUIP 00201 NEW CAP REL COSTS-MVBLE EQUIP MOB			2.00
	00201 NEW CAP REL COSTS-MVBLE EQUIP MOB			2.01
	00203 NEW CAP REL COSTS-MVBLE EQUIP- WJ			2.03
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT			4.00
	00500 ADMINISTRATIVE & GENERAL			5.00
	00700 OPERATION OF PLANT 00701 OPERATION OF PLANT-MOB			7.00
	00702 OPERATION OF PLANT-POB			7.02
7.03	00703 OPERATION OF PLANT-WJ			7.03
	00800 LAUNDRY & LINEN SERVICE			8.00
	00900 HOUSEKEEPI NG 01000 DI ETARY			9.00 10.00
	01100 CAFETERI A			11.00
	01300 NURSING ADMINISTRATION			13.00
	01400 CENTRAL SERVICES & SUPPLY			14.00
-	01600 MEDICAL RECORDS & LIBRARY			16.00
-	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	0	3, 977, 243	30.00
	03100 I NTENSI VE CARE UNI T	0	0	31.00
	04000 SUBPROVIDER - IPF	0	2, 396, 060	40.00
1	04100 SUBPROVIDER - IRF	0	0	41.00
	04200 SUBPROVI DER 04300 NURSERY	0	0 476, 171	42.00 43.00
-	ANCI LLARY SERVICE COST CENTERS	0	470, 171	43.00
	05000 OPERATI NG ROOM	0	3, 419, 500	50.00
	05200 DELIVERY ROOM & LABOR ROOM	0	47, 118	52.00
	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0		53.00 54.00
	05700 CT SCAN	0	2, 777, 540	57.00
	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	Ö	58.00
	05900 CARDI AC CATHETERI ZATI ON	0	0	59.00
		0	2, 868, 782	60.00
	06001 BLOOD LABORATORY 06500 RESPI RATORY THERAPY	0	467, 089	60. 01 65. 00
	06600 PHYSI CAL THERAPY	0	815, 740	66.00
	06700 OCCUPATI ONAL THERAPY	0	139, 067	67.00
	06800 SPEECH PATHOLOGY	0	33, 714	68.00
	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	594, 087 0	69.00 71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	2, 066, 689	73.00
	OUTPATIENT SERVICE COST CENTERS	1 -1	-	
	08800 RURAL HEALTH CLINIC	0	0	88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0	0 833, 314	89.00 90.00
	09001 FAMILY PRACTICE OF JAY COUNTY	0	1, 473, 551	90. 01
	09002 JAY FAMILY MEDICINE	0	1, 119, 963	90.02
	09100 EMERGENCY	0	2, 962, 631	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART) 04040 OTHER OUTPATIENT SERVICE COST CENTER	0	o	92.00 93.00
	OTHER REIMBURSABLE COST CENTERS	<u> </u>		
99.10	09910 CORF	0	0	99. 10
	SPECIAL PURPOSE COST CENTERS			10/ 00
	10600 HEART ACQUISITION 10900 PANCREAS ACQUISITION		0	106.00 109.00
	11000 I NTESTI NAL ACQUI SI TI ON	0	ő	110.00
111.00	11100 I SLET ACQUI SI TI ON	0	О	111.00
	11300 INTEREST EXPENSE		2/ 4/2 252	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	0	26, 468, 259	118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	36, 305	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	192.00
	19300 NONPALD WORKERS	0	О	193.00
	07950 MOB	0	125, 944	194.00
	07951 POB 07952 WEST JAY CLINIC	0	44, 026 952, 698	194. 01 194. 02
	07952 WEST JAY CLINIC 07953 OTHER NONREIMBURSABLE COST CENTERS	0	952, 698	194. 02
	07954 OTHER NONREI MBURSABLE COST CENTERS	0	0	194.03
	07955 OTHER NONREI MBURSABLE COST CENTERS	0	o	194.05

Health Financial Systems		In Lieu of Form CMS-2552-10				
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der	CCN: 151320	Period:	Worksheet B	
				From 10/01/2014 To 09/30/2015	Part I Date/Time Prepared	d:
					2/17/2016 10:07 an	n
Cost Center Description	Intern &	Total				
	Residents Cost					
	& Post					
	Stepdown					
	Adjustments					
	25.00	26.00				
194.0607956 TRI COUNTY	0	1, 936, 519			194.	06
194. 07 07957 HOSPI TALI ST	0	113, 337			194.	07
200.00 Cross Foot Adjustments	0	0			200.	00
201.00 Negative Cost Centers	0	0			201.	00
202.00 TOTAL (sum lines 118-201)	0	29, 677, 088			202.	00

	Financial Systems TION OF CAPITAL RELATED COSTS	JAY COUNTY		Fr	riod: om 10/01/2014	of Form CMS-2 Worksheet B Part II	
				To		Date/Time Pre 2/17/2016 10:	
				CAPI TAL REL	ATED COSTS		
	Cost Center Description	Di rectl y Assi gned New Capi tal	NEW MVBLE EQUI P	NEW MVBLE EQUIP MOB	NEW MVBLE EQUI P-POB	NEW MVBLE EQUIP- WJ	
		Related Costs 0	2.00	2.01	2.02	2.03	
	GENERAL SERVICE COST CENTERS	U U U U U U U U U U U U U U U U U U U	2.00	2.01	2.02	2.00	
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01 2.02 2.03 4.00	00201 NEW CAP REL COSTS-MVBLE EQUIP MOB 00202 NEW CAP REL COSTS-MVBLE EQUIP-POB 00203 NEW CAP REL COSTS-MVBLE EQUIP-WJ 00400 EMPLOYEE BENEFITS DEPARTMENT	0	Ο	0	0	0	
5.00 7.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	0	159, 003 82, 852	2, 189	3, 354	0	
7.00	00701 OPERATION OF PLANT-MOB	0	02,032	0	0	0	
7.02	00702 OPERATION OF PLANT-POB	0	0	0	0	0	
7.03	00703 OPERATION OF PLANT-WJ	0	0	0	0	0	
8.00 9.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	0	8, 961 7, 130	0	0	0	8.00 9.00
10.00	01000 DI ETARY	0	41, 689	373	0	0	10.00
11.00	01100 CAFETERI A	0	40, 033	0	0	0	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	28, 384	0	0	0	13.00
14.00 16.00	01400 CENTRAL SERVICES & SUPPLY 01600 MEDICAL RECORDS & LIBRARY	0	39, 351 27, 565	0	0	0	14.00 16.00
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	27, 505	0	UU	0	10.00
30.00	03000 ADULTS & PEDI ATRI CS	0	260, 751	0	0	0	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	0	0	0	0	31.00
40.00 41.00	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF	0	90, 313	0	0	0	40.00
41.00	04200 SUBPROVI DER	0	0	0	0	0	41.00
43.00	04300 NURSERY	0	20, 124	0	0	0	•
	ANCI LLARY SERVICE COST CENTERS	-		-			
50. 00 52. 00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	124, 678 2, 474	0 0	57, 125 0	0	
53.00	05300 ANESTHESI OLOGY	0	2,474	0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	121, 853	0	0	0	54.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00 59.00	05800 MAGNETIC RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	58.00 59.00
60.00	06000 LABORATORY	0	46, 754	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
65.00	06500 RESPI RATORY THERAPY	0	5, 455	0	0	0	65.00
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	66.00 67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	19, 481	0	0	0	69.00
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	
72.00 73.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0 21, 624	0	0	0	
70.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	21,021				/ 0. 00
88.00		0	0	0	0	0	
89.00 90.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0 81, 820	0	0	0	89.00 90.00
90.00 90.01	09001 FAMILY PRACTICE OF JAY COUNTY	0	01, 020	0	59, 500	0	90.00
90.02	09002 JAY FAMILY MEDICINE	0	0	0	0	0	90.02
91.00		0	90, 586	0	0	0	91.00
92.00 93.00	09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 04040 OTHER OUTPATI ENT SERVICE COST CENTER	0	0	0	0	0	92.00 93.00
<i>7</i> 3.00	OTHER REIMBURSABLE COST CENTERS	<u> </u>	V	0	<u> </u>	0	75.00
99. 10	09910 CORF	0	0	0	0	0	99.10
104 00	SPECIAL PURPOSE COST CENTERS		0	0	0	0	104 00
	10600 HEART ACQUISITION 10900 PANCREAS ACQUISITION	0	0	0	0		106. 00 109. 00
	11000 I NTESTI NAL ACQUI SI TI ON	0	0	0	Ő		110.00
	11100 I SLET ACQUI SI TI ON	0	0	0	0	0	111.00
113.00 118.00	11300 INTEREST EXPENSE		1 220 001	2 5 4 2	110 070	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	0	1, 320, 881	2, 562	119, 979	0	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11, 201	0	0	0	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	О	0	о		192.00
	19300 NONPAID WORKERS 07950 MOB	0	0	0	0		193.00 194.00
	07950 MOB	0	0	7, 723 0			194.00
194.02	07952 WEST JAY CLINIC	0	Ō	0	Ö	31, 142	194. 02
	07953 OTHER NONREI MBURSABLE COST CENTERS	0	0	0	0		194.03
194.04	07954 OTHER NONREI MBURSABLE COST CENTERS	<u> </u> 0	U	0	U	0	194.04

Health Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Peri od:	Worksheet B	
				From 10/01/2014	Part II	
				To 09/30/2015	Date/Time Pre 2/17/2016 10:	of am
			CAPITAL R	ELATED COSTS		
Cost Center Description	Directly	NEW MVBLE	NEW MVBLE	NEW MVBLE	NEW MVBLE	
	Assigned New	EQUI P	EQUIP MOB	EQUI P-POB	EQUIP- WJ	
	Capi tal					
	Related Costs					
	0	2.00	2.01	2. 02	2.03	
194.05079550THER NONREIMBURSABLE COST CENTERS	0	0		0 0	0	194.05
194.0607956 TRI COUNTY	0	0		0 0	0	194.06
194. 07 07957 HOSPI TALI ST	0	0		0 0	0	194.07
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers		0		0 0	0	201.00
202.00 TOTAL (sum lines 118-201)	0	1, 332, 082	10, 28	5 119, 979	31, 142	202.00

<u>Heal th</u>	Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provi der	F	eriod: rom 10/01/2014	Worksheet B Part II	
				T		Date/Time Pre 2/17/2016 10:	
	Cost Center Description	Subtotal	EMPLOYEE BENEFITS	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT-MOB	
		2A	DEPARTMENT 4.00	5.00	7.00	7.01	
	GENERAL SERVICE COST CENTERS	20	4.00	3.00	7.00	7.01	
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201 NEW CAP REL COSTS-MVBLE EQUIP MOB						2.01
2.02 2.03	00202 NEW CAP REL COSTS-MVBLE EQUIP-POB 00203 NEW CAP REL COSTS-MVBLE EQUIP- WJ						2.02 2.03
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0				4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	164, 546	0	164, 546			5.00
7.00	00700 OPERATION OF PLANT	82, 852	0	9, 697	92, 549	001	7.00
7.01 7.02	00701 OPERATION OF PLANT-MOB 00702 OPERATION OF PLANT-POB	0	0	281 584	0	281 0	7.01 7.02
7.02	00703 OPERATION OF PLANT-WJ	0	0		0	0	7.02
8.00	00800 LAUNDRY & LINEN SERVICE	8, 961	0	597	761	0	8.00
9.00	00900 HOUSEKEEPI NG	7,130	0	3, 291	605	0	9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	42, 062 40, 033	0	3, 015 1, 485	3, 539 3, 398	13 0	10.00 11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	28, 384	0		2, 409	0	13.00
	01400 CENTRAL SERVICES & SUPPLY	39, 351	0	1, 023	3, 341	0	14.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	27, 565	0	3, 774	2, 340	0	16.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	260, 751	0	13, 290	22, 134	0	30.00
31.00	03100 I NTENSI VE CARE UNI T	200, 731	0	13, 290	22, 134	0	31.00
40.00	04000 SUBPROVIDER - IPF	90, 313	0	8, 456	7, 667	0	40.00
41.00	04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 43.00	04200 SUBPROVI DER 04300 NURSERY	0 20, 124	0		0 1, 708	0	42.00 43.00
43.00	ANCI LLARY SERVICE COST CENTERS	20, 124	0	2,013	1,708	0	43.00
50.00	05000 OPERATI NG ROOM	181, 803	0	13, 922	10, 584	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2, 474	0		210	0	52.00
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	101 050	0	0 12, 419	0	0	53.00 54.00
54.00 57.00	05700 CT SCAN	121, 853 0	0	12, 419	10, 344	0	54.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	Ő	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59.00
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	46, 754 0	0		3, 969 0	0	60.00
65. 00	06500 RESPIRATORY THERAPY	5, 455	0	0 2,482	463	0	60. 01 65. 00
66.00	06600 PHYSI CAL THERAPY	0,100	0	4, 391	0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	751	0	0	67.00
68.00		0	0	184	0	0	68.00
69.00 71.00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	19, 481 0	0	2, 918 0	1, 654 0	0	69.00 71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	21, 624	0	10, 951	1, 836	0	73.00
00.00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0		0	0	0	00.00
	08800 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	88.00 89.00
	09000 CLINIC	81, 820	0	3, 551	6, 946	0	90.00
	09001 FAMILY PRACTICE OF JAY COUNTY	59, 500	0	7, 188	0	0	90. 01
	09002 JAY FAMILY MEDICINE	0	0	5, 882	0	0	90.02
	09100 EMERGENCY 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	90, 586 0	0	12, 336	7, 690	0	91.00 92.00
	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	
	OTHER REIMBURSABLE COST CENTERS						
99. 10		0	0	0	0	0	99. 10
106 00	SPECIAL PURPOSE COST CENTERS 10600 HEART ACQUI SI TI ON	0	0	0	0	0	106.00
	10900 PANCREAS ACQUISITION	0	0	0	0		109.00
110.00	11000 INTESTINAL ACQUISITION	0	0	0	0		110. 00
	11100 I SLET ACQUI SI TI ON	0	0	0	0	0	111.00
113.00 118.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1-117)	1, 443, 422	0	147, 859	91, 598	13	113. 00 118. 00
116.00	NONREIMBURSABLE COST CENTERS	1, 443, 422	0	147, 039	91, 390	13	116.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	11, 201	0	77	951		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
	19300 NONPALD WORKERS	0	0	0	0		193.00
	07950 MOB 07951 POB	7, 723 0	0	53	0		194. 00 194. 01
	07952 WEST JAY CLINIC	31, 142	0	5, 215	0		194.01
194.03	07953 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194. 03
	07954 OTHER NONRELMBURSABLE COST CENTERS	0	0	0	0		194.04
	07955 OTHER NONREIMBURSABLE COST CENTERS 07956 TRI COUNTY	0	0	0 10, 715	0		194. 05 194. 06
	07957 HOSPI TALI ST	0	0	627	0		194.00 194.07
	· · ·	-			-1	-	·

Health Financial Systems	JAY COUNTY HOSPI TAL			In Lieu of Form CMS-2552-10			
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Period: From 10/01/2014	Worksheet B Part II		
				To 09/30/2015			
Cost Center Description	Subtotal	EMPLOYEE	ADMI NI STRATI V	E OPERATION OF	OPERATION OF		
		BENEFITS	& GENERAL	PLANT	PLANT-MOB		
		DEPARTMENT					
	2A	4.00	5.00	7.00	7.01		
200.00 Cross Foot Adjustments	0					200.00	
201.00 Negative Cost Centers	0	C)	0 0	0	201.00	
202.00 TOTAL (sum lines 118-201)	1, 493, 488	C	164, 54	6 92, 549	281	202.00	

Heal th	Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
	ATION OF CAPITAL RELATED COSTS		Provi der		eriod: rom 10/01/2014	Worksheet B Part II	
					09/30/2015	Date/Time Pre 2/17/2016 10:	
	Cost Center Description	OPERATION OF	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		PLANT-POB 7.02	PLANT-WJ 7.03	LINEN SERVICE 8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS				, i		
2.00 2.01	00200 NEW CAP REL COSTS-MVBLE EQUIP 00201 NEW CAP REL COSTS-MVBLE EQUIP MOB						2.00 2.01
2.02	00202 NEW CAP REL COSTS-MVBLE EQUI P-POB						2.02
2.03	00203 NEW CAP REL COSTS-MVBLE EQUIP- WJ						2.03
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4.00 5.00
7.00	00700 OPERATION OF PLANT						7.00
7.01	00701 OPERATION OF PLANT-MOB						7.01
7.02	00702 OPERATION OF PLANT-POB	584	24				7.02
7.03 8.00	00703 OPERATION OF PLANT-WJ 00800 LAUNDRY & LINEN SERVICE	0	26 0				7.03 8.00
9.00	00900 HOUSEKEEPING	0	0	1, 206			9.00
10.00	01000 DI ETARY	0	0	414	323	49, 366	10.00
11.00		0	0	C		0	11.00
13.00 14.00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	0	0		220 305	0	13.00 14.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	0			0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS			· · ·			
30.00 31.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	0	0	2, 341	2, 019	25, 296	30.00 31.00
40.00	04000 SUBPROVIDER - IPF	0	0	689	699	0 24, 070	
41.00	04100 SUBPROVIDER - IRF	0	0	C		0	41.00
42.00	04200 SUBPROVI DER	0	0	C		0	42.00
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	0	18	156	0	43.00
50.00	05000 OPERATING ROOM	286	0	2, 310	1, 800	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	C		0	52.00
53.00	05300 ANESTHESI OLOGY	0	0	0		0	53.00
54.00 57.00	05400 RADI OLOGY-DI AGNOSTI C 05700 CT SCAN	0	0	889		0	54.00 57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	C	0	0	59.00
60.00		0	0	C	002	0	60.00
60. 01 65. 00	06001 BLOOD LABORATORY 06500 RESPI RATORY THERAPY	0	0		-	0	60. 01 65. 00
66.00	06600 PHYSI CAL THERAPY	0	0	169	.=	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	C		0	67.00
68.00		0	0	152	-	0	68.00
69.00 71.00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0	153		0	69.00 71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	C	-	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	C	167	0	73.00
88.00	OUTPATIENT SERVICE COST CENTERS	0	0			0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	89.00
90.00	09000 CLI NI C	0	0	c c	634	0	90.00
90.01	09001 FAMILY PRACTICE OF JAY COUNTY	298	0	C	870	0	90.01
90. 02 91. 00	09002 JAY FAMILY MEDICINE 09100 EMERGENCY	0	0	2, 130	701	0	90.02 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			_,			92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	C	0	0	93.00
99 10	OTHER REIMBURSABLE COST CENTERS	0	0	C	0	0	99.10
77.10	SPECIAL PURPOSE COST CENTERS		0			0	, , , , , , , , , , , , , , , , , , , ,
	10600 HEART ACQUI SI TI ON	0	0	C	0		106. 00
	0 10900 PANCREAS ACQUISITION 0 11000 INTESTINAL ACQUISITION	0	0		0		109. 00 110. 00
	11100 I SLET ACQUISITION	0	0		0		111.00
	11300 I NTEREST EXPENSE		-			-	113.00
118.00		584	0	10, 319	9, 934	49, 366	118.00
100.00	NONREIMBURSABLE COST CENTERS	0	0		87	0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0		0		190.00
193.00	19300 NONPAI D WORKERS	0	0	c c	0	0	193.00
	07950 MOB	0	0	C	1, 341		194.00
	07951 POB 207952 WEST JAY CLINIC	0	0 26		870		194. 01 194. 02
	07952 WEST SAT CELINIC	0	20		0		194.02 194.03
194.04	07954 OTHER NONREIMBURSABLE COST CENTERS	0	0	C	0	0	194.04
	07955 OTHER NONREI MBURSABLE COST CENTERS	0	0		0		194.05
	07956 TRI COUNTY 707957 HOSPI TALI ST	0	0				194. 06 194. 07
200.00			0			0	200.00

Health Fin	nancial Systems	JAY COUNTY	JAY COUNTY HOSPI TAL			In Lieu of Form CMS-2552-10			
ALLOCATI Of	N OF CAPITAL RELATED COSTS		Provi der	F	Period: From 10/01/2014 To 09/30/2015	Worksheet B Part II Date/Time Pre 2/17/2016 10:			
	Cost Center Description	OPERATION OF PLANT-POB	OPERATION OF PLANT-WJ	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY			
		7.02	7.03	8.00	9.00	10.00			
201.00	Negative Cost Centers	C) C) (0 0	C	201.00		
202.00	TOTAL (sum lines 118-201)	584	26	10, 319	12, 232	49, 366	202.00		

ALI OCATION OF EARIER BRATE CERTS Provide Control Control of Controls of Products 1 (Control of Control of Products 1 (Control of Control of Products 1 (Control of Control of Products 2 (Control of Products 1 (Control	Health Financial Systems	JAY COUNTY	HOSPI TAL		In Lieu	u of Form CMS-	2552-10
Cest Center Description OMPETERIA NUMERING CENTROL Mathematical Services A Pathoda 2.00 CODOCO MAR OF EXPLOSE 11.00 13.00 14.00 10.00 2.01 2.01 CODOCO MAR OF EXPLOSE NUMERISTINUT Services A Services	ALLOCATION OF CAPITAL RELATED COSTS		Provi der	Fr	om 10/01/2014	Part II	
Vert ist STRVITE 00 SERVITE 01 SERVITE 01 SERVITE 01 DESCRIT 0 000000000000000000000000000000000000				Тс			
Internal SUPPLY LIBRARY	Cost Center Description	CAFETERI A				Subtotal	
Improvemental Environ. Environ. 2.00 0.00000000000000000000000000000000000		11.00		SUPPLY	LI BRARY	04.00	
2. 01 00001 MRT (04 PEIL COSTS AMME F DUIP NOB 2. 02 00000 MRT (04 PEIL COSTS AMME F DUIP NOB 2. 03 00001 MRT (04 PEIL COSTS AMME F DUIP NOB 2. 03 00000 MRT (04 PEIL COSTS AMME F DUIP NOB 2. 03 00000 MRT (04 PEIL COSTS AMME F DUIP NOB 2. 03 00000 MRT (04 PEIL AMME F DUIP NOB 2. 03 00000 MRT (04 PEIL AMME F DUIP NOB 2. 00 00000 MRT (04 PEIL AMME F DUIP NOB 2. 00 00000 MRT (04 PEIL AMME F DUIP NOB 2. 00 00000 MRT (04 PEIL AMME F DUIP NOB 2. 00 00000 MRT (04 PEIL AMME F DUIP NOB 2. 00 00000 MRT (04 PEIL AMME F DUIP NOB 2. 00 00000 MRT (04 PEIL AMME F DUIP NOB 2. 00 00000 MRT (04 PEIL AMME F DUIP NOB 2. 00 00000 MRT (04 PEIL AMME F DUIP NOB 2. 00 00000 MRT (04 PEIL AMME F DUIP NOB 2. 00 00000 MRT (04 PEIL AMME F DUIP NOB 2. 00 00000 MRT (04 PEIL AMME F DUIP NOB 2. 00 00000 MRT (04 PEIL AMME F DUIP NOB 2. 00 00000 MRT (04 PEIL AMME F DUIP NOB 2. 00 00000 MRT (04 PEIL AMME F DUIP NOB 2. 00 00000 MRT (04 PEIL AMME F DUIP NOB 2. 00 00000 MRT (04 PEIL AMME F DUIP NOB 2. 00 00000 MRT (04 PEIL AMME F DUIP NOB 2. 00 0000 MRT (04 PEIL AMME F DUIP NOB 2. 00 0000 MRT (04 PEIL AMME F DUIP NOB 2. 00 0000 MRT (04 PEIL AMME F DUIP NOB 2. 00 0000 MRT (05 F CHARTES 2. 00 0000 MR	GENERAL SERVICE COST CENTERS	11.00	13.00	14.00	16.00	24.00	
2 D2 D0D20/MED_CAP_REL_COSTS_MUEL_FOULP-MEL 2.02 2 D2 D0D20/MED_CAP_REL_COSTS_MUEL_FOULP-MEL 2.02 4 D0 D0D20/MED_CAP_REL_ROTS_DEPARTMENT 2.02 0 D020/MED_CAP_REL_TO OF PLAT_MOB 7.01 0 D020/MED_CAP_ROT OF PLAT_MOB 7.01 10 D020/MED_CAP_ROT OF PLAT_MOB 7.00		NOD					
2 03 00203 INF CAP REL COSTS -WRIE COUPS - W1 4 0 00400 FUNCT PARTER TO ENATURE WITH CAS TREASTOREM 4 0 00400 FUNCT PARTER TO ENATURE WITH CAS TREASTOREM 4 0 0 00400 FUNCT PARTER TO ENATURE WITH CAS TREASTOREM 4 0 0 00400 FUNCT PARTER 10 0 FLANT - NOB 7 0 00100 FLANT - NOB 7 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							
5.00 00000 ADMIN ISTATIVE & GENERAL 5.00 5.00 00000 DERATION OF PLANT AVE & GENERAL 7.00 7.00 00000 DERATION OF PLANT AVE & GENERAL 7.00 <t< td=""><td></td><td>WJ</td><td></td><td></td><td></td><td></td><td></td></t<>		WJ					
7.00 DOTOD DEPENTION OF PLANT 7.00 7.00 DOTOD DEPENTION OF PLANT-ADD 7.01 7.00 DOTOD DEPENTION OF PLANT-ADD 0.01 7.00 DOTOD DEPENTION FERTION DEPENTION FERTION 7.010 DOTOD DEPENTION FERTION DEPENTION FERTION 7.010 DOTOD DEPENTION FERTION DEPENTION FERTION 7.010 DOTOD DEPENTION							
7.02 00702 DEFEATION OF FLANT-POR 7.02 00702 DEFEATION OF FLANT-POR 7.03 8.03 004001 LANDERY & LINEN SERVICE 9.03 004001 LANDERY & LINEN 7.03 8.04 004001 LANDERY & LINEN SERVICE 9.01 0.01 01100 CAPTERIA 45.226 11.00 11.00 01100 CAPTERIA 45.226 11.00 11.00 10.00 01000 CAPTERIA 45.226 11.00 11.00 10.00 01000 CAPTERIA 45.226 11.00 <t< td=""><td>7.00 00700 OPERATION OF PLANT</td><td></td><td></td><td></td><td></td><td></td><td>7.00</td></t<>	7.00 00700 OPERATION OF PLANT						7.00
7.03 00720 DEEAT IND OF PLANT-BJ 7.03 00720 0.0200 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>							
9.00 0000 PLARY CALL THE ALL OF A CONTROL OF							
10. 00 01000 DETARY 45, 226 10. 00 100. 00 100							
13. 00 13. 00 13. 00 14. 387 14. 387 14. 387 16. 00 00. 0000 LEDICAL RECORDS & LIBRARY 2, 149 0 45. 00 16. 00 IMPATTER ROUTINE SENTICE COST CENTERS 5. 340 14. 980 2, 083 351, 328 30. 00 31. 00 00.000 AULTS & PUEN ATRIC COST CENTERS 6. 340 14. 980 2, 083 351, 328 30. 00 31. 00 00.000 INFORMUDER - LIP 3. 477 0 0 0 44. 07 0. 40. 00 31. 00 00.000 INFORMUDER - LIP 0 0 0 0 42. 00 31. 00 00.000 INFORMUDER - LIP 0 0 0 0 43. 00 43. 00 00.000 INFORMUDER - LIP 0	10. 00 01000 DI ETARY						10.00
14.00 01400 CENTRAL SERVICES & SUPPLY 525 0 44.54 14.00 16.00 01600 COURTIAL SERVICE COST CENTERS 0							
INPART FART BOUTTINE SERVICE COST CENTERS Impact FART BOUTT	14.00 01400 CENTRAL SERVICES & SUPPLY	525	0				14.00
30.00 33000 ADULTS & PENATRICS 6.340 14.966 2.066 2.063 351.325 30.00 40.00 04000 SUBPROVIDER - IPF 3.477 8.220 202 714 144.507 40.00 40.00 04000 SUBPROVIDER - IPF 0		· · · · · ·	0	45	36, 086		16.00
00.000 04000 SUBPROVIDER 1 FF 3, 477 8, 220 202 714 144, 507 40.00 0	30. 00 03000 ADULTS & PEDIATRICS		14, 986	2, 086	2, 083	351, 326	
11.00 04100 SUBPROVIDER 0		C 3 477	0 8 220	0	0 714		1
43. 00 04300 NURSERY 696 1.646 0 58 26. 419 43. 00 AMULLARY SERVICE COST CENTERS 05000 (PEEATING ROOM 3.329 7.870 11.2033 5.964 239,901 50. 00 53. 00 05300 (PEEATING ROOM 67 159 0 63 3.186 52. 00 53. 00 53. 00 53. 00 53. 00 65. 00 53. 00 65. 00 53. 00 53. 00 56. 00 57. 00 0 0 0 0 55. 00 56. 00 56. 00 56. 00 56. 00 56. 00 56. 00 56. 00 56. 00 56. 00 56. 00 56. 00 56. 00 56. 00 56. 00 56. 00 56. 00 56. 00 56. 00 56. 00 57. 30 66. 00 66. 01 66. 01 66. 01 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 67. 00 67. 00 67. 00 67. 00 67. 00 67. 00 67. 00 67. 00 67. 00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>1</td>							1
NUCLLARY SERVICE COST CENTERS 1 0.00 05000 DEPRATING (ROW 3,229 7,870 12,033 5,964 239,001 50.00 52.00 05300 DELUCRY PROM & LABOR ROOM 67 157 0 63 3,180 52.00 53.00 05300 ARSTHESI LOGY 0 0 0 64.00 53.00 0 56.00 57.00 0				0	-	-	
52.00 05200 DELLYERY BOOM & LABOR ROOM 67 159 0 6.3 3.180 52.00 53.00 53.00 053.00 053.00 053.00 053.00 0 0 0 0 0 0 0 53.00 0			1, 040	0	58	20, 419	43.00
53.00 OS300 (ARSTHESI OLGOY 0 0 0 0 53.00 0							1
57.00 05700 (T SCAN 0				0			
58:00 OSB00 MACHTIC RESONANCE LINAGING (MRI) 0							
99 00 0		-	-	0			
60.01 0001 0000 0 <th< td=""><td></td><td>C</td><td>0</td><td>0</td><td>-</td><td>-</td><td></td></th<>		C	0	0	-	-	
66.00 Code Operation O O Tr6 999 5,735 66.00 67.00 06700 00 0 177 928 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 277 211 68.00 69.00 06900 ELECTROCARDIOLOGY 1,055 0 623 72.8 67.00 71.00 71.00 07100 MOID MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 72.00 0							
67:00 OCTOQ OCCUPATI ONAL THERAPY 0 0 177 728 67:00 68:00 06900 SPECCH ATHOLOGY 0 0 0 27 211 68:00 00 0000 SPECCH ATHOLOGY 1,055 0 623 728 26,763 69:00 0100 0 <td< td=""><td></td><td>C</td><td>0</td><td></td><td></td><td></td><td>1</td></td<>		C	0				1
68:00 OBSONG SPECH PATHOLOGY 0 0 27 211 68:00 00 0000 LECETROCARDIOLOGY 1,055 0 623 728 26,763 69:00 71:00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0							
17.1 00 OTOO DO O <th< td=""><td>68.00 06800 SPEECH PATHOLOGY</td><td></td><td></td><td>0</td><td>27</td><td>211</td><td>68.00</td></th<>	68.00 06800 SPEECH PATHOLOGY			0	27	211	68.00
72.00 07200 INPL. DEV. CHARGED TO PATIENTS 0							
OUTPATLENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	S C	0	0	0	0	72.00
88.00 08800 RURAL. HEALTH CLINIC 0 0 0 0 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0		1, 240	0	383	1, 757	37, 958	73.00
90. 00 09000 CLINIC 2, 425 0 1, 359 135 96, 870 90. 00 90. 01 09001 FAMILY PRACTICE OF JAY COUNTY 5, 816 0 4, 401 402 78, 475 90. 01 90. 02 09002 JAY FAMILY MEDICINE 3, 766 0 4, 332 198 14, 178 90. 01 91. 00 09100 EMERGENCY 4, 444 10, 506 2, 273 2, 951 133, 617 91. 00 92. 00 04040 OTHER OUTPATIENT SERVICE COST CENTER 0 0 0 0 92. 00 0 04040 OTHER OUTPATIENT SERVICE COST CENTERS 0 0 0 0 99. 10 99. 10 099010 CORF 0 0 0 0 0 0 0 0 0 0 0 0 106. 00 10600 106. 00 106. 00 106. 00 106. 00 106. 00 106. 00 106. 00 106. 00 106. 00 106. 00 106. 00 106. 00 107. 00 100 107. 00 <t< td=""><td>88.00 08800 RURAL HEALTH CLINIC</td><td>C</td><td>0</td><td>0</td><td>0</td><td>-</td><td></td></t<>	88.00 08800 RURAL HEALTH CLINIC	C	0	0	0	-	
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY 5,816 0 4,401 402 78,475 90. 01 90. 02 09002 JAY FAMILY MEDICINE 3,766 0 4,332 198 14,178 90. 02 91. 00 09000 EMERGENCY 4,444 10,506 2,273 2,951 133,617 91.00 92. 00 09200 DBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0 0 0 92.00 93. 00 04040 OTHER REI MURSABLE COST CENTERS 0 0 0 0 0 99.10 09910 CORF 0 0 0 0 0 0 0 99.10 06. 00 IOART ACQUI SI TI ON 0 0 0 0 0 106.00 104.00 110.00 111.00 114.00 111.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113			0	0 1 359	0 135	-	1
91.00 09100 EMERGENCY 4,444 10,506 2,273 2,951 133,617 91.00 92.00 09200 DBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 92.00 93.00 4040 OTHER NUTPATIENT SERVICE COST CENTER 0 0 0 0 0 92.00 00 0400 OTHER NUTPATIENT SERVICE COST CENTERS 0 0 0 0 0 92.00 99.10 09910 CORF 0 0 0 0 0 0 0 92.00 99.10 09910 CORF 0 <	90. 01 09001 FAMILY PRACTICE OF JAY COUNTY	5, 816	0	4, 401	402	78, 475	90. 01
92.00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0 10 0 10 0 10 0 10 0 10 0 10 0 10 0 10 0 10 0 10 0 10 0 10 0 10 0 1							
OTHER REI MBURSABLE COST CENTERS 99. 10 OP9710 CORF O	92.00 09200 OBSERVATION BEDS (NON-DISTINCT	PART)	10, 300	2,213	2, 751	133, 017	92.00
99.10 O9910 CORF O		CENTER C	0	0	0	0	93.00
106.00 10600 HEART ACQUI SI TI ON 0	99. 10 09910 CORF	C	0	0	0	0	99.10
109.00 PANCREAS ACQUI SI TI ON 0 0 0 0 0 109.00 110.00 INTESTI NAL ACQUI SI TI ON 0 0 0 0 0 110.00 111.00 INTEST ACQUI SI TI ON 0 0 0 0 0 0 0 0 0 110.00 111.00 INTERT ACQUI SI TI ON 0 0 0 0 0 0 0 0 0 0 0 0 111.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 112.01 113.00 112.01 112.01 112.01 112.01 112.01 112.01 112.01 112.01 12.01 1				0	0	0	106 00
111.00 1SLET ACQUI SI TI ON 0 0 0 111.00 113.00 11300 INTEREST EXPENSE 113.00 113.00 113.00 113.00 118.00 SUBTOTALS (SUM OF LINES 1-117) 45,203 43,387 42,639 36,086 1,421,263 118.00 NONRET IMBURSABLE COST CENTERS 190.00 19200 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 122,316 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 192.00 0 0 192.00 0 0 192.00 0 0 193.00 00 0 193.00 0 193.00 0 0 0 193.00 0 0 193.00 0 0 0 193.00 193.00 0 0 0 193.00 193.00 193.00 193.00 0 0 0 193.00 193.00 193.00 194.01 07951 PDB 0 0 0 194.01 194.01 194.01 194.01 194.02 07952 WEST JAY CLINIC	109.00 10900 PANCREAS ACQUISITION	C C	0	0	0		
113.00 11300 INTEREST EXPENSE 113.00 113.00 118.00 SUBTOTALS (SUM OF LINES 1-117) 45,203 43,387 42,639 36,086 1,421,263 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 12,316 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 192.00 193.00 19300 NONREI MBURSABLE COST CENTERS 0 0 0 192.00 194.00 07950 MOB 0 0 0 0 194.00 194.01 07951 POB 0 0 0 0 870 194.01 194.02 07952 WEST JAY CLINIC 0 0 0 37,601 194.02 194.03 07953 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 194.02 194.04 07954 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 194.02 194.04 07955 OTHER NONREI MBURSABLE COST CENTERS		C	0	0	0		
NONREI MBURSABLE COST CENTERS 190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 12, 316 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 192.00 193.00 19300 NONPAI D WORKERS 0 0 0 0 193.00 194.00 07950 MOB 0 0 0 0 193.00 194.01 07951 POB 0 0 0 97.385 194.00 194.02 07952 WEST JAY CLI NI C 0 0 0 870 194.01 194.02 07952 WEST JAY CLI NI C 0 0 194.01 194.03 194.03 37, 601 194.03 194.04 07954 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 194.04 194.05 07955 OTHER NONREI MBUR			0	0	0	0	
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 12, 316 190.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 192.00 193.00 19300 NONPAI D WORKERS 0 0 0 0 193.00 194.00 07950 MOB 0 0 0 0 193.00 194.01 07950 MOB 0 0 0 0 193.00 194.01 07950 MOB 0 0 0 0 9, 385 194.00 194.02 07952 WEST JAY CLINIC 0 0 0 870 194.01 194.02 07952 WEST JAY CLINIC 0 0 0 194.02 194.03 07953 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 194.03 194.04 07954 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 194.04 194.05 07955 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 194.05 194.	· · · · · · · · · · · · · · · · · · ·	45, 203	43, 387	42, 639	36, 086	1, 421, 263	118.00
193.00 19300 NONPAI D WORKERS 0 0 0 193.00 194.00 07950 MOB 0 0 0 9, 385 194.00 194.01 07951 POB 0 0 0 9, 385 194.00 194.01 07951 POB 0 0 0 870 194.01 194.02 07952 WEST JAY CLINIC 0 0 1,218 0 37,601 194.02 194.03 07953 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 194.03 194.04 07954 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 194.03 194.04 07955 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 194.05 194.06 07955 THER NONREI MBURSABLE COST CENTERS 0 0 0 194.05 194.06 07955 TRI COUNTY 0 0 680 0 11,395 194.06		ANTEEN C	0	0	0	12, 316	190.00
194.00 07950 MOB 0 0 0 9,385 194.00 194.01 07951 POB 0 0 0 0 870 194.01 194.02 07952 WEST JAY CLINIC 0 0 1,218 0 37,601 194.02 194.03 07953 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 194.03 194.04 07954 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 194.03 194.04 07955 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 194.03 194.05 07955 THER NONREI MBURSABLE COST CENTERS 0 0 0 194.05 194.06 07956 TRI COUNTY 0 0 0 0 11,395 194.06		C	0	0	0		
194.01 07951 POB 0 0 0 870 194.01 194.02 07952 WEST JAY CLINIC 0 0 1,218 0 37,601 194.02 194.03 07953 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 194.03 194.04 07954 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 194.04 194.05 07955 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 194.04 194.05 07955 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 194.05 194.06 07955 THER NONREI MBURSABLE COST CENTERS 0 0 0 0 194.05 194.06 07956 TRI COUNTY 0 0 0 0 11,395 194.06				0	o		
194. 03 07953 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 194. 03 194. 04 07954 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 194. 04 194. 05 07955 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 194. 04 194. 05 07955 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 194. 05 194. 06 07956 TRI COUNTY 0 0 680 0 11, 395 194. 06	194. 01 07951 POB	c	0	0	o	870	194. 01
194.04 07954 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 194.04 194.05 07955 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 194.05 194.06 07956 TRI COUNTY 0 0 680 0 11, 395 194.06				1, 218 0	0		1
194. 06 07956 TRI COUNTY 0 0 680 0 11, 395 194. 06	194.0407954 OTHER NONREIMBURSABLE COST CEN	ITERS C	0	Ö	o	0	194.04
		ITERS C		0 680	0		1
		23	0		0		

Health Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Period:	Worksheet B	
				From 10/01/2014 To 09/30/2015		narod
				10 09/30/2015	2/17/2016 10:	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	MEDI CAL	Subtotal	
		ADMI NI STRATI ON	SERVICES &	RECORDS &		
			SUPPLY	LI BRARY		
	11.00	13.00	14.00	16.00	24.00	
200.00 Cross Foot Adjustments					0	200.00
201.00 Negative Cost Centers	0	0		0 0	0	201.00
202.00 TOTAL (sum lines 118-201)	45, 226	43, 387	44, 54	5 36, 086	1, 493, 488	202.00

	icial Systems DF CAPITAL RELATED COSTS	JAY COUNTY H	Provi der C	CN: 151320	Peri od: From 10/01/2014 To 09/30/2015	u of Form CMS-2552- Worksheet B Part II Date/Time Prepare 2/17/2016 10:07 a
	Cost Center Description	Intern & Residents Cost	Total			
		& Post				
		Stepdown				
		Adjustments	26.00			
GENER	AL SERVICE COST CENTERS	25.00	26.00			
	NEW CAP REL COSTS-MVBLE EQUIP					2.
	NEW CAP REL COSTS-MVBLE EQUIP MOB					2.
	NEW CAP REL COSTS-MVBLE EQUIP-POB					2.
	NEW CAP REL COSTS-MVBLE EQUIP- WJ EMPLOYEE BENEFITS DEPARTMENT					2.
	ADMI NI STRATI VE & GENERAL					5.
	OPERATION OF PLANT					7.
	OPERATION OF PLANT-MOB					7.
	OPERATION OF PLANT-POB					7.
	OPERATION OF PLANT-WJ LAUNDRY & LINEN SERVICE					7.
	HOUSEKEEPING					9.
	DIETARY					10.
	CAFETERIA					11.
	NURSING ADMINISTRATION					13.
	CENTRAL SERVICES & SUPPLY MEDICAL RECORDS & LIBRARY					14. 16.
	I ENT ROUTI NE SERVI CE COST CENTERS					10.
	ADULTS & PEDIATRICS	0	351, 326			30.
1.00 03100	INTENSIVE CARE UNIT	0	o			31.
	SUBPROVIDER - IPF	0	144, 507			40.
	SUBPROVIDER - IRF	0	0			41.
1	SUBPROVI DER NURSERY	0	0 26, 419			42.
	LARY SERVICE COST CENTERS	<u> </u>	20,417			43.
	OPERATI NG ROOM	0	239, 901			50.
2.00 05200	DELIVERY ROOM & LABOR ROOM	0	3, 180			52.
	ANESTHESI OLOGY	0	0			53.
	RADI OLOGY-DI AGNOSTI C CT SCAN	0	164, 069 0			54.
	MAGNETIC RESONANCE IMAGING (MRI)	0	0			58.
	CARDI AC CATHETERI ZATI ON	0	0			59.
06000 06000	LABORATORY	0	88, 162			60.
	BLOOD LABORATORY	0	0			60.
		0	8, 964			65.
	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	0	5, 735 928			66. 67.
	SPEECH PATHOLOGY	0	211			68.
	ELECTROCARDI OLOGY	0	26, 763			69.
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			71.
	IMPL. DEV. CHARGED TO PATIENTS	0				72.
	DRUGS CHARGED TO PATIENTS TIENT SERVICE COST CENTERS	0	37, 958			73.
	RURAL HEALTH CLINIC	0	0			88.
9.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	o			89.
	CLINIC	0	96, 870			90.
	FAMILY PRACTICE OF JAY COUNTY	0	78, 475			90. 90.
1.00 09100	JAY FAMILY MEDICINE	0	14, 178 133, 617			90.
	OBSERVATION BEDS (NON-DISTINCT PART)	0	100,017			92.
	OTHER OUTPATIENT SERVICE COST CENTER	0	0			93.
	REIMBURSABLE COST CENTERS	1 -1				
9. 10 09910		0	0			99.
	AL PURPOSE COST CENTERS	0	0			106.
1	PANCREAS ACQUISITION	0	0			109.
	INTESTINAL ACQUISITION	0	0			110.
	I SLET ACQUI SI TI ON	0	0			111.
	INTEREST EXPENSE		1 401 0(0)			113.
8.00	SUBTOTALS (SUM OF LINES 1-117)	0	1, 421, 263			118.
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12, 316			190.
	PHYSICIANS' PRIVATE OFFICES	0	0			192.
3.0019300	NONPAID WORKERS	0	o			193.
4.0007950		0	9, 385			194.
4.0107951		0	870			194.
	WEST JAY CLINIC OTHER NONREIMBURSABLE COST CENTERS	0	37, 601			194. 194.
	OTHER NONREIMBURSABLE COST CENTERS		0			194. 194.
	OTHER NONREIMBURSABLE COST CENTERS	0	0			194.

Health Financial Systems	JAY COUNTY H	IOSPI TAL		In Lieu	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der	CCN: 151320	Period:	Worksheet B	
				From 10/01/2014 To 09/30/2015	Part II Date/Time Pre	nared
				10 0// 00/ 2010	2/17/2016 10:	07 am
Cost Center Description	Intern &	Total				
	Residents Cost					
	& Post					
	Stepdown					
	Adjustments					
	25.00	26.00				
194.06 07956 TRI COUNTY	0	11, 395				194.06
194. 07 07957 HOSPI TALI ST	0	658				194.07
200.00 Cross Foot Adjustments	0	0				200.00
201.00 Negative Cost Centers	0	0				201.00
202.00 TOTAL (sum lines 118-201)	0	1, 493, 488				202.00

	Financial Systems LLLOCATION - STATISTICAL BASIS	JAY COUNTY			eriod:	u of Form CMS-2 Worksheet B-1	2552-10
				To	rom 10/01/2014 09/30/2015	Date/Time Pre 2/17/2016 10:	
			CAPI TAL REL	ATED COSTS			
	Cost Center Description	NEW MVBLE EQUI P (SQUARE FEET)	NEW MVBLE EQUIP MOB (SQUARE FEET)	NEW MVBLE EQUI P-POB (SQUARE FEET)	NEW MVBLE EQUI P- WJ (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
		2.00	2.01	2.02	2.03	4.00	
2.00 2.01 2.02 2.03 4.00 5.00	GENERAL SERVICE COST CENTERS 00200 NEW CAP REL COSTS-MVBLE EQUIP 00201 NEW CAP REL COSTS-MVBLE EQUIP MOB 00202 NEW CAP REL COSTS-MVBLE EQUIP-POB 00203 NEW CAP REL COSTS-MVBLE EQUIP- WJ 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	68, 379 0 0 0 0 0 8, 162	11, 841 0 0 2, 520	11, 625 0 0 325	3, 300 0 0	15, 425, 606 2, 346, 972	2.00 2.01 2.02 2.03 4.00 5.00
7.00 7.01 7.02 7.03 8.00 9.00	00700 OPERATION OF PLANT 00701 OPERATION OF PLANT-MOB 00702 OPERATION OF PLANT-POB 00703 OPERATION OF PLANT-POB 00703 OPERATION OF PLANT-WJ 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY	4, 253 0 0 0 460 366	2, 520 0 0 0 0 0 0 430	0 0 0 0 0 0 0 0		317, 044 4, 987 7, 232 2, 789 35, 288 343, 074	7.00 7.01 7.02 7.03 8.00 9.00
10. 00 11. 00 13. 00 14. 00 16. 00	01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01600 MEDI CAL RECORDS & LI BRARY I NPATI ENT ROUTI NE SERVI CE COST CENTERS	2, 140 2, 055 1, 457 2, 020 1, 415	430 0 0 0	0 0 0	0 0 0 0	176, 945 153, 225 960, 092 67, 779 348, 435	11. 00 13. 00 14. 00
30.00 31.00 40.00 41.00 42.00 43.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04200 SUBPROVIDER 04300 NURSERY	13, 385 0 4, 636 0 0 1, 033	0 0 0 0 0	0 0 0 0 0 0	0 0 0 0 0 0	1, 199, 717 0 651, 976 0 137, 138	31.00 40.00 41.00 42.00
50.00 52.00 53.00 54.00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM 05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	6, 400 127 0 6, 255	0 0 0 0	5, 535 0 0 0	0 0 0	845, 575 17, 453 0 813, 052	52. 00 53. 00
57.00 58.00 59.00 60.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION 06000 LABORATORY	0,233	0 0 0 0 0	0 0 0	0 0 0 0	0 0 0 629, 639	57.00 58.00 59.00
60. 01 65. 00 66. 00 67. 00 68. 00	06001 BLOOD LABORATORY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0 280 0 0 0	0 0 0 0 0	0 0 0	0 0 0 0	0 0 0 0 0	60. 01 65. 00 66. 00 67. 00
69.00 71.00 72.00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 0UTPATI ENT SERVI CE COST CENTERS	1,000 0 1,110	0 0 0 0	0 0 0	0 0 0 0	0 191, 374 0 0 394, 065	69.00 71.00 72.00
89.00 90.00 90.01 90.02 91.00	09800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09001 FAMILY PRACTICE OF JAY COUNTY 09002 JAY FAMILY MEDICINE 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0 0 4,200 0 0 4,650	0 0 0 0 0 0 0	0 0 5, 765 0 0	0 0 0 0 0	0 463, 880 1, 473, 060 1, 012, 896 2, 131, 895	89.00 90.00 90.01 90.02
	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	
99. 10	OTHER RELIMBURSABLE COST CENTERS	0	0	0	0	0	99. 10
109.00 110.00 111.00		0 0 0 0 67, 804	0 0 0 0 2, 950	0 0 0 11, 625	0 0 0 0	0 0	106. 00 109. 00 110. 00 111. 00 113. 00 118. 00
192.00 193.00 194.00 194.01 194.02	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CI ANS' PRI VATE OFFI CES 19300 NONPAI D WORKERS 07950 MOB 07951 POB 07952 WEST JAY CLINIC 07953 OTHER NONREI MBURSABLE COST CENTERS	575 0 0 0 0 0 0 0	0 0 8, 891 0 0 0	0 0 0 0 0 0	0 0 0 0 3, 300 0	0 0 0 452, 947	190. 00 192. 00 193. 00 194. 00 194. 01 194. 02 194. 03

Health Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der	CCN: 151320	Period:	Worksheet B-1	
				From 10/01/2014 To 09/30/2015	Date/Time Pre 2/17/2016 10:	
		CAPI TAL REL	ATED COSTS			
Cost Center Description	NEW MVBLE EQUI P (SQUARE FEET)	NEW MVBLE EQUI P MOB (SQUARE FEET)	NEW MVBLE EQUI P-POB (SQUARE FEET)	NEW MVBLE EQUIP-WJ (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS	
	2.00	2.01	2.02	2.03	SALARIES) 4.00	
194.0407954 OTHER NONREI MBURSABLE COST CENTERS	0	0		0 0		194.04
194.0507955 OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0	0	194.05
194. 06 07956 TRI COUNTY	0	0		0 0	180, 777	194.06
194. 07 07957 HOSPI TALI ST	0	0		0 0	66, 300	194.07
200.00Cross Foot Adjustments201.00Negative Cost Centers						200. 00 201. 00
202.00 Cost to be allocated (per Wkst. B, Part I)	1, 332, 082	10, 285	119, 97	31, 142	5, 587, 695	
203.00 Unit cost multiplier (Wkst. B, Part I)	19. 480864	0. 868592	10. 32077	9. 436970	0. 362235	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)					0	204.00
205.00 Unit cost multiplier (Wkst. B, Part					0. 000000	205. 00

	Financial Systems LLOCATION - STATISTICAL BASIS	JAY COUNTY		CCN: 151320 P	In Lie	u of Form CMS-2 Worksheet B-1	2552-10
CUST A	LLUCATION - STATISTICAL BASIS		Provi der		rom 10/01/2014	Date/Time Prep 2/17/2016 10:0	
	Cost Center Description	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT-MOB (SQUARE FEET)	OPERATION OF PLANT-POB (SQUARE FEET)	
		5A	5.00	7.00	7.01	7.02	
	GENERAL SERVICE COST CENTERS						
	00200 NEW CAP REL COSTS-MVBLE EQUI P 00201 NEW CAP REL COSTS-MVBLE EQUI P MOB 00202 NEW CAP REL COSTS-MVBLE EQUI P-POB 00203 NEW CAP REL COSTS-MVBLE EQUI P- WJ 00400 EMPLOYEE BENEFI TS DEPARTMENT 00500 ADMINI STRATI VE & GENERAL 00700 OPERATI ON OF PLANT 00701 OPERATI ON OF PLANT-MOB 00702 OPERATI ON OF PLANT-MOB 00703 OPERATI ON OF PLANT-POB 00703 OPERATI ON OF PLANT-WJ 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01600 MEDI CAL RECORDS & LI BRARY	-5, 840, 219 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	23, 836, 869 1, 404, 713 40, 767 84, 560 3, 831 86, 462 476, 780 436, 763 215, 093 1, 336, 044 148, 178 546, 680	55, 964 0 0 460 366 2, 140 2, 055 1, 457 2, 020 1, 415	9, 321 0 0 0 430 0 0 0 0 0 0	11, 300 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 2.\ 00\\ 2.\ 01\\ 2.\ 02\\ 2.\ 03\\ 4.\ 00\\ 5.\ 00\\ 7.\ 00\\ 7.\ 00\\ 7.\ 01\\ 7.\ 02\\ 7.\ 03\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 16.\ 00\\ \end{array}$
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	540, 000	1,415		0	10.00
31.00 40.00 41.00 42.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04200 SUBPROVIDER 04300 NURSERY ANCILLARY SERVICE COST CENTERS		1, 925, 250 0 1, 224, 958 0 0 291, 596	13, 385 0 4, 636 0 0 1, 033	0 0 0 0 0 0	0 0 0 0 0	30. 00 31. 00 40. 00 41. 00 42. 00 43. 00
50. 00 52. 00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	2, 016, 812 27, 284	6, 400 127	0	5, 535 0	50. 00 52. 00
53.00	05300 ANESTHESI OLOGY	0	27, 204	0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	1, 799, 055	6, 255	0	0	54.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0	0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	2 010 (07	0	0	0	59.00
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	0	2, 019, 687	2,400	0	0	60. 00 60. 01
65.00	06500 RESPIRATORY THERAPY	0	359, 591	280	0	0	65.00
66, 00	06600 PHYSI CAL THERAPY	0	636, 029	200	0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	108, 738	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	26, 634	0	0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	422, 774	1, 000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	1, 586, 380	1, 110	0	0	73.00
00.00	OUTPATIENT SERVICE COST CENTERS			0	0	0	00.00
	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	88. 00 89. 00
	09000 CLINIC	0	514, 361	4, 200	0	0	90.00
	09001 FAMILY PRACTICE OF JAY COUNTY	0	1,041,223	0	0	5, 765	
90. 02	09002 JAY FAMILY MEDICINE	0	852, 125	0	0	0	90. 02
	09100 EMERGENCY	0	1, 787, 044	4, 650	0	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)			_		_	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
99 10	OTHER REIMBURSABLE COST CENTERS 09910 CORF	0	0	0	0	0	99. 10
77.10	SPECIAL PURPOSE COST CENTERS	<u> </u>	9	0	0	0	77.10
106.00	10600 HEART ACQUI SI TI ON	0	0	0	0	0	106. 00
109.00	10900 PANCREAS ACQUISITION	0	0	0	0		109. 00
	11000 INTESTINAL ACQUISITION	0	0	0	0		110. 00
	11100 I SLET ACQUI SI TI ON	0	0	0	0		111.00
	11300 INTEREST EXPENSE	E 040 010	21 410 412	EE 200	120		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	-5, 840, 219	21, 419, 412	55, 389	430	11, 300	116.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11, 201	575	0	0	190.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	0	0		192.00
	19300 NONPAI D WORKERS	0	0	0	0		193.00
	07950 MOB	0	7, 736	0	8, 891		194.00
	07951 POB	0	0	0	0		194.01
	07952 WEST JAY CLINIC	0	755, 517	0	0		194.02
	07953 OTHER NONREI MBURSABLE COST CENTERS	0	0	0	0		194. 03 194. 04
	07954 OTHER NONREIMBURSABLE COST CENTERS 07955 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194. 04 194. 05
	07956 TRI COUNTY	0	1, 552, 152	0	0		194.05 194.06
	i I	1		-	-1		· · · ·

Health Financial Systems		JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTIC	AL BASIS		Provi der		Period: From 10/01/2014	Worksheet B-1	
					To 09/30/2015	Date/Time Pre 2/17/2016 10:	pared: 07 am
Cost Center Des	cription	Reconciliation	ADMI NI STRATI VE	OPERATION OF	OPERATION OF	OPERATION OF	
			& GENERAL	PLANT	PLANT-MOB	PLANT-POB	
			(ACCUM.	(SQUARE	(SQUARE	(SQUARE	
			COST)	FEET)	FEET)	FEET)	
		5A	5.00	7.00	7.01	7.02	
194. 07 07957 HOSPI TALI ST		0	90, 851	(0 0	0	194.07
200.00 Cross Foot Adju	stments						200.00
201.00 Negative Cost C	enters						201.00
202.00 Cost to be allo Part I)	cated (per Wkst. B,		5, 840, 219	1, 748, 879	9 50, 755	105, 278	202.00
203.00 Unit cost multi	plier (Wkst. B, Part I)		0. 245008	31. 25007 ⁻	1 5. 445231	9. 316637	203.00
204.00 Cost to be allo Part II)	cated (per Wkst. B,		164, 546	92, 549	9 281	584	204.00
205.00 Unit cost multi	plier (Wkst. B, Part		0. 006903	1. 653724	4 0. 030147	0. 051681	205.00

	Financial Systems LLOCATION - STATISTICAL BASIS	JAY COUNTY		CCN: 151320 F	In Lieu Period:	u of Form CMS-2 Worksheet B-1	2552-10
000171				F	From 10/01/2014 To 09/30/2015	Date/Time Pre	
	Cost Center Description	OPERATI ON OF	LAUNDRY &	HOUSEKEEPING	DI ETARY	2/17/2016 10: CAFETERI A	07 am
		PLANT-WJ (SQUARE	LINEN SERVICE (POUNDS OF	(SQUARE FEET)	(MEALS SERVED)	(FTE'S)	
		FEET) 7.03	LAUNDRY) 8.00	9.00	10.00	11.00	
	GENERAL SERVICE COST CENTERS		0.00	1 7.00	10100		
2. 01 2. 02 2. 03 4. 00 5. 00 7. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP 00201 NEW CAP REL COSTS-MVBLE EQUIP MOB 00202 NEW CAP REL COSTS-MVBLE EQUIP-POB 00203 NEW CAP REL COSTS-MVBLE EQUIP- WJ 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00701 OPERATION OF PLANT-MOB						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	00702 OPERATI ON OF PLANT-POB 00703 OPERATI ON OF PLANT-WJ 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERI A	3, 300 0 0 0 0	40, 376 4, 720 1, 620	81, 094 2, 140 2, 055	30, 261 5 0	19, 549	7.02 7.03 8.00 9.00 10.00 11.00
14.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01600 MEDI CAL RECORDS & LI BRARY I NPATI ENT ROUTI NE SERVI CE COST CENTERS	000000000000000000000000000000000000000	0 0 0	1, 457 2, 020 1, 415	0 0	1, 362 227 929	13.00 14.00 16.00
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	0	9, 154	13, 385		2, 740 0	30.00 31.00
40.00	04000 SUBPROVIDER - IPF	0	2, 695	4, 636		1, 503	40.00
42.00	04100 SUBPROVI DER – I RF 04200 SUBPROVI DER	0	0	(0 0	41.00
	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	71	,		301	43.00
52.00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	9, 040 0	11, 935 127		1, 439 29	50.00 52.00
	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0	0 3, 480	6, 255	· · · ·	0 1, 443	53.00 54.00
	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0			0	57.00 58.00
59.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	0	(2,400		0 1, 463	59.00 60.00
60. 01	06001 BLOOD LABORATORY 06500 RESPI RATORY THERAPY	0	0	2, 100	0 0	0	60.01 65.00
66.00	06600 PHYSI CAL THERAPY	0	660	0		0	66.00
68.00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	0	0	(0 0	67.00 68.00
71.00	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	600 0	1, 000 (456 0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0	1, 110		0 536	
	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0	0			0	88.00
89.00	08900 FEDERALLY QUALI FI ED HEALTH CENTER 09000 CLI NI C	0	0	(4, 200		0 1, 048	89.00
90. 01	09001 FAMILY PRACTICE OF JAY COUNTY	0	0	5, 765		2, 514	90.01
91.00	09002 JAY FAMILY MEDICINE 09100 EMERGENCY	0	8, 336	4, 650		1, 628 1, 921	91.00
93.00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 04040 OTHER OUTPATI ENT SERVI CE COST CENTER	0	0		0	0	92.00 93.00
	OTHER REIMBURSABLE COST CENTERS 09910 CORF	0	0	(0	0	99.10
	SPECIAL PURPOSE COST CENTERS 10600 HEART ACQUI SI TI ON		0	· · · · · ·		0	106.00
109.00	10900 PANCREAS ACQUISITION	0	0	(0	109.00
111.00	11000 I NTESTI NAL ACQUI SI TI ON 11100 I SLET ACQUI SI TI ON	0	0	(111.00
113.00 118.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1-117)	0	40, 376	65, 863	3 30, 261	19, 539	113.00 118.00
	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	575	5 0	0	190.00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES 19300 NONPALD WORKERS	0	0	(0	192. 00 193. 00
194.00	07950 NOB 07951 P0B	0	0	8, 891 5, 765		0	194.00 194.01
194.02	07952 WEST JAY CLINIC	3, 300	0	5, 765		0	194. 02
	07953 OTHER NONREIMBURSABLE COST CENTERS 07954 OTHER NONREIMBURSABLE COST CENTERS	0	0				194. 03 194. 04
	07955 OTHER NONREIMBURSABLE COST CENTERS						194.05

Health Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	eu of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Period: From 10/01/2014	Worksheet B-1	
				To 09/30/2015	Date/Time Pre 2/17/2016 10:	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	PLANT-WJ	LINEN SERVICE	(SQUARE	(MEALS	(FTE'S)	
	(SQUARE	(POUNDS OF	FEET)	SERVED)		
	FEET)	LAUNDRY)				
	7.03	8.00	9.00	10.00	11.00	
194. 07 07957 HOSPI TALI ST	0	0		0 0	10	194.07
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	4, 770	122, 021	619, 29	7 634, 228	347, 706	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	1. 445455	3. 022117	7. 63678	0 20. 958594	17. 786383	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	26	10, 319	12, 23	2 49, 366	45, 226	204.00
205.00 Unit cost multiplier (Wkst. B, Part	0. 007879	0. 255573	0. 15083	7 1. 631341	2. 313469	205.00

	Financial Systems LOCATION - STATISTICAL BASIS	JAY COUNTY			CCN: 151320	Peri od	1:	u of Form Worksheet		52-10
							10/01/2014 09/30/2015			
	Cost Center Description	NURSI NG	CENT	RAL	MEDI CAL			2/17/2016	<u>5 10: 07</u>	am
	·	ADMI NI STRATI ON	SERVI (SUPI		RECORDS & LI BRARY					
		(DI RECT	(SUPPLY		(GROSS					
		NRSING FTE)	14	00	CHARGES)					
	GENERAL SERVICE COST CENTERS	13.00	14.	00	16.00					
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP									2.00
2.01 2.02	00201 NEW CAP REL COSTS-MVBLE EQUIP MOB 00202 NEW CAP REL COSTS-MVBLE EQUIP-POB									2.01 2.02
	00203 NEW CAP REL COSTS-MVBLE EQUIP- WJ									2.02
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT									4.00
5.00 7.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT									5.00 7.00
	00701 OPERATION OF PLANT-MOB									7.01
	00702 OPERATION OF PLANT-POB									7.02
	00703 OPERATION OF PLANT-WJ 00800 LAUNDRY & LINEN SERVICE									7.03 8.00
	00900 HOUSEKEEPING									9.00
10.00	01000 DI ETARY									0.00
		7.000								1.00
	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	7,933	2 3	254, 362						3.00 4.00
	01600 MEDICAL RECORDS & LI BRARY	0	2,2	2, 287		79				6.00
	INPATIENT ROUTINE SERVICE COST CENTERS	0.740				- 4				
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	2,740		105, 552 م	4, 479, 9	54				0.00 1.00
	04000 SUBPROVI DER – I PF	1, 503		10, 206	1, 535, 8	60				0.00
41.00	04100 SUBPROVI DER – I RF	0		0		0				1.00
	04200 SUBPROVI DER	0 301		0	124.0	0				2.00
	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	301		0	124, 8	12			43	3.00
50.00	05000 OPERATI NG ROOM	1, 439	(608, 935	12, 825, 8	86				0. 00
	05200 DELIVERY ROOM & LABOR ROOM	29		0	135, 9	46				2.00
	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0		0 134, 360	24, 990, 1	54				3.00 4.00
	05700 CT SCAN	0		0	21,770,1	0				7.00
	05800 MAGNETIC RESONANCE I MAGING (MRI)	0		0		0				8.00
	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	,	0 602, 790	16, 859, 2	40				9.00 0.00
	06001 BLOOD LABORATORY	0		002, 770	10,007,2	0				0.01
	06500 RESPI RATORY THERAPY	0		8, 090						5.00
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0		8, 922 0	2, 147, 5 380, 1					6.00 7.00
	06800 SPEECH PATHOLOGY	0		0	57, 1					8.00
69.00	06900 ELECTROCARDI OLOGY	0		31, 524					69	9.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0		0				1.00
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0		0 19, 405	3, 777, 5	57				2.00 3.00
	OUTPATIENT SERVICE COST CENTERS	-								
	08800 RURAL HEALTH CLINIC	0		0		0				8.00
	08900 FEDERALLY QUALI FIED HEALTH CENTER 09000 CLINIC	0		0 68, 798	290, 3	92				9.00 0.00
	09001 FAMILY PRACTICE OF JAY COUNTY	0		222, 759						0. 01
	09002 JAY FAMILY MEDICINE	0		219, 239						0.02
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 921		115, 023	6, 347, 3	04				1.00 2.00
	04040 OTHER OUTPATIENT SERVICE COST CENTER	0		0		0				3.00
	OTHER REIMBURSABLE COST CENTERS				1					
	09910 CORF SPECIAL PURPOSE COST CENTERS	0		0	1	0			99	9. 10
	10600 HEART ACQUI SI TI ON	0		0		0			106	6. 00
109.00	10900 PANCREAS ACQUISITION	0		0		0			109	9. 00
	11000 I NTESTI NAL ACQUI SI TI ON	0		0		0				0.00
	11100 I SLET ACQUI SI TI ON 11300 I NTEREST EXPENSE	0		0	1	U				1.00 3.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	7,933	2, 1	157, 890	77, 586, 1	79				8.00
	NONREI MBURSABLE COST CENTERS									0.05
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0		0		0				0.00 2.00
	19300 NONPALD WORKERS	0		0		o				3.00
10/ 00	07950 MOB	0		0		0				4.00
	07951 POB	0		0	1	0			194	4. 01
194.01				61 615		0			10/	
194. 01 194. 02	07952 07953 OTHER NONREIMBURSABLE COST CENTERS	0		61, 645 0		0 0				4. 02 4. 03
194. 01 194. 02 194. 03 194. 04	07952 WEST JAY CLINIC	0 0 0		61, 645 0 0		0 0 0			194 194	4. 02

Health Fin	ancial Systems	JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOC	ATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
					From 10/01/2014 To 09/30/2015	Date/Time Pre 2/17/2016 10:	pared: 07 am
	Cost Center Description	NURSI NG	CENTRAL	MEDI CAL			
		ADMI NI STRATI ON		RECORDS &			
			SUPPLY	LI BRARY			
		(DI RECT	(SUPPLY COST)	(GROSS			
		NRSING FTE)		CHARGES)			
		13.00	14.00	16.00			
194.06 079	56 TRI COUNTY	0	34, 411		0		194.06
194.07 079	57 HOSPI TALI ST	0	416	,	0		194.07
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1, 744, 268	267, 072	752, 44	1		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	219. 874953	0. 118469	0.00969	8		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	43, 387	44, 545	36, 08	86		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	5. 469179	0. 019759	0. 00046	5		205. 00

	inancial Systems TION OF RATIO OF COSTS TO CHARGES	JAY COUNTY		CCN: 151320	Peri od:	u of Form CMS- Worksheet C	
					From 10/01/2014 To 09/30/2015	Date/Time Pre	pared:
			T: 41			2/17/2016 10:	07 am
				e XVIII	Hospital Costs	Cost	
	Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
	Cost Center Description	(from Wkst. B,	Adj.		Di sal I owance		
		Part I, col.			broarronanoo		
		26)					
		1.00	2.00	3.00	4.00	5.00	
	NPATIENT ROUTINE SERVICE COST CENTERS	-	1				
	3000 ADULTS & PEDIATRICS	3, 977, 243		3, 977, 24			
	3100 I NTENSI VE CARE UNI T	0			0 0	-	
	4000 SUBPROVIDER - IPF	2, 396, 060		2, 396, 0			
	4100 SUBPROVI DER – I RF 4200 SUBPROVI DER	0			0 0	0	
	4300 NURSERY	476, 171		476, 1		-	
	NCI LLARY SERVI CE COST CENTERS	470,171		470, 1		476, 171	43.00
	5000 OPERATI NG ROOM	3, 419, 500		3, 419, 50	00 00	3, 419, 500	50.00
	5200 DELIVERY ROOM & LABOR ROOM	47, 118		47, 1			
	5300 ANESTHESI OLOGY	0		,.	0 0		
	5400 RADI OLOGY-DI AGNOSTI C	2, 777, 540		2, 777, 5	40 0	2, 777, 540	
	5700 CT SCAN	0			0 0	0	
58.00 0	5800 MAGNETIC RESONANCE IMAGING (MRI)	0			0 0	0	58.00
59.00 0	5900 CARDI AC CATHETERI ZATI ON	0			0 0	0	59.00
	6000 LABORATORY	2, 868, 782		2, 868, 7		2, 868, 782	
	6001 BLOOD LABORATORY	0			0 0	0	
	6500 RESPI RATORY THERAPY	467,089				467, 089	
	6600 PHYSI CAL THERAPY	815, 740		815, 7		815, 740	
	6700 OCCUPATIONAL THERAPY	139,067		139, 0		139,067	
	6800 SPEECH PATHOLOGY	33, 714		33, 7		33, 714	
	6900 ELECTROCARDI OLOGY 7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	594, 087		594, 08	87 0 0 0	594, 087 0	
	7200 IMPL. DEV. CHARGED TO PATIENTS	0			0 0		
	7300 DRUGS CHARGED TO PATIENTS	2,066,689		2,066,6			1
	UTPATIENT SERVICE COST CENTERS	2,000,007		2,000,00	0 / 0	2,000,009	/ 3. 00
	8800 RURAL HEALTH CLINIC	0			0 0	0	88. 00
	8900 FEDERALLY QUALIFIED HEALTH CENTER	0			0 0	0	
	9000 CLINIC	833, 314		833, 3	14 0	833, 314	90.00
90.01 0	9001 FAMILY PRACTICE OF JAY COUNTY	1, 473, 551		1, 473, 5	51 0	1, 473, 551	90.0
	9002 JAY FAMILY MEDICINE	1, 119, 963		1, 119, 90		1, 119, 963	90.02
	9100 EMERGENCY	2, 962, 631		2, 962, 6		2, 962, 631	
	9200 OBSERVATION BEDS (NON-DISTINCT PART)	129, 354		129, 3		129, 354	
	4040 OTHER OUTPATIENT SERVICE COST CENTER	0			0 0	0	93.00
	THER REIMBURSABLE COST CENTERS		1	1	0		00.40
	9910 CORF PECIAL PURPOSE COST CENTERS	0	1		0	0	99.10
	0600 HEART ACQUI SI TI ON	0	1		0	0	106. 00
	0900 PANCREAS ACQUISITION	0			0		100.00
	1000 I NTESTI NAL ACQUI SI TI ON				0		110.00
	1100 I SLET ACQUI SI TI ON	0			0		111.00
	1300 I NTEREST EXPENSE					l	113.00
200.00	Subtotal (see instructions)	26, 597, 613	0	26, 597, 6	13 0	26, 597, 613	
201.00	Less Observation Beds	129, 354		129, 3		129, 354	
	Total (see instructions)						

Heal th Financial Systems	JAY COUNTY		CON 151000		u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 151320	Period: From 10/01/2014 To 09/30/2015	Worksheet C Part I Date/Time Pre	epared:
		Ti +1	e XVIII	Hospi tal	2/17/2016 10: Cost	07 am
		Charges		позрі саі	COST	
Cost Center Description	I npati ent	Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent	
	6.00	7.00	8.00	9.00	Rati o 10.00	
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	9.00	10.00	
30. 00 03000 ADULTS & PEDI ATRI CS	4, 391, 825		4, 391, 82	25		30.00
31. 00 03100 I NTENSI VE CARE UNI T	0		.,,	0		31.00
40. 00 04000 SUBPROVI DER - I PF	1, 535, 860		1, 535, 80	50		40.00
41. 00 04100 SUBPROVI DER – I RF	0		.,,	0		41.00
42. 00 04200 SUBPROVI DER	0			0		42.00
43. 00 04300 NURSERY	124, 872		124, 8	72		43.00
ANCI LLARY SERVI CE COST CENTERS	·					
50. 00 05000 OPERATI NG ROOM	2, 404, 370	10, 421, 516	12, 825, 88	0. 266609	0.000000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	135, 946	0	135, 94	0. 346594	0. 000000	52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0.000000	0.000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 502, 041	23, 488, 113	24, 990, 15	54 0. 111145	0.000000	54.00
57.00 05700 CT SCAN	0	0		0 0.000000	0.000000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0.000000	0.000000	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0.000000	0.000000	59.00
60. 00 06000 LABORATORY	1, 969, 442	14, 889, 798	16, 859, 24	40 0. 170161	0.000000	60.00
60. 01 06001 BLOOD LABORATORY	0	0		0 0.000000	0.000000	60.01
65. 00 06500 RESPI RATORY THERAPY	561, 975	216, 416	778, 39	91 0. 600070	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	338, 197	1, 809, 372	2, 147, 50	69 0. 379843	0.000000	66.00
67.00 06700 OCCUPATIONAL THERAPY	167, 782	212, 394	380, 1		0.00000	67.00
68.00 06800 SPEECH PATHOLOGY	13, 915	43, 208	57, 12		0.00000	
69. 00 06900 ELECTROCARDI OLOGY	132, 279	1, 433, 411	1, 565, 69	0. 379441	0.00000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0. 000000	0. 000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0. 000000	0. 000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 313, 951	2, 463, 606	3, 777, 55	57 0. 547097	0.00000	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0		0		88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0		89.00
90. 00 09000 CLI NI C	29, 438	260, 954			0.000000	
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	0	863, 990			0.000000	
90. 02 09002 JAY FAMILY MEDICINE	0	426, 075			0.000000	
91.00 09100 EMERGENCY	229, 548	6, 117, 756			0.000000	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	88, 129			0.00000	
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0		0 0.000000	0.00000	93.00
OTHER REIMBURSABLE COST CENTERS			1	-		
99. 10 09910 CORF	0	0		0		99.10
SPECIAL PURPOSE COST CENTERS			1			1
106. 00 10600 HEART ACQUI SI TI ON	0	0		0		106.00
109.00 10900 PANCREAS ACQUI SI TI ON	0	0		0		109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0		0		110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		U		111.00
113.00 11300 INTEREST EXPENSE	14 051 444	(0 704 700		70		113.00
200.00Subtotal (see instructions)201.00Less Observation Beds	14, 851, 441	62, 734, 738	77, 586, 1	/9		200.00
	1 1		1			201.00
202.00 Total (see instructions)	14, 851, 441	62, 734, 738	77, 586, 1	70		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 151320 From 09/30/2015 To 09/30/2015 Worksheet C battor Ti to 09/30/2015 Cost Conter Description PPS Inpatient Ratio Title XVIII Hospital 0:00 2000 Apult S + PENALTINE SERVICE COST CENTERS 30.00 3000 Apult S + PENALTINE SERVICE COST CENTERS 30.00 31.00	Health Financial Systems		JAY COUNTY HOS	SPI TAL	In Lie	u of Form CMS-	2552-10
Intervent Intervent <t< td=""><td>COMPUTATION OF RATIO OF COSTS T</td><td>O CHARGES</td><td></td><td>Provider CCN: 151320</td><td></td><td></td><td></td></t<>	COMPUTATION OF RATIO OF COSTS T	O CHARGES		Provider CCN: 151320			
Cost Center Description PPS Inpatient Ratio Title XVIII Hospital Cost INPART ENT ROUTINE SERVICE COST CENTERS 30.00 350.00 350.00 350.00							pared:
Cost Center Description PPS Inpatient Ratio Inpatient Ratio 10 1000 33000 ADULTS & PEDIATRICS 330.00 330.00 3300, ADULTS & PEDIATRICS 11.00 330.00 40.00 10.00 3000 ADULTS & PEDIATRICS 30.00 31.00 330.00 11.00 11.00 40.00 11.00 40.00 41.00 10.00 3UBPROVIDER - IPF 41.00 10.00 04200 SUBPROVIDER 40.00 04200 SUBPROVIDER 40.00 04200 SUBPROVIDER 40.00 04200 SUBPROVIDER 40.00 04200 SUBPROVIDER 40.00 04200 DEFAITING ROM ACLILARY SERVICE COST CENTERS 50.00 05500 DEFAITING ROM 51.00 05400 RADIOLOGY 52.00 05400 RADIOLOGY 51.00 05400 RADIOLOGY 52.00 05400 CARDIOLOGY 51.00 05400 RADIOLOGY 51.00 05400 RADIOLOGY 51.00 05500 CARDIA CLOGY 51.00 05500 CARDIA CLOGY					lloonitol		07 am
Partio Partio 11.00 11.00 30.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 42.00 4	Cost Center Descrin	tion	PPS Innatient		Hospitai	Cost	
INPAT ENT ROUTINE SERVICE COST CENTERS 30.00 30.00 03000 ADULTS & PEDIATRICS 30.00 11.00 11.00 11.00 10.00 03000 ADULTS & PEDIATRICS 30.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 10.00 10.00 0.00 03000 ADULTS & PEDIATRICS 41.00 11.00 10.00 10.00 11.00 11.00 04200 SUBPROVIDER 43.00 10.00 05200 DEFAITIR ROM 0.266609 50.00 52.00 53.00 53.00 53.00 55.00 51.00 54.00 57.00 57.00 57.00 51.00 05000 AGULTS & ATTICKEN ZATION 0.000000 58.00 52.00 05000 CARDATCRY 0.000000 59.00 50.00 05000 CARDATCRY 0.000000 59.00	oust center bescrip						
30:00 03000 ADULTS & PEDIATRICS 30:00 30:00 03000 ADULTS & PEDIATRICS 31:00 30:00 100 KTENSI VE CARE UNIT 41:00 40:00 04000 SUBPROVIDER - IFF 41:00 41:00 04:00 SUBPROVIDER - IFF 41:00 43:00 04:00 SUBPROVIDER - IFF 41:00 40:00 04:00 SUBPROVIDER - IFF 43:00 40:00 04:00 SUBPROVIDER - IFF 43:00 40:00 04:00 SUBPROVIDER - IFF 43:00 40:00 04:00 OPERATINE ROOM 0.266:09 50:00 51:00 05:00 DELTERY ROOM 0.346:54 50:00 52:00 05:00 PEDIATRICE ROOM 0.266:09 50:00 51:00 05:00 DEGOC CARDIAC CATHERIZATION 0.000000 55:00 61:00 05:00 DEGOC ARDIAC CATHERE ZATION 0.000000 55:00 60:00 06:00 ARDIACRY 0.379843 66:00 60:00 06:00 OCHAROLANDIOLOCY 0.379							
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40.00 G4000 SUBPROVIDER - 1 (F 40.00 41.00 G4000 SUBPROVIDER - 1 (F 41.00 42.00 G4200 SUBPROVIDER - 1 (F 42.00 43.00 G4300 SUBPROVIDER - 1 (F 42.00 40.00 G4200 SUBPROVIDER - 1 (F 42.00 40.00 G4200 SUBPROVIDER - 1 (F 50.00 50.00 G5200 OFELORO (PERATING ROOM 0.266609 50.00 OFEDORO (PERATING ROOM 0.346594 55.00 51.00 OFEDORO (ALBORN TIC RESONANCE IMAGING (MRI) 0.000000 55.00 51.00 OFEDORO (ARDINCA CHIFTER LATION 0.000000 55.00 59.00 G6000 LABORATORY 0.000000 56.00 60.01 G6001 LABORATORY 0.000000 56.00 60.01 G6001 LABORATORY 0.379433 66.00 61.00 G6000 CEIPATIONAL THERAPY 0.379441 69.00 62.00 GEECTRCARD OLOGY 0.540000 71.00 73.00							
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50.00 05000 DELIVERY ROM & LABOR ROM 0.266609 50.00 52.00 05200 DELIVERY ROM & LABOR ROM 0.346594 52.00 53.00 05300 ANESTHESI OLOGY 0.000000 53.00 54.00 05400 (ROMOSTIC 0.111145 54.00 57.00 05700 (CT SCAN 0.000000 57.00 58.00 05800 (ARGNETIC RESONANCE IMAGING (MRI) 0.000000 58.00 59.00 0500 (CARDIAC CATHETERIZATION 0.000000 59.00 60.00 06000 (LABORATORY 0.000000 60.01 60.00 06000 PHYSICAL THERAPY 0.000000 60.01 65.00 06500 PHYSICAL THERAPY 0.365766 67.00 67.00 06700 OCUPATI ONAL THERAPY 0.365766 67.00 68.00 06800 SPEECH PATHOLOGY 0.337943 66.00 71.00 0700 OCUPATI ONAL THERAPY 0.379441 69.00 72.00 72.00 73.00 72.00 73.00 73.00 07000 DRUEAL SUPPLIES CHARED TO PATIENTS 0.46754 90.01 72.00 <td></td> <td>NTERC</td> <td></td> <td></td> <td></td> <td></td> <td>43.00</td>		NTERC					43.00
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89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 90.00 09000 CLINIC 2.869618 90.00 90.01 09001 FAMILY PRACTICE OF JAY COUNTY 1.705519 90.01 90.02 09002 JAY FAMILY MEDICINE 2.628558 90.02 91.00 09100 EMERGENCY 0.466754 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1.467780 92.00 93.00 O4040 OTHER OUTPATIENT SERVICE COST CENTER 0.000000 93.00 07HER REIMBURSABLE COST CENTERS 0.000000 93.00 99.10 09910 CORF 0.000000 99.10 99.10 O9910 CORF 0.000000 99.10 106.00 10600 HART ACQUISITION 106.00 109.00 10900 PANCREAS ACQUISITION 106.00 101.00 INTESTINAL ACQUISITION 110.00 111.00 ISLET ACQUISITION 110.00 111.00 ISLET ACQUISITION 113.00 113.00 INTEREST EXPENSE 200.00 200.00 Subtotal (see instructions)	OUTPATIENT SERVICE COST C	ENTERS					
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SPECIAL PURPOSE COST CENTERS 106.00 106.00 10600 HEART ACQUISITION 106.00 109.00 10900 PANCREAS ACQUISITION 109.00 110.00 11000 INTESTINAL ACQUISITION 109.00 111.00 INTESTINAL ACQUISITION 110.00 111.00 ISLET ACQUISITION 110.00 113.00 INTERST EXPENSE 113.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00		ENTERS					00 10
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201.00 Less Observation Beds 201.00		uctions)					
202.00 Total (see instructions) 202.00							201.00
	202.00 Total (see instruct	i ons)					202.00

	N OF RATIO OF COSTS TO CHARGES		Provider	CCN: 151320	Peri od:	Worksheet C	
					From 10/01/2014		
					To 09/30/2015		pared:
			Ti t	le XIX	Hospi tal	2/17/2016 10: Cost	<u>07 am</u>
					Costs	0031	
	Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
		(from Wkst. B,	Adj.		Di sal I owance		
		Part I, col.					
		<u>26)</u> 1.00	2.00	2.00	4.00	F 00	
	TI ENT ROUTI NE SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	-
	0 ADULTS & PEDIATRICS	3, 977, 243		3, 977, 2	43 0	3, 977, 243	30.00
	O INTENSIVE CARE UNIT	0		0,,,,,2	0 0		
40.00 0400	O SUBPROVI DER – I PF	2, 396, 060		2, 396, 0	60 0	2, 396, 060	40.00
41.00 0410	O SUBPROVI DER – I RF	0			0 0	0	41.00
	O SUBPROVI DER	0			0 0		
	O NURSERY	476, 171		476, 1	71 0	476, 171	43.00
	LLARY SERVICE COST CENTERS	0 440 500	1	0.440.5		0.440.500	-
	O OPERATING ROOM	3, 419, 500		3, 419, 50			
	0 DELIVERY ROOM & LABOR ROOM 0 ANESTHESIOLOGY	47, 118		47, 1			
	0 RADI OLOGY -DI AGNOSTI C	2, 777, 540		2, 777, 54	-	2, 777, 540	
	O CT SCAN	2,777,340		2, 111, 3	0 0	2,777,340	
	MAGNETIC RESONANCE IMAGING (MRI)	0			0 0		
	O CARDI AC CATHETERI ZATI ON	0			0 0		
60.00 0600	0 LABORATORY	2, 868, 782		2, 868, 7	82 0	2, 868, 782	60.00
	1 BLOOD LABORATORY	0			0 0	0	60.01
	O RESPI RATORY THERAPY	467, 089				467, 089	
	0 PHYSI CAL THERAPY	815, 740		815, 7,		815, 740	
	0 OCCUPATI ONAL THERAPY	139,067		139, 0		139, 067	1
	0 SPEECH PATHOLOGY 0 ELECTROCARDI OLOGY	33, 714 594, 087	0	33, 7		33, 714 594, 087	
	0 MEDICAL SUPPLIES CHARGED TO PATIENTS	594, 087		594, 08	0 0	594,087	
	0 IMPL. DEV. CHARGED TO PATIENTS	0			0 0		
	0 DRUGS CHARGED TO PATIENTS	2,066,689		2, 066, 6			
	ATIENT SERVICE COST CENTERS	2,000,007		2,000,0		2,000,007	1 101 00
88.00 0880	O RURAL HEALTH CLINIC	0			0 0	0	88. 00
	O FEDERALLY QUALIFIED HEALTH CENTER	0			0 0	0	
		833, 314		833, 3		833, 314	
	1 FAMILY PRACTICE OF JAY COUNTY	1, 473, 551		1, 473, 5		1, 473, 551	
	2 JAY FAMILY MEDICINE	1, 119, 963		1, 119, 90		1, 119, 963	
	0 EMERGENCY 0 OBSERVATION BEDS (NON-DISTINCT PART)	2, 962, 631 129, 354		2, 962, 6 129, 3		2, 962, 631 129, 354	
	0 OTHER OUTPATIENT SERVICE COST CENTER	129, 334		129, 3	0 0	129, 334	
	R REIMBURSABLE COST CENTERS	0	1	1	0 0	0	75.00
99.10 0991		0			0	0	99.10
SPEC	I AL PURPOSE COST CENTERS			•			1
	O HEART ACQUI SI TI ON	0			0		106.00
	O PANCREAS ACQUISITION	0			0		109.00
	O INTESTINAL ACQUISITION	0			0		110.00
	O I SLET ACQUI SI TI ON	0			0	0	111.00
200.00	0 INTEREST EXPENSE	24 507 412		24 507 4	13 0	24 507 412	113.00
200.00	Subtotal (see instructions) Less Observation Beds	26, 597, 613 129, 354		26, 597, 6 129, 3		26, 597, 613 129, 354	
	Total (see instructions)	26, 468, 259					

	ncial Systems OF RATIO OF COSTS TO CHARGES	JAY COUNTY		CCN: 151320	Peri od:	u of Form CMS- Worksheet C	2552-10
COMPUTATION	I OF RAILO OF CUSIS TO CHARGES		Provider	CCN. 151520	From 10/01/2014 To 09/30/2015	Part I Date/Time Pre	epared:
					llooni tal	2/17/2016 10:	07 am
			Charges	le XIX	Hospi tal	Cost	
	Cost Center Description	Inpatient	Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent	
						Ratio	
		6.00	7.00	8.00	9.00	10.00	
	TI ENT ROUTI NE SERVI CE COST CENTERS	4, 391, 825		4, 391, 8	25		30,00
	DINTENSIVE CARE UNIT	4, 391, 823		4, 391, 0	20		31.00
	SUBPROVIDER - IPF	1, 535, 860		1, 535, 8	60		40.00
	SUBPROVIDER - IRF	1, 555, 860		1, 000, 0	00		40.00
	D SUBPROVI DER	0			0		41.00
	D NURSERY	124, 872		124, 8	72		42.00
	LARY SERVICE COST CENTERS	124,072		124,0	72		40.00
	O OPERATI NG ROOM	2, 404, 370	10, 421, 516	12, 825, 8	86 0. 266609	0.00000	50.00
	D DELIVERY ROOM & LABOR ROOM	135, 946	0			0. 000000	
	D ANESTHESI OLOGY	0	0	100, 7	0 0.000000	0. 000000	
	D RADI OLOGY-DI AGNOSTI C	1, 502, 041	23, 488, 113	24, 990, 1		0. 000000	
	D CT SCAN	0	20, 100, 110		0 0.000000	0. 000000	
	MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0. 000000	0.000000	
59.00 05900	D CARDI AC CATHETERI ZATI ON	0	0		0 0. 000000	0.000000	
	DLABORATORY	1, 969, 442	14, 889, 798	16, 859, 2		0.000000	
	1 BLOOD LABORATORY	0	0		0 0. 000000	0.000000	
	D RESPI RATORY THERAPY	561, 975	216, 416	778, 3		0.000000	
	O PHYSI CAL THERAPY	338, 197	1, 809, 372			0.000000	
	O OCCUPATIONAL THERAPY	167, 782	212, 394			0.000000	
	SPEECH PATHOLOGY	13, 915	43, 208			0. 000000	
	ELECTROCARDI OLOGY	132, 279	1, 433, 411	1, 565, 6		0. 000000	
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0.000000	0. 000000	
	IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0.000000	0. 000000	
	D DRUGS CHARGED TO PATIENTS	1, 313, 951	2, 463, 606	3, 777, 5		0. 000000	
OUTPA	ATIENT SERVICE COST CENTERS						
88.00 08800	ORURAL HEALTH CLINIC	0	0	1	0 0.000000	0.00000	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0. 000000	0. 000000	89.00
		29, 438	260, 954	290, 3	92 2.869618	0. 000000	90.00
90.01 0900	1 FAMILY PRACTICE OF JAY COUNTY	0	863, 990	863, 9	90 1. 705519	0.000000	90.01
	2 JAY FAMILY MEDICINE	0	426, 075	426, 0	75 2.628558	0.000000	90.02
	DEMERGENCY	229, 548	6, 117, 756	6, 347, 3	0. 466754	0.000000	91.00
92.00 09200	O OBSERVATION BEDS (NON-DISTINCT PART)	0	88, 129	88, 1	29 1. 467780	0.000000	92.00
	O OTHER OUTPATIENT SERVICE COST CENTER	0	0		0 0.000000	0.000000	93.00
	R REIMBURSABLE COST CENTERS						
	D CORF	0	0		0		99.10
SPECI	AL PURPOSE COST CENTERS	r		1	1	-	
	DHEART ACQUISITION	0	0		0		106.00
	D PANCREAS ACQUISITION	0	0		0		109.00
	DINTESTINAL ACQUISITION	0	0		0		110.00
	DISLET ACQUISITION	0	0		0		111.00
	DINTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	14, 851, 441	62, 734, 738	77, 586, 1	79		200.00
201.00	Less Observation Beds						201.00
201.00	Total (see instructions)	14, 851, 441	62, 734, 738	77, 586, 1			202.00

Health Financial Systems	JAY COUNTY HOS	SPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 151320	Period: From 10/01/2014	Worksheet C Part I
			To 09/30/2015	Date/Time Prepared:
			lloonital	2/17/2016 10:07 am
Cost Center Description	PPS Inpatient	Title XIX	Hospital	Cost
cost center bescription	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
40. 00 04000 SUBPROVIDER – IPF				40.00
41. 00 04100 SUBPROVIDER – IRF				41.00
42. 00 04200 SUBPROVI DER				42.00
43. 00 04300 NURSERY				43.00
ANCI LLARY SERVI CE COST CENTERS				
50.00 05000 OPERATING ROOM	0.00000			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.00000			52.00
53. 00 05300 ANESTHESI OLOGY	0.00000			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0.000000			54.00
57.00 05700 CT SCAN	0. 000000			57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 59.00 05900 CARDIAC CATHETERIZATION	0. 000000			58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	0.000000			59.00 60.00
60. 01 06000 EABORATORY	0.000000			60.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0. 000000			88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000			89.00
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
91.00 09100 EMERGENCY	0. 000000			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.00000			92.00
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTER	0. 000000			93.00
OTHER REIMBURSABLE COST CENTERS				
99.10 09910 CORF				99.10
SPECIAL PURPOSE COST CENTERS 106.00 10600 HEART ACQUI SI TI ON				106.00
109. 00 10900 PANCREAS ACQUISITION				109.00
110. 00 110900 PANCREAS ACCOTSTITION 110. 00 11000 I NTESTI NAL ACQUI SI TI ON				110, 00
111. 00 11100 I SLET ACQUI SI TI ON				111.00
113. 00 11300 I NTEREST EXPENSE				113.00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201.00
202.00 Total (see instructions)				202.00

Health Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der	CCN: 151320	Peri od:	Worksheet D	
				From 10/01/2014		
				To 09/30/2015	Date/Time Pre 2/17/2016 10:	pared:
		Ti †I	e XVIII	Hospi tal	2/1//2018 10: Cost	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,				column 4)	
	Part II, col.	8)	2)	5	· · · ·	
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	÷	•	•		•	
50.00 05000 OPERATING ROOM	239, 901	12, 825, 886	0. 01870	512, 614	9, 588	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	3, 180	135, 946	0. 02339	92 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0.0000	0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	164, 069	24, 990, 154	0.00656	55 440, 399	2, 891	54.00
57.00 05700 CT SCAN	0	0	0.0000	0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.0000	0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0.0000	0 0	0	59.00
60. 00 06000 LABORATORY	88, 162	16, 859, 240	0.00522	624, 302	3, 264	60.00
60.01 06001 BLOOD LABORATORY	0	0	0.0000	0 0	0	60. 01
65. 00 06500 RESPI RATORY THERAPY	8, 964	778, 391	0. 0115	16 187, 080	2, 154	65.00
66. 00 06600 PHYSI CAL THERAPY	5, 735	2, 147, 569	0.0026	70 87, 012	232	66.00
67.00 06700 OCCUPATI ONAL THERAPY	928	380, 176	0.00244	41 30, 447	74	67.00
68.00 06800 SPEECH PATHOLOGY	211	57, 123	0.00369	2, 546	9	68.00
69.00 06900 ELECTROCARDI OLOGY	26, 763	1, 565, 690	0. 0170	93 109, 301	1, 868	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.0000	0 00	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.0000	0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	37, 958	3, 777, 557	0. 01004	48 316, 753	3, 183	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	0.0000	0 0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.0000		0	89.00
90. 00 09000 CLINIC	96, 870				1, 686	90.00
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	78, 475	863, 990	0. 09082	29 0	0	90.01
90. 02 09002 JAY FAMILY MEDICINE	14, 178			76 0	0	90. 02
91.00 09100 EMERGENCY	133, 617	6, 347, 304	0. 0210	51 19, 750	416	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	14,040	88, 129			0	92.00
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.0000	0 0	0	93.00
200.00 Total (lines 50-199)	913, 051	71, 533, 622		2, 335, 258	25, 365	200.00

Health Financial Systems	JAY COUNTY H	IOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PASS		CCN: 151320	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part IV Date/Time Pre 2/17/2016 10:	
			e XVIII	Hospi tal	Cost	
Cost Center Description	Non Physician Nu	ursing School	Allied Healt		Total Cost	
	Anesthetist			Medi cal	(sum of col 1	
	Cost			Education Cost	5	
					4)	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1 1		L		L	
50.00 05000 OPERATI NG ROOM	0	0		0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
53.00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
57.00 05700 CT SCAN	0	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
60.01 06001 BLOOD LABORATORY	0	0		0 0	0	60. 01
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	89.00
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
91.00 09100 EMERGENCY	0	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 0	0	92.00
93.00 04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0		0 0	0	93.00
200.00 Total (lines 50-199)	0	0		0 0	0	200.00

Health Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PAS	S Provi der		Peri od:	Worksheet D	
THROUGH COSTS				From 10/01/2014	Part IV	
				To 09/30/2015	Date/Time Pre 2/17/2016 10:	
		Titl	e XVIII	Hospi tal	Cost	
Cost Center Description	Total	Total Charges			Inpati ent	
	Outpati ent	(from Wkst. C,	to Charges	Ratio of Cost	Program	
	Cost (sum of	Part I, col.	(col. 5 ÷ col	. to Charges	Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)			7)		
	6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVI CE COST CENTERS	1	1	1	-	-	
50.00 05000 OPERATI NG ROOM	0	,,			512, 614	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	135, 946				52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0.00000			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	24, 990, 154				54.00
57.00 05700 CT SCAN	0	0	0.00000			57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.00000			58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0.00000			59.00
60. 00 06000 LABORATORY	0	16, 859, 240				60.00
60.01 06001 BLOOD LABORATORY	0	0	0.00000	0 0. 000000	0	60. 01
65. 00 06500 RESPI RATORY THERAPY	0	778, 391	0.00000	0 0.000000	187, 080	65.00
66. 00 06600 PHYSI CAL THERAPY	0	2, 147, 569	0.00000	0 0.000000	87, 012	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	380, 176	0.00000	0 0.000000	30, 447	67.00
68.00 06800 SPEECH PATHOLOGY	0	57, 123	0.00000	0 0.000000	2, 546	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	1, 565, 690	0. 00000	0.000000	109, 301	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0. 00000	0.000000	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0. 00000	0.000000	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	3, 777, 557	0.00000	0 0.000000	316, 753	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	0.00000	0 0.000000	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.00000	0 0.000000	0	89.00
90. 00 09000 CLINIC	0	290, 392	0.00000	0 0.000000	5, 054	90.00
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	0	863, 990		0 0.000000	0	90.01
90. 02 09002 JAY FAMILY MEDICINE	0	426, 075				90.02
91.00 09100 EMERGENCY	0	6, 347, 304				
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	88, 129	0.00000			92.00
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.00000	0 0. 000000	0	93.00
200.00 Total (lines 50-199)	0	71, 533, 622			2, 335, 258	200.00

Health Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	eu of Form CMS-2552-1
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PASS	Provi der	CCN: 151320	Period: From 10/01/2014 To 09/30/2015	
		Ti tl	e XVIII	Hospi tal	Cost
Cost Center Description	Inpatient	Outpati ent	Outpati ent		
	Program	Program	Program		
	Pass-Through	Charges	Pass-Throug	h	
	Costs (col. 8		Costs (col.	9	
	x col. 10)		x col. 12)		
	11.00	12.00	13.00		
ANCI LLARY SERVI CE COST CENTERS	-		1	1	
50. 00 05000 OPERATI NG ROOM	0	0		0	50.0
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	52.0
53. 00 05300 ANESTHESI OLOGY	0	0		0	53.0
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	54.0
57.00 05700 CT SCAN	0	0		0	57.0
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0	58.0
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0	59.0
60. 00 06000 LABORATORY	0	0		0	60.0
60. 01 06001 BLOOD LABORATORY	0	0		0	60. 0
65. 00 06500 RESPI RATORY THERAPY	0	0		0	65.0
66. 00 06600 PHYSI CAL THERAPY	0	0		0	66. 0
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0	67.0
68.00 06800 SPEECH PATHOLOGY	0	0		0	68.0
69.00 06900 ELECTROCARDI OLOGY	0	0		0	69.0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	71.0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	72.0
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	73.0
OUTPATIENT SERVICE COST CENTERS			1		
88.00 08800 RURAL HEALTH CLINIC	0	0		0	88.0
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	89.0
	0	0		0	90.0
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY	0	0		0	90.0
90. 02 09002 JAY FAMILY MEDICINE	0	0	1	0	90. 0 91. 0
91.00 09100 EMERGENCY	0	0	1	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 93.00 04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0		0	92. 0 93. 0
200.00 Total (lines 50-199)	0	0 0		0	200. 0
200.00 10tal (11185 30-199)	I U	0	1	U	1200. 0

APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	CCN: 151320	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part V Date/Time Pre 2/17/2016 10:	pared: 07 am
			Ti tl	e XVIII	Hospi tal	Cost	
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	·	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins			
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0. 266609		2, 304, 79	04 0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 346594	0		0 0	0	52.00
53.00	05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 111145	0	6, 162, 42	20 0	0	54.00
57.00	05700 CT SCAN	0. 000000	0		0 0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0 0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59.00
60.00	06000 LABORATORY	0. 170161	0	4, 679, 22	28 0	0	60.00
60. 01	06001 BLOOD LABORATORY	0. 000000	0		0 0	0	60.01
65.00	06500 RESPI RATORY THERAPY	0. 600070	0	32, 65	51 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 379843	0	485, 56	0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 365796	0	37, 20	01 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0. 590200	0	10, 39	06 0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0. 379441	0	606, 13	36 0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 547097	0	886, 18	52, 966	0	73.00
	OUTPATIENT SERVICE COST CENTERS		•	•			1
88.00	08800 RURAL HEALTH CLINIC	0. 000000				0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	89.00
90.00	09000 CLI NI C	2.869618	0	38, 34	16, 857	0	90.00
90.01	09001 FAMILY PRACTICE OF JAY COUNTY	1. 705519	0	91, 10		0	90.01
90.02	09002 JAY FAMILY MEDICINE	2. 628558	0	116, 01	4 0	0	90.02
91.00	09100 EMERGENCY	0. 466754	0	1, 033, 75	0 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 467780	0			0	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0. 000000	0		0 0	0	93.00
200.00	Subtotal (see instructions)		0	16, 512, 26	69, 823	0	200.00
201.00	Less PBP Clinic Lab. Services-Program				0 0		201.00
	Only Charges						
202.00	Net Charges (line 200 +/- line 201)	1	0	16, 512, 26	69, 823	0	202.00

Health Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS	-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provi der	CCN: 151320	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part V Date/Time Pr 2/17/2016 10	
		Ti tl	e XVIII	Hospi tal	Cost	
	Cos	sts		· · · · · · · · · · · · · · · · · · ·		
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)	4			
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS						
50.00 O5000 OPERATING ROOM	614, 479					50.00
52.00 O5200 DELIVERY ROOM & LABOR ROOM	0	-				52.00
53.00 05300 ANESTHESI OLOGY	0	C				53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	684, 922					54.00
57.00 05700 CT SCAN	0	C				57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	C				59.00
60. 00 06000 LABORATORY	796, 222	C				60.00
60.01 06001 BLOOD LABORATORY	0	C				60. 01
65. 00 06500 RESPI RATORY THERAPY	19, 593					65.00
66. 00 06600 PHYSI CAL THERAPY	184, 437		1			66.00
67.00 06700 OCCUPATI ONAL THERAPY	13, 608					67.00
68.00 06800 SPEECH PATHOLOGY	6, 136					68.00
69. 00 06900 ELECTROCARDI OLOGY	229, 993					69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	-				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	484, 826	28, 978	8			73.00
OUTPATIENT SERVICE COST CENTERS			1			-
88.00 08800 RURAL HEALTH CLINIC	0		•			88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0					89.00
90. 00 09000 CLINIC	110, 024					90.00
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY	155, 376					90.01
90. 02 09002 JAY FAMILY MEDICINE	304, 950					90.02
91.00 09100 EMERGENCY	482, 507					91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	41, 824		•			92.00
93.00 04040 OTHER OUTPATIENT SERVICE COST CENTER	0					93.00
200.00 Subtotal (see instructions)	4, 128, 897	77, 351				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges	4 400 007					
202.00 Net Charges (line 200 +/- line 201)	4, 128, 897	77, 351				202.00

Health Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der	CCN: 151320	Peri od:	Worksheet D	
		Componen	t CCN: 15M320	From 10/01/2014 To 09/30/2015	Part II Date/Time Pre	narod
		componen	L CON. 1510520	10 09/ 30/ 2013	2/17/2016 10:	
		Ti tl	e XVIII	Subprovider -	PPS	
	T			I PF		
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,			(column 3 x	
	(from Wkst. B,		(col. 1 ÷ co	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATING ROOM	239, 901	12, 825, 886	0.0187	29	1	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	3, 180				0	52.00
53. 00 05300 ANESTHESI OLOGY	3,100		0.0000		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	164, 069				609	
57. 00 05700 CT SCAN	0		0.0000		0	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0.0000		0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	c c	0.0000		0	59.00
60. 00 06000 LABORATORY	88, 162	16, 859, 240			978	60.00
60. 01 06001 BLOOD LABORATORY	0	C	0.0000	0 00	0	60.01
65. 00 06500 RESPI RATORY THERAPY	8, 964	778, 391	0. 0115	16 50, 278	579	65.00
66. 00 06600 PHYSI CAL THERAPY	5, 735	2, 147, 569	0.0026	70 35, 305	94	66.00
67.00 06700 OCCUPATI ONAL THERAPY	928	380, 176	0.0024	41 14, 447	35	67.00
68.00 06800 SPEECH PATHOLOGY	211	57, 123			21	68.00
69. 00 06900 ELECTROCARDI OLOGY	26, 763	1, 565, 690			282	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C			0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C	0.0000		0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	37, 958	3, 777, 557	0.0100	48 264, 169	2, 654	73.00
OUTPATIENT SERVICE COST CENTERS	-	-			-	
88.00 08800 RURAL HEALTH CLINIC	0	C			-	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0.0000		0	
	96, 870				7, 813	
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY	78, 475				0	90.01
90. 02 09002 JAY FAMILY MEDICINE 91. 00 09100 EMERGENCY	14, 178				0 160	90.02 91.00
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	133, 617				001	
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTER					0	
200.00 Total (lines 50-199)	899,011			697, 276	-	
200.00 [10tal (11165 30-177)	077,011	/1, 555, 622	1	077,270	13, 220	200.00

Health Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	S Provi der	CCN: 151320	Peri od:	Worksheet D	
THROUGH COSTS		Component	t CCN: 15M320	From 10/01/2014 To 09/30/2015		narod
		component	L CON. 1510520	10 09/ 30/ 2013	2/17/2016 10:	
		Ti tl	e XVIII	Subprovider -	PPS	
				I PF		
Cost Center Description	Non Physician	Nursing School	Allied Healt		Total Cost	
	Anesthetist			Medi cal	(sum of col 1	
	Cost			Education Cost	through col. 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	0.00	1.00	0.00	
50. 00 05000 OPERATI NG ROOM	0	C)	0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C)	0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	C		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0 0	0	54.00
57.00 05700 CT SCAN	0	C		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
60.01 06001 BLOOD LABORATORY	0	0		0 0	0	60. 01
65. 00 06500 RESPI RATORY THERAPY	0	C		0 0	0	65.00
66.00 06600 PHYSI CAL THERAPY	0	C		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	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 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
73. 00 07300 DRUGS CHARGED TO PATI ENTS OUTPATI ENT SERVI CE COST CENTERS	0	U	1	0 0	0	/3.00
88.00 08800 RURAL HEALTH CLINIC	0	0	1	0 0	0	88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0			0	89.00
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
91. 00 09100 EMERGENCY	0	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	C		0 0	0	92.00
93.00 04040 OTHER OUTPATIENT SERVICE COST CENTER	0	C)	0 0	0	93.00
200.00 Total (lines 50-199)	0	C		0 0	0	200. 00

Health Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PAS	S Provider		Period:	Worksheet D	
THROUGH COSTS		Componen		From 10/01/2014 To 09/30/2015		narod
		component	CCN. 1510520	10 077 307 2013	2/17/2016 10:	
		Ti tl	e XVIII	Subprovider -	PPS	
				I PF		
Cost Center Description	Total	Total Charges			Inpati ent	
	Outpati ent	(from Wkst. C,		Ratio of Cost		
	Cost (sum of	Part I, col.			Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col. 7)		
	4)	7.00	8,00	9.00	10.00	
ANCI LLARY SERVI CE COST CENTERS	0.00	7.00	0.00	9.00	10.00	
50. 00 05000 OPERATING ROOM	0	12, 825, 886	0.0000	0.00000	29	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	135, 946				
53. 00 05300 ANESTHESI OLOGY	0		0.00000			
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0	24, 990, 154				
57. 00 05700 CT SCAN	0	21,770,101	0.00000			•
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0.00000			
59. 00 05900 CARDI AC CATHETERI ZATI ON	0		0.00000			
60. 00 06000 LABORATORY	0	16, 859, 240				60.00
60. 01 06001 BLOOD LABORATORY	0	C	0.00000	0.00000		
65. 00 06500 RESPI RATORY THERAPY	0	778, 391	0.00000	0.00000	50, 278	65.00
66. 00 06600 PHYSI CAL THERAPY	0	2, 147, 569	0. 00000	0. 000000	35, 305	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	380, 176	0. 00000	0. 000000	14, 447	67.00
68.00 06800 SPEECH PATHOLOGY	0	57, 123	0.00000	0.00000	5, 694	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	1, 565, 690				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C				
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C	0.00000			
73.00 07300 DRUGS CHARGED TO PATIENTS	0	3, 777, 557	0.00000	0.00000	264, 169	73.00
OUTPATIENT SERVICE COST CENTERS		I				
88.00 08800 RURAL HEALTH CLINIC	0	C				
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C	0.00000			
90. 00 09000 CLINIC	0	290, 392				
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	0	863, 990				
90. 02 09002 JAY FAMILY MEDICINE	0	426, 075				10.02
91.00 09100 EMERGENCY	0	6, 347, 304				
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	88, 129				
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTER	0	C	0.00000	0.00000		
200.00 Total (lines 50-199)	0	71, 533, 622			697, 276	1200. OO

Health Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS-	-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI	RVICE OTHER PASS	Provi der	CCN: 151320	Peri od:	Worksheet D	
THROUGH COSTS		Componen	t CCN: 15M320	From 10/01/2014 To 09/30/2015		onarod
		componen	L CCN. 1510320	10 097 307 2013	2/17/2016 10	epareu. :07 am
		Titl	e XVIII	Subprovider -	PPS	
				IPF		
Cost Center Description	Inpati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Throug			
	Costs (col. 8		Costs (col.	9		
	x col. 10) 11.00	12.00	x col. 12) 13.00			
ANCI LLARY SERVI CE COST CENTERS	11.00	12.00	13.00			
50. 00 05000 OPERATI NG ROOM	0	0		0		50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0		52.00
53. 00 05300 ANESTHESI OLOGY	0	C		0		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0		54.00
57. 00 05700 CT SCAN	0	C		0		57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	C		0		58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	C		0		59.00
60. 00 06000 LABORATORY	0	C		0		60.00
60. 01 06001 BLOOD LABORATORY	0	C		0		60.01
65. 00 06500 RESPI RATORY THERAPY	0	C		0		65.00
66. 00 06600 PHYSI CAL THERAPY	0	C		0		66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	C		0		67.00
68.00 06800 SPEECH PATHOLOGY	0	C		0		68.00
69. 00 06900 ELECTROCARDI OLOGY	0	C		0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C		0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C)	0		73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	C)	0		88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C		0		89.00
90. 00 09000 CLI NI C	0	C)	0		90.00
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY	0	C		0		90.01
90. 02 09002 JAY FAMILY MEDICINE	0	C		0		90.02
91.00 09100 EMERGENCY	0	C		0		91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0	C		0		92.00
93.00 04040 OTHER OUTPATIENT SERVICE COST CENTER	0	C		0		93.00
200.00 Total (lines 50-199)	0	C	9	0		200.00

Health Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der		Period:	Worksheet D	
		Component		From 10/01/2014 To 09/30/2015	Part V Date/Time Pre	narod
		component	CON. 152520	10 09/30/2015	2/17/2016 10:	07 am
		Ti tl	e XVIII S	Swing Beds - SNF		
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATING ROOM	0. 266609	0		0 0	-	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 346594	0		0 0	0	
53. 00 05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 111145	0		0 0	0	54.00
57.00 05700 CT SCAN	0. 000000	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59.00
60. 00 06000 LABORATORY	0. 170161	0		0 0	0	60.00
60. 01 06001 BLOOD LABORATORY	0. 000000	0		0 0	0	60.01
65. 00 06500 RESPI RATORY THERAPY	0. 600070	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 379843	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 365796	0		0 0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 590200	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 379441	0		0 0	0	69.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0. 000000	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0		0 0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 547097	0		0 0	0	73.00
0UTPATI ENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC	0. 000000				0	88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	88.00
90. 00 09000 CLINIC	2. 869618	0		0 0	0	90.00
90.00 09000 CETNIC 90.01 09001 FAMILY PRACTICE OF JAY COUNTY	1. 705519	0		0 0	0	90.00
90.02 09002 JAY FAMILY MEDICINE	2. 628558	0		0 0	0	90.01
91. 00 09100 EMERGENCY	0. 466754	0		0 0	0	90.02
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 467780	0		0 0	0	
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTER	0. 000000	0		0 0	0	
200.00 Subtotal (see instructions)	0.000000	0			-	200.00
201.00 Less PBP Clinic Lab. Services-Program		0			0	200.00
Only Charges						201.00
202.00 Net Charges (line 200 +/- line 201)		0		o o	0	202.00
	1 I	0	I	-1 0	0	

Health Financial Systems	JAY COUNTY	HOSPI TAL		. In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	CCN: 151320	Period:	Worksheet D	
		0	000 457000	From 10/01/2014	Part V	
		Componen	t CCN: 15Z320	To 09/30/2015	Date/Time Pre 2/17/2016 10:	epared:
		Ti †I	e XVIII	Swing Beds - SNF		
	Cos			Jowning Deus Juli	0031	
Cost Center Description	Cost	Cost	1			
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00	1			
ANCI LLARY SERVICE COST CENTERS		•				
50. 00 05000 OPERATI NG ROOM	0	C				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C C				52.00
53. 00 05300 ANESTHESI OLOGY	0	C C				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	l c				54.00
57.00 05700 CT SCAN	0	l c				57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	l c				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	l c				59.00
60. 00 06000 LABORATORY	0					60,00
60. 01 06001 BLOOD LABORATORY	0					60.01
65. 00 06500 RESPIRATORY THERAPY	0					65.00
66. 00 06600 PHYSI CAL THERAPY	0					66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0		1			67.00
68. 00 06800 SPEECH PATHOLOGY	0					68.00
69. 00 06900 ELECTROCARDI OLOGY	0					69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0					71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	-				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0		•			73.00
OUTPATIENT SERVICE COST CENTERS	0		1			/ 3. 00
88. 00 08800 RURAL HEALTH CLINIC	0	C				88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0					89.00
90. 00 09000 CLINIC	0					90.00
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY	0					90.01
90. 02 09002 JAY FAMILY MEDICINE						90.01
91. 00 09100 EMERGENCY						91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTER						93.00
200.00 Subtotal (see instructions)						200.00
201.00 Less PBP Clinic Lab. Services-Program						200.00
Only Charges						201.00
202.00 Net Charges (line 200 +/- line 201)	0	c				202.00
			Т			1-02.00

	Financial Systems JAY COUNTY HOS TATION OF INPATIENT OPERATING COST	Provi der CCN: 151320	Peri od: From 10/01/2014	u of Form CMS-2 Worksheet D-1	_JJZ
			To 09/30/2015	Date/Time Prep 2/17/2016 10:0	
	Cost Center Description	Title XVIII	Hospi tal	Cost	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
00 00	Inpatient days (including private room days and swing-bed days)			2,641	1
00	Inpatient days (including private room days, excluding swing-be Private room days (excluding swing-bed and observation bed days		ivate room days,	2, 127 0	
	do not complete this line.		J .		
00 00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private room		er 31 of the cost	2, 042 121	4
00	reporting period	5.		121	
00	Total swing-bed SNF type inpatient days (including private room	m days) after December	31 of the cost	363	6
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	davs) through December	31 of the cost	8	5
	reporting period	5			
00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after December 3	1 of the cost	22	8
00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	839	9
	newborn days)				
. 00	Swing-bed SNF type inpatient days applicable to title XVIII on through December 31 of the cost reporting period (see instruct		oom days)	0	10
. 00	Swing-bed SNF type inpatient days applicable to title XVIII on	ly (including private r	oom days) after	276	11
. 00	December 31 of the cost reporting period (if calendar year, en Swing-bed NF type inpatient days applicable to titles V or XIX		a room dave)	0	12
. 00	through December 31 of the cost reporting period	only (including privat	e room days)	0	14
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13
. 00	after December 31 of the cost reporting period (if calendar year Medically necessary private room days applicable to the Program			0	14
	Total nursery days (title V or XIX only)	iii (exci ddi ng swi ng-bed	uays	0	
	Nursery days (title V or XIX only)			0	16
00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service:	s through December 31 c	of the cost		17
. 00	reporting period	s through becchiber of t			
. 00	Medicare rate for swing-bed SNF services applicable to services reporting period	s after December 31 of	the cost		18
. 00	Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	126.36	19
. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	126.36	20
	reporting period	、			
	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December		ing period (line	3, 977, 243 0	21
. 00	5 x line 17)		ing period (inte	0	
. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportir	ng period (line 6	0	23
. 00	x line 18) Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	1, 011	24
00	7 x line 19)	1 of the east reporting	namind (line 0	2 700	2
. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	i oi the cost reporting	period (inne 8	2, 780	23
. 00	Total swing-bed cost (see instructions)			740, 347	
. 00	General inpatient routine service cost net of swing-bed cost (PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	line 21 minus line 26)		3, 236, 896	27
. 00	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	28
. 00	Private room charges (excluding swing-bed charges)		0	0	29
. 00	Semi-private room charges (excluding swing-bed charges)			0	30
. 00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0.000000	
. 00 . 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00	
. 00	Average per diem private room charge differential (line 32 minute)	us line 33)(see instruc	tions)	0.00	
. 00	Average per diem private room cost differential (line 34 x line			0.00	
. 00	Private room cost differential adjustment (line 3 x line 35)	,		0	36
. 00	General inpatient routine service cost net of swing-bed cost an	nd private room cost di	fferential (line	3, 236, 896	37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS	STMENTS			
	Adjusted general inpatient routine service cost per diem (see			1, 521. 81	
. 00		38)		1, 521. 81 1, 276, 799 0	39

OMPUT	ATION OF INPATIENT OPERATING COST		Provi der	CCN: 151320	Period: From 10/01/2014	Worksheet D-1	l
					To 09/30/2015		
			Ti †I	e XVIII	Hospi tal	2/17/2016 10: Cost	07 a
	Cost Center Description	Total	Total	Average Per		Program Cost	
		Inpatient Costl	npatient Days		÷	(col. 3 x col.	
		1.00	2.00	col . 2) 3.00	4.00	4)	
2.00	NURSERY (title V & XIX only)	0	2.00				42
	Intensive Care Type Inpatient Hospital Units						
. 00	INTENSIVE CARE UNIT	0	C	0.	0 00	0	
. 00	CORONARY CARE UNI T BURN INTENSIVE CARE UNI T						44
	SURGI CAL I NTENSI VE CARE UNI T						40
	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description					1.00	_
. 00	Program inpatient ancillary service cost (Wk	st D-3 col 3	line 200)			1.00	48
. 00	Total Program inpatient costs (sum of lines			ons)		1, 965, 088	
	PASS THROUGH COST ADJUSTMENTS						
. 00	Pass through costs applicable to Program inpa	atient routine s	services (from	n Wkst. D, sur	n of Parts I and	0	50
. 00	<pre>III) Pass through costs applicable to Program inpa</pre>	atient ancillary	v services (fr	om Wkst D «	sum of Parts II	0	51.
. 50	and IV)		, 30, 7, 663 (11	O_{ii} $M_{ii}O_{i}$ D_{i} O_{i}		l	
. 00	Total Program excludable cost (sum of lines !					0	
3.00	Total Program inpatient operating cost exclud		ated, non-phy	vsician anestl	netist, and	0	53
	medical education costs (line 49 minus line 5 TARGET AMOUNT AND LIMIT COMPUTATION	(۷۷					1
. 00	Program di scharges					0	54
. 00	Target amount per discharge					0.00	
. 00	Target amount (line 54 x line 55)					0	
. 00	Difference between adjusted inpatient operati Bonus payment (see instructions)	ing cost and tar	rget amount (I	ine 56 minus	line 53)	0	
. 00	Lesser of lines 53/54 or 55 from the cost rep	porting period e	endina 1996, u	updated and co	ompounded by the		
	market basket	51	5 ,				
0.00	Lesser of lines 53/54 or 55 from prior year of					0.00	
. 00	If line 53/54 is less than the lower of lines which operating costs (line 53) are less than					0	61
	amount (line 56), otherwise enter zero (see i		3 (TTTES 54 X	00), 01 1/0	the target		
	Relief payment (see instructions)					0	
. 00	Allowable Inpatient cost plus incentive payme	ent (see instruc	ctions)			0	63
. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost	ts through Decer	mber 31 of the	e cost reporti	na period (See	0	64
	instructions) (title XVIII only)	to the ought boool		, obser i opor ei	ng poir ou (oco		
. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	er 31 of the c	ost reporting	g period (See	420, 020	65
. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routin	no coste (lino d	64 plus lipo 6	5) (+i +l o V/II	Lonly) For	420, 020	66
5. 00	CAH (see instructions)		54 prus rine c	5)(title xvi	i oniy). Toi	420, 020	/ 00
7.00	Title V or XIX swing-bed NF inpatient routine	e costs through	December 31 c	of the cost re	eporting period	0	67
	(line 12 x line 19)	C t D		****			
3. 00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	e costs arter De	ecemper 31 or	the cost repo	orting period	0	68
9.00	Total title V or XIX swing-bed NF inpatient	routine costs (I	ine 67 + line	e 68)		0	69
	PART III - SKILLED NURSING FACILITY, OTHER NU						
). 00 . 00	Skilled nursing facility/other nursing facili	5)		70
. 00	Adjusted general inpatient routine service co Program routine service cost (line 9 x line		ne /o ÷ i i ne	2)			72
. 00	Medically necessary private room cost applica		(line 14 x li	ne 35)			73
. 00	Total Program general inpatient routine servi						74
. 00	Capital-related cost allocated to inpatient	routine service	costs (from W	lorksheet B, I	Part II, column		75
. 00	26, line 45) Per diem capital-related costs (line 75 ÷ lin	ne 2)				1	76
. 00	Program capital -related costs (line 9 x line					1	77
. 00	Inpatient routine service cost (line 74 minus						78
00	Aggregate charges to beneficiaries for excess	· ·		,	Nuc Line 70)	l .	79
. 00 . 00	Total Program routine service costs for compa Inpatient routine service cost per diem limit		JST THE TATION	ι (IIIe /ၓ MII	ius IIIIe /9)	1	80
. 00	Inpatient routine service cost limitation (li)			1	82
. 00	Reasonable inpatient routine service costs (see instructions					83
. 00	Program inpatient ancillary services (see ins		>				84
	Utilization review - physician compensation					1	85
. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		ougn 65)			L	1 00
7.00	Total observation bed days (see instructions)					85	
3. 00	Adjusted general inpatient routine cost per o	diem (line 27 ÷	line 2)			1, 521. 81	88
	Observation bed cost (line 87 x line 88) (see	A 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				129, 354	

Health Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period:	Worksheet D-1	
				From 10/01/2014 To 09/30/2015	Date/Time Pre 2/17/2016 10:	pared: 07 am
		Titl	e XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	351, 326	3, 236, 896	0. 10853	8 129, 354	14, 040	90.00
91.00 Nursing School cost	0	3, 236, 896	0.00000	0 129, 354	0	91.00
92.00 Allied health cost	0	3, 236, 896	0. 00000	0 129, 354	0	92.00
93.00 All other Medical Education	0	3, 236, 896	0. 00000	0 129, 354	0	93.00

OMPUT	ATION OF INPATIENT OPERATING COST From 10/01/2014 Component CCN: 15M320 To 09/30/2015	Worksheet D-1 Date/Time Pre	
	Title XVIII Subprovider -	2/17/2016 10: PPS	
	Cost Center Description		
	PART I – ALL PROVIDER COMPONENTS	1.00	
	I NPATI ENT DAYS		
. 00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,943	
. 00 . 00	Inpatient days (including private room days, excluding swing-bed and newborn days) Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	1, 943 0	2. 3.
. 00 . 00	Semi-private room days (excluding swing-bed and observation bed days) Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	1, 943 0	
. 00	reporting period Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.
. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.
. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	
. 00 0. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	1, 415	
1. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	
2.00	December 31 of the cost reporting period (if calendar year, enter 0 on this line) Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.
3. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.
4. 00 5. 00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Medically necessary private room days applicable to the Program (excluding swing-bed days) Total nursery days (title V or XIX only)	0	
	Nursery days (title V or XIX only) SWING BED ADJUSTMENT	0	
7.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.
8.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.
9.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	
0.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period Total general inpatient routine service cost (see instructions)	0.00	
2.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	
3.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	
4.00 5.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	
6. 00	x line 20) Total swing-bed cost (see instructions)	0	
	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	2, 396, 060	
	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	
9.00 0.00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)	0	29. 30.
. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	
2.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	
. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.
. 00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	
. 00	Average per diem private room cost differential (line 34 x line 31)	0.00	
. 00 . 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 differential (line 27 minus line 36)	0 2, 396, 060	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		-
3. 00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 233. 18	38
	Program general inpatient routine service cost (line 9 x line 38)	1, 744, 950	
	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	
	Total Program general inpatient routine service cost (line 39 + line 40)	1, 744, 950	

	ATION OF INPATIENT OPERATING COST		Provi der	CCN: 151320	Peri od:	Worksheet D-1	2552 1
			Componen	t CCN: 15M320	From 10/01/2014 To 09/30/2015	Date/Time Pre	
			Ti tl	e XVIII	Subprovi der –	2/17/2016 10: PPS	07 a
	Cost Center Description	Total	Total	Average Per	IPF Program Days	Program Cost	
		Inpatient Cost	Inpatient Days	Diem (col. 1 col. 2)	÷	(col. 3 x col. 4)	
. 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00 00 0	5.00 0 0) 42
. 00	Intensive Care Type Inpatient Hospital Units			<u>, 0.</u>	00 0	<u> </u>	42
	INTENSIVE CARE UNIT	0	(0.	00 C	0 0	
	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44
. 00	SURGI CAL I NTENSI VE CARE UNI T						46
. 00	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description					1.00	+
00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	3, line 200)			315, 913	3 48
. 00	Total Program inpatient costs (sum of lines	41 through 48)(see instructi	ons)		2, 060, 863	3 49
. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	atient routine	services (fro	n Wkst D su	m of Parts L and	0	50
. 00			30111003 (110	ii wikst. D, Su			
. 00	Pass through costs applicable to Program inp	atient ancillar	ry services (f	rom Wkst. D,	sum of Parts II	13, 226	51
. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				13, 226	52
. 00	Total Program inpatient operating cost exclu	ding capital re	elated, non-phy	ysician anest	hetist, and	2, 047, 637	
	medical education costs (line 49 minus line	52)				<u> </u>	-
	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54
. 00	Target amount per discharge					0.00	
	Target amount (line 54 x line 55)	ing eact and to	waat amount (ing E(minug	Line E2)	0	
. 00 . 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	inger amount (The so minus	TThe 53)		
. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996, i	updated and c	ompounded by the	0.00	
00	market basket	aget report ur	datad by the	norkat bookat		0.00	
. 00 . 00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line					0.00	
	which operating costs (line 53) are less tha	n expected cost					
. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62
	Allowable Inpatient cost plus incentive paym	ent (see instru	uctions)				
	PROGRAM INPATIENT ROUTINE SWING BED COST						
. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Dece	ember 31 of the	e cost report	ing period (See	0	64
. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the (cost reportin	g period (See	0	65
	instructions)(title XVIII only)						
o. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line	64 plus line	55)(title XVI	ll only). For	0	66
. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31	of the cost r	eporting period	0	67
	(line 12 x line 19)	-)	4h			
3. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs arter L	ecember 31 or	the cost rep	orting period	0	68
9.00	Total title V or XIX swing-bed NF inpatient		•			0	69
. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil				<u>\</u>	1	70
. 00	Adjusted general inpatient routine service of)		71
. 00	Program routine service cost (line 9 x line	71)					72
. 00 . 00	Medically necessary private room cost applic Total Program general inpatient routine serv	0	•				73
. 00	Capital -related cost allocated to inpatient	•			Part II, column		75
	26, line 45)						
. 00 . 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line	,					76
. 00	Inpatient routine service cost (line 74 minu	,					78
	Aggregate charges to beneficiaries for exces						79
. 00 . 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		cost limitation	n (line 78 mi	nus line 79)		80
	Inpatient routine service cost per drem frim Inpatient routine service cost limitation (I)				82
. 00	Reasonable inpatient routine service costs (see instruction					83
	Program inpatient ancillary services (see in		ne)				84
	Utilization review - physician compensation Total Program inpatient operating costs (sum						86
	PART IV - COMPUTATION OF OBSERVATION BED PAS	S THROUGH COST				1	
00	Total observation bed days (see instructions	.)				0	
	Adjusted general inpatient routine cost per	diam /11: - 07	Line 2			0.00	

Health Financial Systems	JAY COUNTY	HOSPI	TAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST			Provi der		Period: From 10/01/2014	Worksheet D-1	
			Component	CCN: 15M320	To 09/30/2015	Date/Time Prep 2/17/2016 10:0	pared: 07 am
			Title	e XVIII	Subprovider - IPF	PPS	
Cost Center Description	Cost	Routi	ne Cost	column 1 ÷	Total	Observati on	
		(from	line 27)	column 2	Observati on	Bed Pass	
					Bed Cost (from	Through Cost	
					line 89)	(col. 3 x col.	
						4) (see	
						instructions)	
	1.00	2	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST						
90.00 Capital-related cost	C) 2	2, 396, 060	0.00000	0 0	0	90.00
91.00 Nursing School cost	C) 2	2, 396, 060	0.00000	0 0	0	91.00
92.00 Allied health cost	c c		2, 396, 060	0.00000	0 0	0	92.00
93.00 All other Medical Education	с	2	2, 396, 060	0.00000	0 0	0	93.00

	Financial Systems JAY COUNTY ATION OF INPATIENT OPERATING COST JAY COUNTY	HOSPITAL Provi der CCN: 151320	Peri od:	u of Form CMS-2 Worksheet D-1	2552-1
			From 10/01/2014 To 09/30/2015	Date/Time Prep 2/17/2016 10:0	
		Title XIX	Hospi tal	Cost	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
1.00	INPATIENT DAYS Inpatient days (including private room days and swing-bed d	avs. excluding newborn)		2, 641	1.00
2.00	Inpatient days (including private room days, excluding swin	g-bed and newborn days)		2, 127	2.00
3.00	Private room days (excluding swing-bed and observation bed do not complete this line.	days). If you have only pr	ivate room days,	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation	bed days)		2,042	4.00
5.00	Total swing-bed SNF type inpatient days (including private	room days) through December	er 31 of the cost	121	5.0
6.00	reporting period Total swing-bed SNF type inpatient days (including private	room days) after December	31 of the cost	363	6.0
	reporting period (if calendar year, enter 0 on this line)				
7.00	Total swing-bed NF type inpatient days (including private r reporting period	oom days) through December	31 of the cost	8	7.0
8.00	Total swing-bed NF type inpatient days (including private r	oom days) after December 3	1 of the cost	22	8.0
0.00	reporting period (if calendar year, enter 0 on this line)	to the Dreamon (avaluding	owing had and	20	
9.00	Total inpatient days including private room days applicable newborn days)	to the Program (excluding	swing-bed and	38	9.0
10.00	Swing-bed SNF type inpatient days applicable to title XVIII		oom days)	0	10. 0
11.00	through December 31 of the cost reporting period (see instr Swing-bed SNF type inpatient days applicable to title XVIII		room days) after	0	11.0
	December 31 of the cost reporting period (if calendar year,	enter 0 on this line)	5 ,		
12.00	Swing-bed NF type inpatient days applicable to titles V or through December 31 of the cost reporting period	XIX only (including privat	e room days)	0	12.0
13.00	Swing-bed NF type inpatient days applicable to titles V or			0	13.0
14.00	after December 31 of the cost reporting period (if calendar Medically necessary private room days applicable to the Pro			0	14.0
14.00	Total nursery days (title V or XIX only)	gram (excruaring swring-bed	uays)	-	14.0
	Nursery days (title V or XIX only)			0	
17.00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to serv	ices through December 31 c	of the cost		17.0
	reporting period	Ũ			
18.00	Medicare rate for swing-bed SNF services applicable to serv reporting period	ices after December 31 of	the cost		18.0
19. 00	Medicaid rate for swing-bed NF services applicable to servi	ces through December 31 of	the cost	0.00	19.0
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to servi	cas after December 31 of t	he cost	0.00	20. 0
20.00	reporting period				
21.00	Total general inpatient routine service cost (see instructi		ing and diag	3, 977, 243	
22.00	Swing-bed cost applicable to SNF type services through Dece 5×1 (ine 17)	inder 31 of the cost report	ing period (ine	0	22.0
23.00	Swing-bed cost applicable to SNF type services after Decemb	er 31 of the cost reportin	ng period (line 6	0	23.0
24.00	x line 18) Swing-bed cost applicable to NF type services through Decem	ber 31 of the cost reporti	ng period (line	0	24.0
	7 x line 19)				
25.00	Swing-bed cost applicable to NF type services after December x line 20)	er 31 of the cost reporting	period (line 8	0	25.0
26.00	Total swing-bed cost (see instructions)			737, 258	26.0
27.00	General inpatient routine service cost net of swing-bed cos	t (line 21 minus line 26)		3, 239, 985	27.0
28.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-	bed and observation bed ch	arges)	0	28.0
	Private room charges (excluding swing-bed charges)		5,	0	
30.00	Semi -private room charges (excluding swing-bed charges)			0	30.0
	General inpatient routine service cost/charge ratio (line 2	7 ÷ line 28)		0.000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)	`		0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4		ti ana)	0.00	
34.00 35.00	Average per diem private room charge differential (line 32 Average per diem private room cost differential (line 34 x			0.00 0.00	
36.00	Private room cost differential adjustment (line 3 x line 35			0.00	36.0
37.00	General inpatient routine service cost net of swing-bed cos		fferential (line	3, 239, 985	
	27 minus line 36)	•	•		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST A	DJUSTMENTS			
38.00	Adjusted general inpatient routine service cost per diem (s			1, 523. 26	38 0
	Program general inpatient routine service cost (line 9 x li			57, 884	
	Medically necessary private room cost applicable to the Pro			0	
40.00					

OMPU I	TATION OF INPATIENT OPERATING COST		Provi der	CCN: 151320	Period: From 10/01/2014	Worksheet D-1	1
					To 09/30/2015		
			Ti t	le XIX	Hospi tal	2/17/2016 10: Cost	07 a
	Cost Center Description	Total	Total	Average Per		Program Cost	
		Inpatient Cost	Inpatient Days		÷	(col. 3 x col.	
		1.00	2.00	col. 2) 3.00	4.00	<u>4)</u> 5.00	
. 00	NURSERY (title V & XIX only)	476, 171	153) 42
	Intensive Care Type Inpatient Hospital Units						
. 00	INTENSIVE CARE UNIT	0	0	0. (0 00	0	
. 00 . 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44
00							40
	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description						_
00	Program inpatient ancillary service cost (Wk	st D-3 col 3	Line 200)			1.00 19,325	5 48
. 00			· · ·	ns)		77, 209	
	PASS THROUGH COST ADJUSTMENTS						
. 00	Pass through costs applicable to Program inpa	atient routine	services (from	Wkst. D, sun	n of Parts I and	C	50
. 00	<pre>III) Pass through costs applicable to Program inpa</pre>	atient ancillar	v services (fr	om Wkst D s	sum of Parts II	C	51
	and IV)		5 301 11 003 (11	S. mot. D, S			
. 00	Total Program excludable cost (sum of lines !					C	
. 00	Total Program inpatient operating cost exclud		lated, non-phy	sician anesth	netist, and	C	53
	medical education costs (line 49 minus line 5 TARGET AMOUNT AND LIMIT COMPUTATION) ∠)					
. 00						C	54
. 00						0.00	
00	5	ng poot and l	mant operat ()		Line F2)	0	
. 00 . 00	Difference between adjusted inpatient operati Bonus payment (see instructions)	ing cost and ta	rget amount (I	ine 56 minus	iine 53)		
. 00	Lesser of lines 53/54 or 55 from the cost rep	orting period	ending 1996, u	pdated and co	ompounded by the	0.00	
	market basket	0.1	0		. ,		
. 00	Lesser of lines 53/54 or 55 from prior year of lines				the emount by	0.00	
. 00	If line 53/54 is less than the lower of lines which operating costs (line 53) are less than					C) 61
	amount (line 56), otherwise enter zero (see i				the target		
. 00	1 5 (C	
. 00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ctions)			0) 63
. 00		ts through Dece	mber 31 of the	cost reporti	ng period (See	C	64
	instructions)(title XVIII only)	Ū			0 1 1		
. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the c	ost reportino	g period (See	C) 65
. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 nlus line 6	5)(title XVII	lonly) For	C	66
. 00	CAH (see instructions)				1 011 3). 101		
. 00	5	e costs through	December 31 o	f the cost re	eporting period	C	67
3. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine	e costs after D	ecember 31 of	the cost ren	orting period	0	68
. 00	(line 13 x line 20)		ecember 51 01	the cost rept	bitting period		
. 00	Total title V or XIX swing-bed NF inpatient					0) 69
	PART III - SKILLED NURSING FACILITY, OTHER NU				,		1 70
. 00 . 00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service co	5)		70
. 00	Program routine service cost (line 9 x line			2)			72
. 00	Medically necessary private room cost application	able to Program	(line 14 x li	ne 35)			73
. 00	Total Program general inpatient routine servi	•					74
. 00	Capital-related cost allocated to inpatient (26, line 45)	routine service	costs (from W	orksheet B, H	Part II, column		75
. 00	Per diem capital-related costs (line 75 ÷ lin	ne 2)					76
. 00	Program capital-related costs (line 9 x line						77
00	Inpatient routine service cost (line 74 minus			-)			78
00 00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa	· · ·		·	nus line 70)		80
00	Inpatient routine service cost per diem limi				103 ITHE / 7)		81
00	Inpatient routine service cost limitation (li)				82
. 00	Reasonable inpatient routine service costs (see instruction					83
. 00	Program inpatient ancillary services (see ins		>				84
. 00 . 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85
	PART IV - COMPUTATION OF OBSERVATION BED PASS						
. 00	Total observation bed days (see instructions))				85	
. 00	Adjusted general inpatient routine cost per o	•	line 2)			1, 523. 27 129, 478	
	Observation bed cost (line 87 x line 88) (see						

Health Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period:	Worksheet D-1	
				From 10/01/2014 To 09/30/2015	Date/Time Pre 2/17/2016 10:0	pared: 07 am
		Tit	le XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	351, 326	3, 239, 985	0. 10843	4 129, 478	14, 040	90.00
91.00 Nursing School cost	0	3, 239, 985	0.00000	0 129, 478	0	91.00
92.00 Allied health cost	0	3, 239, 985	0. 00000	0 129, 478	0	92.00
93.00 All other Medical Education	0	3, 239, 985	0. 00000	0 129, 478	0	93.00

)MPUT.		Provider CCN: 151320 Component CCN: 15M320 Title XIX	Peri od: From 10/01/2014 To 09/30/2015 Subprovi der -	Worksheet D-1 Date/Time Pre 2/17/2016 10:0 Cost	pare
	Cost Center Description		IPF	0031	
			-	1.00	
	PART I – ALL PROVIDER COMPONENTS				
00	Inpatient days (including private room days and swing-bed days,	excluding newborn)		1, 943	1.
00	Inpatient days (including private room days, excluding swing-bed			1, 943	2.
00	Private room days (excluding swing-bed and observation bed days) do not complete this line.	. If you have only pr	ivate room days,	0	3.
00	Semi-private room days (excluding swing-bed and observation bed	davs)		1, 943	4.
00	Total swing-bed SNF type inpatient days (including private room		r 31 of the cost	0	
~~	reporting period				
00	Total swing-bed SNF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after December :	31 of the cost	0	6
00	Total swing-bed NF type inpatient days (including private room d	ays) through December	31 of the cost	0	7
	reporting period	<i></i>			
00	Total swing-bed NF type inpatient days (including private room dare porting period (if calendar year, enter 0 on this line)	ays) after December 3	1 of the cost	0	8
00	Total inpatient days including private room days applicable to the	he Program (excluding	swing-bed and	40	9
	newborn days)		-		
. 00	Swing-bed SNF type inpatient days applicable to title XVIII only		oom days)	0	10
. 00	through December 31 of the cost reporting period (see instruction Swing-bed SNF type inpatient days applicable to title XVIII only		nom davs) after	0	11
. 00	December 31 of the cost reporting period (if calendar year, ente		som days) ar ter	0	
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX of	nly (including privat	e room days)	0	12
. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX of	nly (including privat	a room davc)	0	13
. 00	after December 31 of the cost reporting period (if calendar year			0	13
. 00	Medically necessary private room days applicable to the Program			0	14
	Total nursery days (title V or XIX only)			153	
. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16
. 00	Medicare rate for swing-bed SNF services applicable to services	through December 31 o	f the cost		17
. 00	reporting period Medicare rate for swing-bed SNF services applicable to services a reporting period	after December 31 of	the cost		18
. 00	Medicaid rate for swing-bed NF services applicable to services the reporting period	hrough December 31 of	the cost	0.00	19
	Medicaid rate for swing-bed NF services applicable to services a reporting period	fter December 31 of t	he cost	0.00	
. 00	Total general inpatient routine service cost (see instructions)	21 of the east report	ing posted (Line	2, 396, 060	
. 00	Swing-bed cost applicable to SNF type services through December 3 5 x line 17)	31 OF the cost report	ing period (ine	0	22
. 00	Swing-bed cost applicable to SNF type services after December 31 x line 18)	of the cost reporting	g period (line 6	0	23
. 00	Swing-bed cost applicable to NF type services through December 3 7 x line 19)	1 of the cost reportion	ng period (line	0	24
. 00	Swing-bed cost applicable to NF type services after December 31	of the cost reporting	period (line 8	0	25
. 00	x line 20) Total swing-bed cost (see instructions)			0	26
	General inpatient routine service cost net of swing-bed cost (li	ne 21 minus line 26)		2, 396, 060	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-bed a	nd observation bed ch	arges)	0	
00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29
	General inpatient routine service cost/charge ratio (line 27 ÷ 1	ine 28)		0.000000	
00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32
	Average semi-private room per diem charge (line 30 ÷ line 4)	line 22) (' '	tional	0.00	
	Average per diem private room charge differential (line 32 minus Average per diem private room cost differential (line 34 x line 3		u ons)	0.00 0.00	
. 00	Private room cost differential adjustment (line 3 x line 35)	,		0.00	36
. 00	General inpatient routine service cost net of swing-bed cost and	private room cost di	fferential (line	2, 396, 060	
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST				1
	Adjusted general inpatient routine service cost per diem (see in:			1, 233. 18	
1 11 1	Program general inpatient routine service cost (line 9 x line 38)			49, 327	39
	Medically necessary private room cost applicable to the Program	$(1 n \alpha 1/1 \gamma 1) n \alpha 7 \kappa$		0	40

JUNIPUT	Financial Systems ATION OF INPATIENT OPERATING COST	JAT COUNT	HOSPI TAL Provi der	CCN: 151320	Period:	eu of Form CMS- Worksheet D-1	
			Componen	t CCN: 15M320	From 10/01/2014 To 09/30/2015		
			Ti t	le XIX	Subprovider - IPF	Cost	<u>. 07 ali</u>
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
12.00		1.00	2.00	3.00	4.00	5.00	
2.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	Ĺ	0.		<u>л</u> () 42.0
3.00	INTENSIVE CARE UNIT	0	C	0.	00 C) (
4.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44.0
6. 00	SURGICAL INTENSIVE CARE UNIT						46.
7.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.
8.00	Program inpatient ancillary service cost (Wks	t D 2 col 2	Line 200)			1.00	4 48.
	Total Program inpatient costs (sum of lines 4			ons)		58, 231	
0. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	atient routine	services (from	n Wkst. D, su	m of Parts I and	(50.
1. 00	<pre>III) Pass through costs applicable to Program inpa</pre>	atient ancillar	y services (fr	om Wkst. D, s	sum of Parts II	0	51.
2 00	and IV)		, , , , , , , , , , , , , , , , , , ,				5
52.00 53.00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclud	,	lated, non-phy	sician anestl	netist, and		
	medical education costs (line 49 minus line 5 TARGET AMOUNT AND LIMIT COMPUTATION	52)					-
4.00	Program di scharges					0	54.
5.00 6.00	Target amount per discharge Target amount (line 54 x line 55)					0.00	
	Difference between adjusted inpatient operati	ng cost and ta	rget amount (I	ine 56 minus	line 53)		
3.00	Bonus payment (see instructions)					(
9.00	Lesser of lines 53/54 or 55 from the cost rep market basket	orting period	ending 1996, L	ipdated and c	ompounded by the	0.00	59.
0.00	Lesser of lines 53/54 or 55 from prior year of					0.00	
1.00	If line 53/54 is less than the lower of lines which operating costs (line 53) are less than					0	61.
	amount (line 56), otherwise enter zero (see i			00), 01 18 0	the target		
2.00 3.00	Relief payment (see instructions) Allowable Inpatient cost plus incentive payme	ent (see instru	ctions)				
	PROGRAM INPATIENT ROUTINE SWING BED COST						
4.00	Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only)	s through Dece	mber 31 of the	e cost report	ng period (See	0	64.
5.00	Medicare swing-bed SNF inpatient routine cost	s after Decemb	er 31 of the c	ost reporting	g period (See	0	65.
6. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line 6	5)(title XVI	II only). For	0	66.
7 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routine	costs through	December 31 c	of the cost r	eporting period	0	67.
	(line 12 x line 19)	-					
8.00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	e costs after D	ecember 31 of	the cost rep	orting period	0	68.
9.00	Total title V or XIX swing-bed NF inpatient i						69.
0. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili)		70.
1.00	Adjusted general inpatient routine service co	ost per diem (I					71.
2.00 3.00	Program routine service cost (line 9 x line 7 Medically necessary private room cost applica		(line 14 x li	ne 35)			72.
4.00	Total Program general inpatient routine servi	ce costs (line	72 + line 73)	,			74.
5.00	Capital-related cost allocated to inpatient r 26, line 45)	outine service	costs (from V	lorksheet B, I	Part II, column		75.
6.00	Per diem capital-related costs (line 75 ÷ lin						76.
7.00 3.00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus						77.
9.00	Aggregate charges to beneficiaries for excess		rovi der record	ls)			79.
0.00	Total Program routine service costs for compa		ost limitatior	ı (line 78 min	nus line 79)		80.
1.00 2.00	Inpatient routine service cost per diem limit Inpatient routine service cost limitation (li)				81. 82.
3.00	Reasonable inpatient routine service costs (s						83.
4.00	Program inpatient ancillary services (see ins						84.
5.00 6.00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 86.
0.00	PART IV - COMPUTATION OF OBSERVATION BED PASS					I	00.
37.00	Total observation bed days (see instructions)	1				(
0 00	Adjusted general inpatient routine cost per o	$n \circ m (l \circ n \circ 27)$				0.00	88.

Health Financial Systems	JAY COUNTY	HOSPI T	AL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Р	rovi der		Period: From 10/01/2014	Worksheet D-1	
		C	omponent	CCN: 15M320			pared: 07 am
			Ti t	le XIX	Subprovider - IPF	Cost	
Cost Center Description	Cost	Routir	ne Cost	column 1 ÷	Total	Observation	
		(from I	ine 27)	column 2	Observati on	Bed Pass	
					Bed Cost (from	Through Cost	
					line 89)	(col. 3 x col.	
						4) (see	
						instructions)	
	1.00	2.	00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST						
90.00 Capital-related cost	144, 507	2,	396, 060	0. 06031	0 0	0	90.00
91.00 Nursing School cost	0	2,	396, 060	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	2,	396, 060	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	2,	396, 060	0.00000	0 0	0	93.00

Health Financial Systems JAY COUN	TY HOSPI TAL		In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 151320	Peri od:	Worksheet D-3	
			From 10/01/2014		
			To 09/30/2015	Date/Time Pre 2/17/2016 10:	
	T; +I	e XVIII	Hospi tal	2/1//2018 10: Cost	07 am
Cost Center Description	1111	Ratio of Cos		Inpatient	
cost center bescription		To Charges	Program	Program Costs	
		10 charges	Charges	$(col. 1 \times col.)$	
			onar ges	2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS			2100	0,00	
30. 00 03000 ADULTS & PEDI ATRI CS			1, 412, 394		30.00
31. 00 03100 I NTENSI VE CARE UNI T			0		31.00
40. 00 04000 SUBPROVIDER - IPF			0		40.00
41.00 04100 SUBPROVI DER – I RF			0		41.00
42. 00 04200 SUBPROVI DER			0		42.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS					101.00
50. 00 05000 0PERATI NG ROOM		0. 26660	512, 614	136, 668	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0.34659		0	
53. 00 05300 ANESTHESI OLOGY		0.00000		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 11114		48, 948	
57. 00 05700 CT SCAN		0. 00000		0	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0.00000		0	
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 00000		0	
60. 00 06000 LABORATORY		0. 17016		106, 232	
60. 01 06001 BLOOD LABORATORY		0. 00000		00,202	60.01
65. 00 06500 RESPIRATORY THERAPY		0. 60007		112, 261	
66. 00 06600 PHYSI CAL THERAPY		0. 37984		33, 051	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 36579		11, 137	
68. 00 06800 SPEECH PATHOLOGY		0. 59020		1, 503	
69. 00 06900 ELECTROCARDI OLOGY		0. 37944		41, 473	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 00000		0	
72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS		0. 00000		0	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 54709		173, 295	
OUTPATIENT SERVICE COST CENTERS		0.0170	010,700	170,270	/0.00
88. 00 08800 RURAL HEALTH CLINIC		0.0000	00	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000		0	
90. 00 09000 CLINIC		2. 8696		14, 503	
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY		1. 7055		0	90.01
90. 02 09002 JAY FAMILY MEDICINE		2. 62855		0	
91. 00 09100 EMERGENCY		0. 46675		9, 218	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 46778		0	
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTER		0. 00000		0	
200.00 Total (sum of lines 50-94 and 96-98)		0.00000	2, 335, 258		
201.00 Less PBP Clinic Laboratory Services-Program only ch	arges (line 61)		2, 333, 230	000,207	200.00
202.00 Net Charges (Line 200 minus Line 201)	.a. 900 (1110 01)		2, 335, 258		202.00
		I	2,000,200	I	1-02.00

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 151320	Peri od:	Worksheet D-3	3
			From 10/01/2014		
	Componen	t CCN: 15M320	To 09/30/2015	Date/Time Pre 2/17/2016 10:	
	Ti tl	e XVIII	Subprovider -	PPS	07 01
			I PF		
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
0. 00 03000 ADULTS & PEDIATRICS			0		30.
1. 00 03100 I NTENSI VE CARE UNI T			0		31.
0.00 04000 SUBPROVI DER – I PF			1, 089, 100		40.
1.00 04100 SUBPROVIDER - IRF			0		41.
12. 00 04200 SUBPROVI DER		1	0		42.
3. 00 04300 NURSERY					43.
ANCI LLARY SERVI CE COST CENTERS					
0.00 05000 OPERATING ROOM		0. 2666	09 29	8	50.
2.00 05200 DELIVERY ROOM & LABOR ROOM		0.3465	94 0	0	52.
3. 00 05300 ANESTHESI OLOGY		0.0000	00 0	0	53.
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1111	45 92, 801	10, 314	54.
7.00 05700 CT SCAN		0.0000	00 00	0	57.
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0.0000		0	
9. 00 05900 CARDI AC CATHETERI ZATI ON		0.0000		0	
0. 00 06000 LABORATORY		0. 1701		31, 827	
0. 01 06001 BLOOD LABORATORY		0.0000		0	
5. 00 06500 RESPI RATORY THERAPY		0.6000			
6. 00 06600 PHYSI CAL THERAPY		0. 3798		13, 410	
7. 00 06700 OCCUPATI ONAL THERAPY		0.3657		5, 285	
8. 00 06800 SPEECH PATHOLOGY		0. 5902		3, 361	
9.00 06900 ELECTROCARDI OLOGY		0. 3794		6, 265	
1. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS		0.0000		0	
2. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 3. 00 07300 DRUGS CHARGED TO PATI ENTS		0.0000		0	1
OUTPATIENT SERVICE COST CENTERS		0.5470	97 264, 169	144, 526	73.
8. 00 08800 RURAL HEALTH CLINIC		0.0000	00	0	88.
9. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000		0	
0. 00 09000 CLINIC		2.8696		67, 209	
0.01 09001 FAMILY PRACTICE OF JAY COUNTY		1. 7055		0	
0. 02 09002 JAY FAMILY MEDICINE		2. 6285		0	90.
1.00 09100 EMERGENCY		0. 4667		3, 538	91.
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1.4677		0	
3. 00 04040 OTHER OUTPATI ENT SERVI CE COST CENTER		0.0000		0	93.
00.00 Total (sum of lines 50-94 and 96-98)			697, 276	315, 913	
01.00 Less PBP Clinic Laboratory Services-Program only charge	es (line 61)		0		201.
Net Charges (line 200 minus line 201)	. ,		697, 276		202.

Health Financial Systems JAY COUNT	Y HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 151320	Peri od:	Worksheet D-3	
	Component	CCN: 15Z320	From 10/01/2014 To 09/30/2015	Date/Time Pre 2/17/2016 10:	
	Title	e XVIII	Swing Beds - SNF		
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS			0		30.00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 I NTENSI VE CARE UNI T			0		30.00
40. 00 04000 SUBPROVIDER - IPF			0		40.00
41. 00 04100 SUBPROVIDER - IRF			0		41.00
42. 00 04200 SUBPROVI DER			0		42.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVICE COST CENTERS				I	1
50. 00 05000 OPERATI NG ROOM		0. 26660)9 20	5	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 34659	94 0	0	52.00
53. 00 05300 ANESTHESI OLOGY		0. 00000	0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 11114	45 21, 805	2, 424	54.00
57.00 05700 CT SCAN		0.0000	0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0.0000		0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.0000		0	59.00
60. 00 06000 LABORATORY		0. 17016		4, 629	
60. 01 06001 BLOOD LABORATORY		0.0000		0	60.01
65.00 06500 RESPIRATORY THERAPY		0.60007			•
66.00 06600 PHYSI CAL THERAPY		0. 37984			
67.00 06700 OCCUPATIONAL THERAPY		0.36579			•
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY		0. 59020			68.00
69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		0. 37944 0. 00000		2, 454 0	69.00 71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0.00000		0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 54709		-	
OUTPATIENT SERVICE COST CENTERS		0.0170.		27,700	/ 0. 00
88. 00 08800 RURAL HEALTH CLINIC		0.0000	00	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000		0	89.00
90. 00 09000 CLINIC		2.86961		2, 763	•
90.01 09001 FAMILY PRACTICE OF JAY COUNTY		1. 70551		0	90.01
90. 02 09002 JAY FAMILY MEDICINE		2. 62855	58 0	0	90.02
91. 00 09100 EMERGENCY		0. 46675	54 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 46778		0	92.00
93. 00 04040 OTHER OUTPATI ENT SERVI CE COST CENTER		0.0000		0	93.00
200.00 Total (sum of lines 50-94 and 96-98)			286, 124	112, 695	
201.00 Less PBP Clinic Laboratory Services-Program only cha	arges (line 61)		0		201.00
202.00 Net Charges (line 200 minus line 201)			286, 124		202.00

Health Financial Systems	JAY COUNTY HOSPITAL		In Lie	eu of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 151320	Peri od:	Worksheet D-3	;
			From 10/01/2014		
			To 09/30/2015		
	Ti +	le XIX	Hospi tal	2/17/2016 10: Cost	07 аш
Cost Center Description		Ratio of Cos		Inpatient	
cost center bescription		To Charges	Program	Program Costs	
		TO charges	Charges	(col. 1 x col.	
			chai yes	2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS			37, 250	1	30.00
31. 00 03100 I NTENSI VE CARE UNI T			37,230		31.00
40. 00 04000 SUBPROVI DER - I PF			0		
			0		40.00
41.00 04100 SUBPROVIDER - IRF			0		41.00
42. 00 04200 SUBPROVI DER			0		42.00
43.00 04300 NURSERY			0	I	43.00
		0.2(())	22 15/	0.040	- FO 00
50. 00 05000 OPERATING ROOM		0.26660			
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0.34659		-	
53. 00 05300 ANESTHESI OLOGY		0.0000		-	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 11114			
57.00 05700 CT SCAN		0.0000		-	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0.0000		-	
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.0000		-	
60. 00 06000 LABORATORY		0. 1701			
60.01 06001 BLOOD LABORATORY		0.0000		-	
65. 00 06500 RESPI RATORY THERAPY		0.6000			
66. 00 06600 PHYSI CAL THERAPY		0. 37984	13 159	60	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 36579		0	67.00
68.00 06800 SPEECH PATHOLOGY		0. 59020	0 00	0	68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 37944	41 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.0000	0 00	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0.0000	0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 5470	97 9, 163	5, 013	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC		0.0000	0 00	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000	0 00	0	89.00
90. 00 09000 CLINIC		2. 8696 ⁻		0	90.00
90.01 09001 FAMILY PRACTICE OF JAY COUNTY		1.7055		0	90.01
90.02 09002 JAY FAMILY MEDICINE		2.6285		0	90.02
91. 00 09100 EMERGENCY		0. 46675		1, 086	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 46778		0	
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTER		0. 00000		0	
200.00 Total (sum of lines 50-94 and 96-98)		0.0000	68, 398		
201.00 Less PBP Clinic Laboratory Services-Progr	cam only charges (line 61)		0	, 020	201.00
202.00 Net Charges (line 200 minus line 201)			68, 398		201.00
		I	00, 370	I	1202.00

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 151320	Peri od:	Worksheet D-3	3
	0	+ CON 154200	From 10/01/2014		
	Componen	t CCN: 15M320	To 09/30/2015	Date/Time Pre 2/17/2016 10:	
	Ti t	le XIX	Subprovider -	Cost	<u>07 an</u>
			I PF		
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
0. 00 03000 ADULTS & PEDI ATRI CS			0		30.
1. 00 03100 I NTENSI VE CARE UNI T			0		31.
10. 00 04000 SUBPROVI DER – I PF			35, 007		40.
11. 00 04100 SUBPROVIDER - IRF			0		41.
12. 00 04200 SUBPROVI DER		1	0		42.
3. 00 04300 NURSERY			0		43.
ANCI LLARY SERVICE COST CENTERS		1			
0. 00 05000 OPERATI NG ROOM		0. 26660	0 0	0	50.
2.00 05200 DELIVERY ROOM & LABOR ROOM		0. 34659	94 0	0	52.
3. 00 05300 ANESTHESI OLOGY		0.0000	0 00	0	53.
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 11114	45 4, 499	500	54.
7. 00 05700 CT SCAN		0.0000	0 00	0	57.
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0.0000			
9. 00 05900 CARDI AC CATHETERI ZATI ON		0.0000		-	
0. 00 06000 LABORATORY		0. 1701		2, 063	
0. 01 06001 BLOOD LABORATORY		0.0000		-	
5. 00 06500 RESPI RATORY THERAPY		0.6000			
6. 00 06600 PHYSI CAL THERAPY		0. 37984			
7.00 06700 OCCUPATI ONAL THERAPY		0.36579			
8.00 06800 SPEECH PATHOLOGY		0. 59020			
9.00 06900 ELECTROCARDI OLOGY		0. 37944			
1.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		0.0000			
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0.0000		-	
3. 00 07300 DRUGS CHARGED TO PATI ENTS OUTPATI ENT SERVI CE COST CENTERS		0. 5470	97 10, 929	5, 979	73.
8. 00 08800 RURAL HEALTH CLINIC		0.0000	0 00	0	88.
9. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000			
0. 00 09000 CLINIC		2.8696			
0. 01 09001 FAMILY PRACTICE OF JAY COUNTY		1. 7055			
0. 02 09002 JAY FAMILY MEDICINE		2. 6285			
1.00 09100 EMERGENCY		0. 46675		0	
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 46778		0	
3. 00 04040 OTHER OUTPATI ENT SERVICE COST CENTER		0.0000		0	
200.00 Total (sum of lines 50-94 and 96-98)			28, 421	8, 904	
201.00 Less PBP Clinic Laboratory Services-Program only c	harges (line 61)		0		201.
Net Charges (line 200 minus line 201)	5		28, 421		202.

Health Financial Systems	JAY COUNTY HOSPI TAL		In Lie	u of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 151320	Peri od:	Worksheet D-3	
			From 10/01/2014		
	Component	CCN: 15Z320	To 09/30/2015	Date/Time Pre 2/17/2016 10:	
		le XIX	Swing Beds - SNF		
Cost Center Description		Ratio of Cos		Inpatient	
Cost center bescription		To Charges	Program	Program Costs	
		10 charges	Charges	$(col. 1 \times col.$	
			ondriges	2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			0		30.00
31.00 03100 INTENSIVE CARE UNIT			0		31.00
40. 00 04000 SUBPROVIDER - IPF			0		40.00
41.00 04100 SUBPROVIDER - IRF			0		41.00
42. 00 04200 SUBPROVI DER			0		42.00
43.00 04300 NURSERY			0		43.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATI NG ROOM		0. 26660)9 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 34659	94 0	0	52.00
53. 00 05300 ANESTHESI OLOGY		0.00000	0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 11114	15 0	0	54.00
57.00 05700 CT SCAN		0.00000	0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0.00000		0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.00000		0	59.00
60. 00 06000 LABORATORY		0. 17016		0	60.00
60. 01 06001 BLOOD LABORATORY		0.00000		0	60. 01
65. 00 06500 RESPI RATORY THERAPY		0. 60007		0	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 37984		0	66.00
67.00 06700 OCCUPATI ONAL THERAPY		0.36579		0	67.00
68.00 06800 SPEECH PATHOLOGY		0. 59020		0	68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 37944		0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.00000		0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0.00000		0	72.00
73.00 O7300 DRUGS CHARGED TO PATIENTS		0. 54709	97 0	0	73.00
OUTPATIENT SERVICE COST CENTERS			-	-	
88.00 08800 RURAL HEALTH CLINIC		0.0000		0	88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000		0	89.00
		2.86961		0	90.00
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY		1.70551		0	90.01
90. 02 09002 JAY FAMILY MEDICINE		2. 62855		0	90.02
91.00 09100 EMERGENCY		0.46675		0	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)		1.46778		0	92.00
93.00 04040 OTHER OUTPATIENT SERVICE COST CENTER 200.00 Total (sum of lines 50-94 and 96-98)		0.00000		0	93.00
200.00Total (sum of lines 50-94 and 96-98)201.00Less PBP Clinic Laboratory Services-Prod	arom only charges (line (1)		0	0	200. 00 201. 00
201.00 [Less PBP Clinic Laboratory Services-Prog 202.00 [Net Charges (line 200 minus line 201)]	gram only charges (True 61)		0		201.00
202.00 [Net Charges (TTHE 200 IIIThus TTHE 201)		I	0		202.00

Heal th	Financial Systems JAY COUNTY HOS	PI TAL	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151320	Period: From 10/01/2014	Worksheet E Part B	
			To 09/30/2015	Date/Time Pre	
		Title XVIII	Hospi tal	2/17/2016 10: Cost	07 am
			nospitai	0031	
				1.00	
1.00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)			4, 206, 248	1.00
2.00	Medical and other services reimbursed under OPPS (see instructi	ons)		0	2.00
3.00	PPS payments			0	
4.00	Outlier payment (see instructions)			0	4.00
5.00 6.00	Enter the hospital specific payment to cost ratio (see instruct Line 2 times line 5	lions)		0.000	
7.00	Sum of line 3 plus line 4 divided by line 6			0.00	
8.00	Transitional corridor payment (see instructions)			0	1
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IN	/, col. 13, line 200		0	9.00
	Organ acqui si ti ons			0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			4, 206, 248	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				-
12.00	Ancillary service charges			0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, lir	ne 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0	14.00
15 00	Customary charges	umant for convision on	a abarra basia	0	1 1 5 00
	Aggregate amount actually collected from patients liable for pa Amounts that would have been realized from patients liable for			0	
10.00	had such payment been made in accordance with 42 CFR §413.13(e)			0	10.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17.00
	Total customary charges (see instructions)			0	
19.00	Excess of customary charges over reasonable cost (complete only instructions)	/ifline 18 exceeds li	ne 11) (see	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only	/ifline 11 exceeds li	ne 18) (see	0	20.00
20.00	instructions)			0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	instructions)		4, 248, 310	21.00
	Interns and residents (see instructions)			0	
	Cost of physicians' services in a teaching hospital (see instru Total prospective payment (sum of lines 3, 4, 8 and 9)	uctions)		0	23.00 24.00
24.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	24.00
25.00	Deductibles and coinsurance (for CAH, see instructions)			59, 930	25.00
	Deductibles and Coinsurance relating to amount on line 24 (for			2, 411, 143	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pl	us the sum of lines 22	and 23] (see	1, 777, 237	27.00
28.00	instructions) Direct graduate medical education payments (from Wkst. E-4, lir	ne 50)		0	28.00
	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29.00
30.00	Subtotal (sum of lines 27 through 29)			1, 777, 237	30.00
	Primary payer payments			1, 098	
32.00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	-67		1, 776, 139	32.00
33.00	Composite rate ESRD (from Wkst. 1-5, line 11)	.5)		0	33.00
	Allowable bad debts (see instructions)			400, 218	
	Adjusted reimbursable bad debts (see instructions)			260, 142	
	Allowable bad debts for dual eligible beneficiaries (see instru	uctions)		337, 637	
	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			2, 036, 281 0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	38.00 39.00
	Pioneer ACO demonstration payment adjustment (see instructions))		0	39.50
	Partial or full credits received from manufacturers for replace		tions)	0	39. 98
	RECOVERY OF ACCELERATED DEPRECIATION			0	39.99
	Subtotal (see instructions)			2, 036, 281	40.00
	Sequestration adjustment (see instructions) Interim payments			40, 726 2, 066, 686	
	Tentative settlement (for contractors use only)			2,000,000	42.00
	Balance due provider/program (see instructions)			-71, 131	1
44.00	Protested amounts (nonallowable cost report items) in accordance	ce with CMS Pub. 15-2,	chapter 1,	0	44.00
	\$115.2				
90.00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90.00
	Outlier reconciliation adjustment amount (see instructions)			0	
	The rate used to calculate the Time Value of Money			0.00	
	Time Value of Money (see instructions)			0	
94.00	Total (sum of lines 91 and 93)			0	94.00

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der	CCN: 151320	Period: From 10/01/2014 To 09/30/2015		
					2/17/2016 10:0	
			e XVIII t Part A	Hospi tal	Cost	
			t fait A	10	10	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00 2.00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		1, 730, 0	47 0	1, 853, 486 0	1.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.00
3.01	ADJUSTMENTS TO PROVIDER			0 04/13/2015	213, 200	3.01
3.02				0	0	3. 02
3.03				0	0	3.0
3.04 3.05				0	0	3.04 3.05
3.05	Provider to Program			0	0	3.00
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3.51				0	0	
3.52				0	0	3.5
3.53 3.54				0	0	3.53 3.54
3.99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)			0	213, 200	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1, 730, 0	47	2, 066, 686	4.00
	TO BE COMPLETED BY CONTRACTOR	L				
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					5.00
5.01	TENTATI VE TO PROVI DER			0	0	5.0 [.]
5.02				0	0	
5.03				0	0	5.0
5.50	Provider to Program TENTATIVE TO PROGRAM			0	0	5.5
5.50 5.51				0	0	
5.52				0	0	5. 5
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5.9
5.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.0
5.01	SETTLEMENT TO PROVIDER		40.0	0	0	6.0
5.02 7.00	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		13, 2 1, 716, 8		71, 131 1, 995, 555	6.0 7.0
. 00			1, 710, 0	Contractor	NPR Date	7.0
				Number	(Mo/Day/Yr)	
		()	1.00	2.00	

NALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		CCN: 151320 t CCN: 15M320	Period: From 10/01/2014 To 09/30/2015		pared
		Ti tl	e XVIII	Subprovider - IPF	PPS	
		I npati er	nt Part A		rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
. 00 . 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		1, 307, 2	70 0	000	
. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. (
. 01	ADJUSTMENTS TO PROVIDER		1	0	0	3. (
. 02				0	0	
. 03				0	0	3.
. 04				0	0	3.
. 05				0	0	3.
	Provider to Program		1		1	
50	ADJUSTMENTS TO PROGRAM			0	0	
51				0	0	
52				0	0	
53				0	0	
. 54				0	0	
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3.
~~	3. 50-3. 98)		1 007 0	70		
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1, 307, 2	70	0	4.
	TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none,					5.
	write "NONE" or enter a zero. (1)					
	Program to Provider		1		1	
01	TENTATI VE TO PROVIDER			0	0	
02				0	0	
03	Provider to Program			0	0	5.
50	TENTATI VE TO PROGRAM		1	0	0	5.
50 51				0	0	
52				0	0	
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	
00	5.50-5.98) Determined net settlement amount (balance due) based on					6
	the cost report. (1)					.
01	SETTLEMENT TO PROVIDER			0	0	6.
02	SETTLEMENT TO PROGRAM			0	0	
. 00	Total Medicare program liability (see instructions)		1, 307, 2	70	0	7.
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
	Name of Contractor		0	1.00	2.00	

ANALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der		Period: From 10/01/2014	Worksheet E- Part I	1
		Component		To 09/30/2015		
		Titl	e XVIII S	Swing Beds - SNF		07 alli
			t Part A		T B	
		 mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	-
		1.00	2.00	3.00	4.00	
. 00	Total interim payments paid to provider		524, 07	7	() 1.C
2.00	Interim payments payable on individual bills, either			0	0	2.0
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none, write "NONE" or enter a zero					
. 00	List separately each retroactive lump sum adjustment					3. (
. 00	amount based on subsequent revision of the interim rate					5.0
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
. 01	ADJUSTMENTS TO PROVIDER			0	0	
. 02				0	(
. 03				0	(
. 04				0		
. 05	Provider to Program			0	<u> </u>) 3.
50	ADJUSTMENTS TO PROGRAM			0	(3.
51				0		
. 52				0		3.
. 53				0		3.
. 54				0	(3.
. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	() 3.
~~	3. 50-3. 98)		504.07	-		
. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as		524, 07	/	(4.
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
. 00	List separately each tentative settlement payment after					5.
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
. 01	Program to Provider TENTATIVE TO PROVIDER	[1	o		5.
. 01	TENTATIVE TO PROVIDER			0		
. 02				0		
	Provider to Program	1		-1		
. 50	TENTATI VE TO PROGRAM			0	(5.
. 51				0	0	
. 52				0	0	
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	(5.
00	5.50-5.98) Determined net settlement amount (balance due) based on					4
00	the cost report. (1)					6.
. 01	SETTLEMENT TO PROVIDER			0		6.
. 02	SETTLEMENT TO PROGRAM		93	-		
00	Total Medicare program liability (see instructions)		523, 14			
				Contractor	NPR Date	
			2	Number	(Mo/Day/Yr)	
			C	1.00	2.00	1

Heal th	Financial Systems JAY COUNTY	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 151320	Period: From 10/01/2014 To 09/30/2015		
		Title XVIII	Hospi tal	Cost	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULAT				
1.00	Total hospital discharges as defined in AARA §4102 from Wk		14	667	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1		14	839	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	, 0 12		96	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1	. 8-12		2,042	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			77, 586, 179	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col.	3 line 20		693, 436	6.00
7.00	CAH only - The reasonable cost incurred for the purchase o line 168	f certified HIT technology	Wkst. S-2, Pt. I	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)		0	8.00
9.00	Sequestration adjustment amount (see instructions)			0	9.00
10.00	Calculation of the HIT incentive payment after sequestration	on (see instructions)		0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			0	30.00
31.00	Other Adjustment (specify)			0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 an	d line 31) (see instruction	s)	0	32.00

Heal th	Financial Systems JAY COL	JNTY HOSPI TAL	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 151320	Peri od:	Worksheet E-2	
			From 10/01/2014		
		Component CCN: 15Z320	To 09/30/2015	Date/Time Prep 2/17/2016 10:0	
		Title XVIII	Swing Beds - SNF		JI alli
			Part A	Part B	
			1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instruc	tions)	424, 220	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instruct	i ons)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, f		113, 822	0	3.00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH,	see instructions)			
4.00	Per diem cost for interns and residents not in approved	teaching program (see		0.00	4.00
	instructions)				
5.00	Program days		276	0	5.00
6.00	Interns and residents not in approved teaching program	(see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optio	nal method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		538, 042	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		538, 042	0	10.00
11.00	Deductibles billed to program patients (exclude amounts	applicable to physician	0	0	11.00
	professional services)				
12.00	Subtotal (line 10 minus line 11)		538, 042	0	
13.00	Coinsurance billed to program patients (from provider r for physician professional services)	ecords) (excl ude coi nsurance	4, 220	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or	line 14)	533, 822	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instr	uctions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	,	0		16.55
17.00	Allowable bad debts (see instructions)		0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (se	e instructions)	0	0	18.00
19.00	Total (see instructions)	·	533, 822	0	19.00
19.01	Sequestration adjustment (see instructions)		10, 676	0	19.01
20.00	Interim payments		524,077	0	20.00
21.00	Tentative settlement (for contractor use only)		0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01	, 20, and 21)	-931	0	22.00
23.00	Protested amounts (nonallowable cost report items) in a		0	0	23.00
	chapter 1, §115.2				

Heal th	Financial Systems	JAY COUNTY HOSP	PI TAL	In Lie	u of Form CMS	-2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 151320 Component CCN: 15Z320	Period: From 10/01/2014 To 09/30/2015	Worksheet E- Date/Time Pr	
			Component CCN: 152320	10 09/30/2015	2/17/2016 10	
			Title XIX	Swing Beds - SNF		
				Part A	Part B	
				1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES					_
1.00	Inpatient routine services - swing bed-SNF (see			0		1.00
2.00	Inpatient routine services - swing bed-NF (see i			0		2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line			0		3.00
4 00	Part V, cols. 6 and 7, line 202, for Part B) (Fo			0.00		1 00
4.00	Per diem cost for interns and residents not in a instructions)	approved teachin	g program (see	0.00		4.00
5.00	Program days			0		5.00
6.00	Interns and residents not in approved teaching p	oroaram (see ins	tructions)	0		6.00
7.00	Utilization review - physician compensation - SI			0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6		ou on y	0		8.00
9.00	Primary payer payments (see instructions)			0		9,00
10.00	Subtotal (line 8 minus line 9)			0		10.00
11.00	Deductibles billed to program patients (exclude	amounts applica	ble to physician	0		11.00
	professional services)	anounco apprioa		Ŭ		1.1.00
12.00				0		12.00
13.00	Coinsurance billed to program patients (from pro	ovider records)	(excl ude coi nsurance	0		13.00
	for physician professional services)	· · · ·				
14.00	80% of Part B costs (line 12 x 80%)			0		14.00
15.00	Subtotal (enter the lesser of line 12 minus line	e 13, or line 14)	0		15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0		16.00
16.50	Pioneer ACO demonstration payment adjustment (se	ee instructions)		0		16.50
16.55	410A RURAL DEMONSTRATION PROJECT			0		16.55
17.00	Allowable bad debts (see instructions)			0		17.00
17.01	Adjusted reimbursable bad debts (see instruction			0		17.01
18.00	Allowable bad debts for dual eligible benefician	ries (see instru	ctions)	0		18.00
19.00	Total (see instructions)			0		19.00
19.01	Sequestration adjustment (see instructions)			0		19.01
20.00	Interim payments			0		20.00
21.00	Tentative settlement (for contractor use only)			0		21.00
22.00	Balance due provider/program (line 19 minus line			0		22.00
23.00	Protested amounts (nonallowable cost report iter	ms) in accordanc	e with CMS Pub. 15-2,	0		23.00
	chapter 1, §115.2					1

	Financial Systems JAY COUNTY H ATION OF REIMBURSEMENT SETTLEMENT	OSPITAL Provider CCN: 151320	Peri od:	u of Form CMS-2 Worksheet E-3	
			From 10/01/2014 To 09/30/2015	Part V Date/Time Pre 2/17/2016 10:	pare
		Title XVIII	Hospi tal	2/1//2018 10. Cost	07 a
			nospi tui	0031	
				1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE	E PART A SERVICES - COST	REIMBURSEMENT		
. 00	Inpatient services			1, 965, 088	
. 00	Nursing and Allied Health Managed Care payment (see instruct)	i ons)		0	
. 00	Organ acquisition			0	
. 00	Subtotal (sum of lines 1 through 3)			1, 965, 088	
. 00	Primary payer payments			0	
. 00	Total cost (line 4 less line 5). For CAH (see instructions)			1, 978, 058	6.
	COMPUTATION OF LESSER OF COST OR CHARGES				-
. 00	Reasonable charges			0	7.
. 00	Routi ne servi ce charges Anci I l ary servi ce charges			0	
. 00	Organ acquisition charges, net of revenue			0	
0.00	Total reasonable charges			0	
0.00	Customary charges			0	
1.00	Aggregate amount actually collected from patients liable for	payment for services on	a charge basis	0	1 11
2.00	Amounts that would have been realized from patients liable for			0	
	had such payment been made in accordance with 42 CFR 413.13(1 5	<u>.</u>		
3.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.00000	13
4.00	Total customary charges (see instructions)			0	14
5.00	Excess of customary charges over reasonable cost (complete or	nly if line 14 exceeds li	ne 6) (see	0	15
	instructions)				
6.00	Excess of reasonable cost over customary charges (complete or	nly if line 6 exceeds lin	e 14) (see	0	16
	instructions)			_	
7.00	Cost of physicians' services in a teaching hospital (see ins	tructions)		0	17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	4 11		0	1 10
B. 00 9. 00	Direct graduate medical education payments (from Worksheet E Cost of covered services (sum of lines 6, 17 and 18)	-4, ITHE 49)		1, 978, 058	
9.00 0.00	Deductibles (exclude professional component)			255, 836	
1.00	Excess reasonable cost (from line 16)			255, 850	
2.00	Subtotal (line 19 minus line 20 and 21)			1, 722, 222	
3.00	Coi nsurance			1, 722, 222	
4.00	Subtotal (line 22 minus line 23)			1, 722, 222	
5.00	Allowable bad debts (exclude bad debts for professional servi	ices) (see instructions)		45, 634	
5.00	Adjusted reimbursable bad debts (see instructions)	,		29, 662	
7.00	Allowable bad debts for dual eligible beneficiaries (see inst	tructions)		37, 879	
B. 00	Subtotal (sum of lines 24 and 25, or line 26)	~		1, 751, 884	
9.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
9.50	Pioneer ACO demonstration payment adjustment (see instruction	ns)		0	29
9. 99	Recovery of Accel erated Depreciation			0	29
0. 00	Subtotal (see instructions)			1, 751, 884	30
0. 01	Sequestration adjustment (see instructions)			35, 038	
	Interim payments			1, 730, 047	
2.00	Tentative settlement (for contractor use only)			0	
3.00	Balance due provider/program (line 30 minus lines 30.01, 31,			-13, 201	
4.00	Protested amounts (nonallowable cost report items) in accorda	anco with CMS Dub 15 2	chaptor 1	0	34

	Financial Systems JAY COUNTY			u of Form CMS-2552	
ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151320	Period:	Worksheet E-3	
		Component CCN: 15M320	From 10/01/2014 To 09/30/2015	Part II Date/Time Pre	
		Title XVIII	Subprovider - IPF	2/17/2016 10:0 PPS	07 a
				1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS			1.00	
. 00	Net Federal IPF PPS Payments (excluding outlier, ECT, and m	nedical education payments)		1, 351, 277] 1.
. 00	Net IPF PPS Outlier Payments			68, 732	
. 00	Net IPF PPS ECT Payments			0	
. 00	Unweighted intern and resident FTE count in the most recent 15, 2004. (see instructions)	t cost report filed on or b	efore November	0.00	4
. 01	Cap increases for the unweighted intern and resident FTE co	ount for residents that were	e displaced by	0.00	4
	program or hospital closure, that would not be counted with CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)				
. 00	New Teaching program adjustment. (see instructions)			0.00	5
. 00	Current year's unweighted FTE count of I&R excluding FTEs i	n the new program growth p	eriod of a "new	0.00	
55	teaching program" (see instuctions)			0.00	
. 00	Current year's unweighted I&R FTE count for residents withi teaching program" (see instuctions)	n the new program growth p	eriod of a "new	0.00	7
00	Intern and resident count for IPF PPS medical education adj	ustment (see instructions)		0.00	8
00	Average Daily Census (see instructions)			5. 323288	
0.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised 1	to the power of .5150 -1}.		0.000000	
. 00	Teaching Adjustment (line 1 multiplied by line 10).			0	11
. 00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11	1)		1, 420, 009	12
3.00	Nursing and Allied Health Managed Care payment (see instruc	ction)		0	13
4.00	Organ acquisition (DO NOT USE THIS LINE)				14
5.00	Cost of physicians' services in a teaching hospital (see in	nstructions)		0	15
5.00	Subtotal (see instructions)			1, 420, 009	
. 00	Primary payer payments			0	17
3.00	Subtotal (line 16 less line 17).			1, 420, 009	
9.00	Deductibles			83, 540	
0.00	Subtotal (line 18 minus line 19)			1, 336, 469	
1.00 2.00	Coinsurance			2,520	
2.00 3.00	Subtotal (line 20 minus line 21) Allowable bad debts (exclude bad debts for professional ser	wices) (see instructions)		1, 333, 949 0	23
. 00 . 00	Adjusted reimbursable bad debts (see instructions)	vices) (see first actions)		0	24
5.00	Allowable bad debts for dual eligible beneficiaries (see in	structions)		0	25
b. 00	Subtotal (sum of lines 22 and 24)			1, 333, 949	
7.00	Direct graduate medical education payments (from Wkst. E-4,	line 49)		0000, 717	27
3.00	Other pass through costs (see instructions)			0	28
9.00	Outlier payments reconciliation			0	29
0. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	30
). 50	Pioneer ACO demonstration payment adjustment (see instructi	ons)		0	30
). 99	Recovery of Accel erated Depreciation			0	30
1.00	Total amount payable to the provider (see instructions)			1, 333, 949	
I. 01	Sequestration adjustment (see instructions)			26, 679	
2.00	Interim payments			1, 307, 270	
	Tentative settlement (for contractor use only)			0	
4.00	Balance due provider/program (line 31 minus lines 31.01, 32			0	
5.00	Protested amounts (nonallowable cost report items) in accor §115.2	rdance with CMS Pub. 15-2, o	chapter 1,	0	35
0 00	TO BE COMPLETED BY CONTRACTOR)		40 700	-
	Original outlier amount from Worksheet E-3, Part II, line 2 Outlier recordination adjustment amount (see instructions)			68, 732	
1.00 2.00	Outlier reconciliation adjustment amount (see instructions)	1		0	51
/ 111	The rate used to calculate the Time Value of Money			0.00	1 22

	Financial Systems JAY COUNTY HOSP			u of Form CMS-2	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151320	Period: From 10/01/2014 To 09/30/2015		pared:
			11	2/17/2016 10:	07 am
	· · · · · · · · · · · · · · · · · · ·	Title XIX	Hospi tal Inpati ent	Cost Outpatient	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	ICES FOR TITLES V OR XI		2100	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		77, 209		1.00
2.00	Medical and other services			0	
3.00	Organ acquisition (certified transplant centers only)		0	0	3.00
4.00 5.00	Subtotal (sum of lines 1, 2 and 3)		77, 209	0	4.00
5.00 6.00	Inpatient primary payer payments Outpatient primary payer payments		0	0	•
7.00	Subtotal (line 4 less sum of lines 5 and 6)		77, 209	0	
	COMPUTATION OF LESSER OF COST OR CHARGES			-	1
	Reasonabl e Charges				
8.00	Routine service charges		37, 250		8.00
9.00	Ancillary service charges		68, 398	0	
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		105 (49	0	11.00
12.00	Total reasonable charges (sum of lines 8 through 11) CUSTOMARY CHARGES		105, 648	0	12.00
13.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13.00
10.00	basi s	services on a onarge	0	0	10.00
14.00	Amounts that would have been realized from patients liable for	payment for services o	n 0	0	14.00
	a charge basis had such payment been made in accordance with 42	CFR §413.13(e)			
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.00000	•
16.00	Total customary charges (see instructions)		105, 648	0	
17.00	Excess of customary charges over reasonable cost (complete only	28, 439	0	17.00	
18.00	line 4) (see instructions) Excess of reasonable cost over customary charges (complete only	if line 4 exceeds line		0	18.00
10.00	16) (see instructions)	IT THE 4 EXCEEds THE	0	0	10.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instru	ctions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16		77, 209	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co	ompleted for PPS provid			
22.00	Other than outlier payments		0	0	
23.00	Outlier payments		0	0	
24.00 25.00	Program capital payments		0		24.00 25.00
26.00	Capital exception payments (see instructions) Routine and Ancillary service other pass through costs		0	0	
27.00	Subtotal (sum of Lines 22 through 26)		0	0	
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	
29.00	Titles V or XIX (sum of lines 21 and 27)		77, 209	0	•
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				1
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		77, 209	0	
32.00	Deductibles		0	0	
	Coinsurance	0	0		
34.00 35.00	Allowable bad debts (see instructions) Utilization review	0	0	34.00 35.00	
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	77, 209	0	•	
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	, , , 207	0	37.00	
38.00	Subtotal (line 36 \pm line 37)	77, 209	0	38.00	
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00	
40.00	Total amount payable to the provider (sum of lines 38 and 39)	77, 209	0		
41.00	Interim payments		48, 092	0	•
42.00	Balance due provider/program (line 40 minus line 41)		29, 117	0	
43.00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub 15-2,	0	0	43.00
	chapter 1, §115.2				1

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151320	Period: From 10/01/2014	u of Form CMS-2 Worksheet E-3	
		Component CCN: 15M320	To 09/30/2015		
		Title XIX	Subprovider - IPF	Cost	
			I npati ent	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SEF COMPUTATION OF NET COST OF COVERED SERVICES	RVICES FOR TITLES V OR XI	X SERVICES		
00	Inpatient hospital/SNF/NF services		58, 231		1 1
00	Medical and other services			0	
00	Organ acquisition (certified transplant centers only)		0		
00	Subtotal (sum of lines 1, 2 and 3)		58, 231	0	4
00	Inpatient primary payer payments		0	_	5
00	Outpatient primary payer payments		50.001	0	
00	Subtotal (line 4 less sum of lines 5 and 6) COMPUTATION OF LESSER OF COST OR CHARGES		58, 231	0	
	Reasonable Charges				
00	Routi ne servi ce charges		35,007		1 8
00	Ancillary service charges		28, 421	0	
. 00	Organ acquisition charges, net of revenue		0		1(
. 00	Incentive from target amount computation		0		1
. 00	Total reasonable charges (sum of lines 8 through 11)		63, 428	0	1:
~ ~	CUSTOMARY CHARGES	· · · ·			
. 00	Amount actually collected from patients liable for payment for basis	r services on a charge	0	0	1:
. 00	Amounts that would have been realized from patients liable for	0	0	14	
. 00	a charge basis had such payment been made in accordance with	1 5		0	'
. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.00000	1
. 00	Total customary charges (see instructions)	, , ,			1
. 00	Excess of customary charges over reasonable cost (complete onl	ly if line 16 exceeds	5, 197	0	1
	line 4) (see instructions)				
. 00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line			0	18
. 00	16) (see instructions) Interns and Residents (see instructions)		0	0	10
. 00	Cost of physicians' services in a teaching hospital (see inst	ructions)	0	0	20
. 00	Cost of covered services (enter the lesser of line 4 or line		58, 231	0	
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be		lers.]
. 00	Other than outlier payments		0	0	
. 00	Outlier payments		0	0	-
. 00	Program capital payments		0		2
. 00 . 00	Capital exception payments (see instructions) Routine and Ancillary service other pass through costs		0	0	2
. 00	Subtotal (sum of lines 22 through 26)		0	0	
. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28
. 00	Titles V or XIX (sum of lines 21 and 27)		58, 231	0	2
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
. 00	Excess of reasonable cost (from line 18)		0	0	
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6))	58, 231	0	
	Deducti bl es		0	0	
. 00 . 00	Coinsurance Allowable bad debts (see instructions)		0	0	
. 00	Utilization review		0	0	3!
. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)			0	
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	58, 231 0	0		
. 00	Subtotal (line 36 ± line 37)		58, 231	0	38
. 00	Direct graduate medical education payments (from Wkst. E-4)		0		39
. 00	Total amount payable to the provider (sum of lines 38 and 39)		58, 231	0	
. 00	Interim payments		34, 675	0	
. 00	Balance due provider/program (line 40 minus line 41)		23, 556	0	
3.00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub 15-2,	0	0	43

	E SHEET (If you are nonproprietary and do not maintain		CCN: 151320	Period: From 10/01/2014	Worksheet G	
und-t	ype accounting records, complete the General Fund column onl	y)		To 09/30/2015		
		General Fund	Speci fi c	Endowment Fund	2/17/2016 10: Pl ant Fund	07 am
		1.00	Purpose Fund 2.00	3.00	4.00	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
. 00	Cash on hand in banks	2, 296, 619		0 0	0	
. 00	Temporary investments	0		0 0	0	
. 00	Notes receivable			0 0	0	
. 00 . 00	Accounts recei vabl e Other recei vabl e	16, 141, 374		0 0	0	
. 00	Allowances for uncollectible notes and accounts receivable	0		0 0	0	
. 00	Inventory	749, 555		0 0	0	
. 00	Prepai d'expenses	0		0 0	0	8. (
. 00	Other current assets	0		0 0	0	
0.00	Due from other funds	0		0 0	0	
1.00	Total current assets (sum of lines 1-10)	19, 187, 548		0 0	0	11. (
2. 00	FI XED ASSETS Land	347, 733		0 0	0	12. (
3.00	Land improvements	1 347,733 0		0 0	0	
	Accumulated depreciation	0		0 0	0	
5.00	Bui I di ngs	0		0 0	0	15.
6. 00	Accumulated depreciation	0		0 0	0	16.
	Leasehold improvements	0		0 0	0	
	Accumulated depreciation	0		0 0	0	
	Fixed equipment	0		0 0	0	
	Accumulated depreciation			0 0	0	
	Automobiles and trucks Accumulated depreciation			0 0	0	
	Major movable equipment	12, 579, 294		0 0	0	
	Accumul ated depreciation	0		0 0	0	
	Minor equipment depreciable	0		0 0	0	
	Accumulated depreciation	0		0 0	0	26.
. 00	HIT designated Assets	0		0 0	0	27.
	Accumulated depreciation	0		0 0	0	
	Minor equipment-nondepreciable	0		0 0	0	
	Total fixed assets (sum of lines 12-29)	12, 927, 027		0 0	0	30.
	OTHER ASSETS Investments	0		0 0	0	31.
	Deposits on Leases			0 0	0	
3.00	Due from owners/officers	0		0 0	0	
	Other assets	16, 663, 835		0 0	0	
5.00	Total other assets (sum of lines 31-34)	16, 663, 835		0 0	0	35.
b. 00	Total assets (sum of lines 11, 30, and 35)	48, 778, 410		0 0	0	36.
	CURRENT LI ABI LI TI ES	L	1			
	Accounts payable	518, 017		0 0	0	
3.00	Salaries, wages, and fees payable	1, 499, 370		0 0	0	
	Payroll taxes payable Notes and Loans payable (short term)			0 0	0	
	Deferred income				0	1 .0.
2.00	Accelerated payments	0		0	0	42.
	Due to other funds	0		0 0	0	
1.00	Other current liabilities	-14, 678		0 0	0	44.
5.00	Total current liabilities (sum of lines 37 thru 44)	2, 002, 709		0 0	0	45.
	LONG TERM LI ABI LI TI ES					1
1	Mortgage payable	0		0 0	0	
7.00 3.00	Notes payable Unsecured Loans			0 0	0	
	Other long term liabilities	2, 198, 076		0 0	0	
. 00	Total long term liabilities (sum of lines 46 thru 49	2, 198, 076		0 0	0	
	Total liabilites (sum of lines 45 and 50)	4, 200, 785		0 0		
	CAPI TAL ACCOUNTS					
. 00	General fund balance	44, 577, 625				52.
. 00	Specific purpose fund			0		53.
. 00	Donor created - endowment fund balance - restricted			0		54.
. 00	Donor created - endowment fund balance - unrestricted			0		55.
. 00	Governing body created - endowment fund balance			0	_	56.
. 00	Plant fund balance - invested in plant				0	
8. 00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.
9.00	Total fund balances (sum of lines 52 thru 58)	44, 577, 625		0 0	0	59.
). 00). 00	Total liabilities and fund balances (sum of lines 51 and	48, 778, 410		0 0	0	
	59)		1		U U	1

Heal th	Financial Systems	JAY COUNTY I	HOSPI TAL			In Lie	eu of Form CMS.	2552-10
	ENT OF CHANGES IN FUND BALANCES			r CCN: 151320		eriod: com 10/01/2014	Worksheet G-	1 epared:
		General	Fund	Speci al	Pu	rpose Fund	Endowment Fund	ł
		1.00	2.00	3.00		4.00	5.00	
$\begin{array}{c} 1.00\\ 2.00\\ 3.00\\ 4.00\\ 5.00\\ 6.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 12.00\\ 13.00\\ 14.00\\ 15.00\\ 16.00\\ 17.00\\ 18.00\\ 19.00\end{array}$	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		42, 581, 6 1, 996, 0 44, 577, 6 44, 577, 6	02 25 0 25 0	0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0		5.00 6.00 7.00 8.00 9.00 10.00 11.00 0.12.00 13.00 14.00 15.00 16.00
	sheet (line 11 minus line 18)					0		19.00
		Endowment Fund	PI a	nt Fund				
		6.00	7.00	8.00				
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0		0 0 0 0 0 0	0			1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0		0 0 0 0 0 0	0 0 0 0			10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

Heal th	Financial Systems JAY COUNTY HOSP	I TAL			In Lie	u of Form CMS-2	2552-10
STATEM	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der	CCN: 151320	Per Fro To	riod: om 10/01/2014 09/30/2015	Worksheet G-2 Parts I & II Date/Time Prep 2/17/2016 10:0	oared: D7 am
	Cost Center Description		Inpatient		Outpatient	Total	
	PART I - PATIENT REVENUES		1.00		2.00	3.00	
	General Inpatient Routine Services						
1.00	Hospi tal		4, 740, 7	72		4, 740, 772	1.00
2.00	SUBPROVIDER - IPF		1, 535, 8	60		1, 535, 860	2.00
3.00	SUBPROVIDER - IRF			0		0	3.00
4.00	SUBPROVIDER			0		0	4.00
5.00	Swing bed - SNF			0		0	5.00
6.00	Swing bed - NF			0		0	6.00
7.00 8.00	SKILLED NURSING FACILITY NURSING FACILITY						7.00 8.00
8.00 9.00	OTHER LONG TERM CARE						8.00 9.00
10.00	Total general inpatient care services (sum of lines 1-9)		6, 276, 6	32		6, 276, 632	
10.00	Intensive Care Type Inpatient Hospital Services		0,270,0	52	I	0, 270, 032	10.00
11.00	INTENSIVE CARE UNIT			0		0	11.00
12.00	CORONARY CARE UNIT						12.00
13.00	BURN INTENSIVE CARE UNIT						13.00
14.00	SURGI CAL INTENSI VE CARE UNI T						14.00
15.00	OTHER SPECIAL CARE (SPECIFY)						15.00
16.00	Total intensive care type inpatient hospital services (sum of I	ines		0		0	16.00
17 00	11-15)			22		()7(())	17 00
17.00 18.00	Total inpatient routine care services (sum of lines 10 and 16) Ancillary services		6, 276, 6 8, 762, 5		58, 082, 532	6, 276, 632 66, 845, 036	17.00 18.00
18.00	Outpatient services		495.7		18, 443, 092	18, 938, 833	
20.00	RURAL HEALTH CLINIC		493,7	0	10, 443, 092	10, 950, 055	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0	0	0	21.00
22,00	HOME HEALTH AGENCY			-	-	-	22.00
23.00	AMBULANCE SERVICES						23.00
24.00	СМНС						24.00
24.10	CORF			0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D. P.)						25.00
26.00	HOSPICE						26.00
27.00	OTHER (SPECIFY)		45 504 0	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 t	D WKST.	15, 534, 8	//	76, 525, 624	92, 060, 501	28.00
	G-3, line 1) PART II - OPERATING EXPENSES						
29.00	Operating expenses (per Wkst. A, column 3, line 200)				37, 084, 180		29.00
30.00	ADD (SPECIFY)			0			30.00
31.00				0			31.00
32.00				0			32.00
33.00				0			33.00
34.00				0			34.00
35.00				0			35.00
36.00	Total additions (sum of lines 30-35)			~	0		36.00
37.00	DEDUCT (SPECI FY)			0			37.00
38. 00 39. 00				0			38. 00 39. 00
40.00				0			40. 00
40.00				0			40.00
42.00	Total deductions (sum of lines 37-41)			-	О		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfer			37, 084, 180		43.00
	to Wkst. G-3, line 4)						

Heal th	Health Financial Systems JAY COUNTY HOSP				In Lie	u of Form CMS-2	2552-10
STATE	STATEMENT OF REVENUES AND EXPENSES P		/ider CC	N: 151320	Peri od:	Worksheet G-3	
					From 10/01/2014 To 09/30/2015	Date/Time Pre	arad
					10 097 307 2013	2/17/2016 10:0	
						1.00	
1.00	Total patient revenues (from Wkst. G-2, Part	I, column 3, line 28)				92, 060, 501	1.00
2.00	Less contractual allowances and discounts on	patients' accounts				53, 099, 389	2.00
3.00	Net patient revenues (line 1 minus line 2)					38, 961, 112	3.00
4.00	Less total operating expenses (from Wkst. G-2					37, 084, 180	
5.00	Net income from service to patients (line 3 m	ninus line 4)				1, 876, 932	5.00
	OTHER INCOME						
6.00	Contributions, donations, bequests, etc					0	6.00
7.00	Income from investments					0	7.00
8.00	Revenues from telephone and other miscellaned	ous communication servic	es			0	8.00
9.00	Revenue from television and radio service					0	9.00
10.00	Purchase di scounts					0	10.00
11.00	· · ·					0	11.00
12.00						0	12.00
13.00						0	13.00
14.00	1 5 5	sts				0	14.00
15.00	Revenue from rental of living quarters					0	15.00
16.00	Revenue from sale of medical and surgical sup		ients			0	16.00
17.00	Revenue from sale of drugs to other than pati					0	17.00
18.00	Revenue from sale of medical records and abst					0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, e					0	19.00
20.00	Revenue from gifts, flowers, coffee shops, an	nd canteen				0	20.00
21.00	5					0	
22.00						0	
23.00	The second secon					0	
24.00	NONOP REV TRANSFER FOUND					119, 070	
25.00	Total other income (sum of lines 6-24)					119, 070	
26.00						1, 996, 002	
	OTHER EXPENSES (SPECIFY)					0	27.00
	Total other expenses (sum of line 27 and subs					0	28.00
29.00	Net income (or loss) for the period (line 26	minus line 28)				1, 996, 002	29.00