| 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 | | | | |
| Display Was the cost report prepared only using the provider's records? If yes, see N N 21.0 Committee Bit Cost and the Mail State of the Mail State of the Mail State of the Mail State Ost and Stat | | | | | | | | |
| Instructions. 1.00 COMPLETED BY COST RELIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) 1.00 Capital Related Cost N 22.0 22.00 Reversests been relifed for Nedicare purposes? If yes, see instructions N 22.1 23.01 Have changes occurred in the Medicare purposes? If yes, see instructions N 22.1 24.00 Free Seen new control to a set the see entered into during this cost reporting period? If yes, see instructions. N 22.1 25.00 Have there been new control tailized leases entered into during the cost reporting period? If yes, see instructions. N 22.1 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions. N 22.1 27.00 Has the provider is capitalized leases ontered into during the cost reporting period? If yes, see instructions. N 22.1 28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting or (a secont and/or bond funds (Det Service Reserve Fund) Y 29.1 28.01 Have changes or new agreements occurred in patient care services furnished through contractual instructions. N 30.1 30.01 Has edd be or replaced prior to its scheduled maturity with new debt? If yes, see instructions. N 32.1 30.02 H | 21.00 | Was the cost report prepared only using the | | 0 | | 2.00 | | 21.00 |
| Completies 1.00 Completies | | | | | | | | |
| COMPLETED BY COST RETINEURSD AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) 22.0 Capit tal Related Cost N 22.0 21.00 Have assets been relifed for Medicare purposes? If yes, see instructions N 22.0 22.00 Have assets been relifed for Medicare dupreciation expense due to appriasist made during the cost reporting period? If yes, see instructions N 22.0 22.00 Have melloases and/or amendments to existing leases entered into during the cost reporting period? If yes, see N 22.1 23.00 Have melloases and/or amendments to existing leases entered into during the cost reporting period? If yes, see N 22.1 24.00 Were new leases, and/or amendments to existing lease entered into during the cost reporting period? If yes, see N 22.1 25.00 Have the provider have apit talization policy changed during the cost reporting period? If yes, submit N 22.1 20.00 Has the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) Y 28.1 21.00 Have asisting debt been replaced prior to its scheduled maturity without issuance of new debt? If yes, see N 33.1 32.00 Have acisting debt been replaced prior to its scheduled maturity without issuance of new debt? If yes, see N 33.1 33.00 If Fine 32 is yes, were there and agreements occurred in patient c | | instructions. | | | | | | |
| COMPLETED BY COST RETINEURSD AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) 22.0 Capit tal Related Cost N 22.0 21.00 Have assets been relifed for Medicare purposes? If yes, see instructions N 22.0 22.00 Have assets been relifed for Medicare dupreciation expense due to appriasist made during the cost reporting period? If yes, see instructions N 22.0 22.00 Have melloases and/or amendments to existing leases entered into during the cost reporting period? If yes, see N 22.1 23.00 Have melloases and/or amendments to existing leases entered into during the cost reporting period? If yes, see N 22.1 24.00 Were new leases, and/or amendments to existing lease entered into during the cost reporting period? If yes, see N 22.1 25.00 Have the provider have apit talization policy changed during the cost reporting period? If yes, submit N 22.1 20.00 Has the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) Y 28.1 21.00 Have asisting debt been replaced prior to its scheduled maturity without issuance of new debt? If yes, see N 33.1 32.00 Have acisting debt been replaced prior to its scheduled maturity without issuance of new debt? If yes, see N 33.1 33.00 If Fine 32 is yes, were there and agreements occurred in patient c | | | | | | | 1 00 | |
| 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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| If yes, see instructions. If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office. N 38.00 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. N 39.00 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. SEVERS 41.0 42.00 Enter the employer/company name of the cost report preparer. BLUE & CO., LLC 42.0 | | | | concerned by the | hama affi as? | | | 36.00 |
| 38.00 If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office. N 38.0 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. N 39.0 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.0 41.00 Cost Report Preparer Contact Information TINA SEVERS 41.0 42.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. BLUE & CO., LLC 42.0 | 37.00 | | atement been pr | epared by the | nome office? | IN | | 37.00 |
| 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. N 39.0 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.0 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.0 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.0 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.0 41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. SEVERS 41.0 42.00 Enter the employer/company name of the cost report BLUE & CO., LLC 42.0 | 38.00 | If line 36 is yes , was the fiscal year end o | | | | Ν | | 38.00 |
| 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 41.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 41.00 If line 36 is yes, did the provider render services to the home of the cost report BLUE & CO., LLC 41.00 If line 36 is yes, did the provider render services to the home of the cost report BLUE & CO., LLC 42.0 | 39 00 | | | | | Ν | | 39.00 |
| Instructions. Image: Cost Report Preparer Contact Information 41.00 Enter the first name, I ast name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report preparer. | 37.00 | | | | ients: 11 yes, | | | 57.00 |
| Cost Report Preparer Contact Information 1.00 2.00 41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. TINA SEVERS 41.0 42.00 Enter the employer/company name of the cost report preparer. BLUE & CO., LLC 42.0 | 40.00 | | ervices to the | home office? | lf yes, see | Ν | | 40.00 |
| Cost Report Preparer Contact Information 41.00 Enter the first name, I ast name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report preparer. | | | | | | | | |
| 41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. TINA SEVERS 41.0 42.00 Enter the employer/company name of the cost report preparer. BLUE & CO., LLC 42.0 | | | | 1. | 00 | 2. | 00 | |
| held by the cost report preparer in columns 1, 2, and 3, respectively.42.00Enter the employer/company name of the cost report preparer.BLUE & CO., LLC42.00 | | | | | | | | 44.05 |
| 42.00 respectively. Enter the employer/company name of the cost report BLUE & CO., LLC 42.0 | 41.00 | - | | IINA | | SEVERS | | 41.00 |
| 42.00 Enter the employer/company name of the cost report BLUE & CO., LLC 42.0 | | | ı, ∠, anu 3, | | | | | |
| | 42.00 | Enter the employer/company name of the cost r | report | BLUE & CO., LL | .C | | | 42.00 |
| 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 | 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 | 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 | - | - | |
| 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 | | | 1, 040 | 0 | 58 | 20, 419 | 43.00 |
| 53.00 OS300 (ARSTHESI OLGOY 0 0 0 0 53.00 | | | | | | | 1 |
| 57.00 05700 (T SCAN 0 | | | | 0 | | | |
| 58:00 OSB00 MACHTIC RESONANCE LINAGING (MRI) 0 | | | | | | | |
| 99 00 | | - | - | 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 | | | | | | | |
| 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 | | | | | | | |
| 31.0.0 03100 INTENSIVE CARE UNIT 31.00 00.00 04000 SUBPROV DER - IFF 40.00 41.00 04100 SUBPROV DER - IFF 42.00 42.00 04200 NURSERV 42.00 MILLIARY SERVICE COST CENTERS 50.00 52.00 05200 PERVICE COST CENTERS 50.00 50.00 05200 DELIVERY ROW & LABOR ROM 0.266609 53.00 51.00 05200 DELIVERY ROW & LABOR ROM 0.346594 52.00 52.00 05200 DELIVERY ROW & LABOR ROM 0.346594 52.00 52.00 05400 RADILOGY-DIAGNOSTIC 0.111145 54.00 58.00 05600 MARCHTIC RESONANCE I MAGING (MRI) 0.000000 55.00 60.00 06600 LABORATORY 0.170161 60.01 60.01 06000 LABORATORY 0.300200 66.00 60.00 06000 PHYSICAL THERAPY 0.379431 66.00 60.00 06000 CHABORATORY 0.379441 69.00 61.00 ORGON DURUS CHARGED TO PATIENTS 0.540907 70.00 | INPATIENT ROUTINE SERVICE | COST CENTERS | | | | | |
| 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 | | | | | | | |
| 11.00 Q4100 SUBPROVIDER - 1.RF 41.00 20.00 Q4200 SUBPROVIDER 42.00 ANCLLARY SERVICE COST CENTERS 50.00 OSDOO (DPEATING ROOM 0.266609 50.00 OSDOO DELIVERY NOM & LABOR ROOM 0.346594 53.00 52.00 DSJOO DELIVERY NOM & LABOR ROOM 0.346594 53.00 53.00 DSJOO ANESTHESI OLOGY 0.000000 53.00 54.00 DSJOO ANESTHESI OLOGY 0.000000 53.00 57.00 DSJOO ANESTHESI OLOGY 0.000000 56.00 58.00 DSJOO ANESTHESI OLOGY 0.000000 56.00 59.00 DSJOO ANESTHESI OLOGY 0.000000 56.00 60.00 DSJOO MACHTI CR SJONANCE IMAGI NG (MRI) 0.000000 56.00 60.00 DSGOO HELOEI LABORATORY 0.000000 66.00 60.00 DGGOO HYSI SCA THERAPY 0.379843 66.00 60.00 DGGOO SPECEH PATHOLOGY 0.379441 66.00 60.00 DGGOO IRUBAC HEALT HCLINTS 0.000000 71.00 72.00 OTZOO IMEDICAL SUPPLIES CHARED TO PATIENTS 0.000000 72.00 | | | | | | | |
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| 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 DSERVATION BEDS (NON-DISTINCT PART) 1.467780 92.00 93.00 Other outpatient service cost center 0.000000 93.00 OHER REIMBURSABLE COST CENTERS 99.10 09910 CORF 99.10 99.10 09910 CORF 99.10 106.00 10600 HEART ACQUISITION 106.00 104.00 10600 PANCREAS ACQUISITION 100.00 109.00 100.00 | | | | | | | 1 |
| 90.01 09001 FAMI LY PRACTICE OF JAY COUNTY 1.705519 90.01 90.02 09002 JAY FAMI LY MEDICINE 2.628558 90.02 91.00 09100 EMERGENCY 0.466754 91.00 92.00 09SERVATI ON BEDS (NON-DI STI NCT PART) 1.467780 92.00 93.00 04040 OTHER OUTPATI ENT SERVICE COST CENTER 0.00000 92.00 07HER REI MBURSABLE COST CENTERS 99.10 0.09910 CORF 99.10 99.10 09900 PANCREAS ACQUI SI TI ON 106.00 10600 HEART ACQUI SI TI ON 106.00 100.00 10000 INTEST INAL ACQUI SI TI ON 110.00 109.00 109.00 111.00 11000 INTERST EXPENSE 111.00 111.00 111.00 111.00 111.00 113.00 113.00 113.00 113.00 200.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00 201.00 201.00 201.00 | | HEALTH CENTER | | | | | |
| 90.02 09002 JAY FAMILY MEDICINE 2.628558 90.02 91.00 09100 EMERGENCY 0.466754 91.00 92.00 09SERVATION BEDS (NON-DISTINCT PART) 1.467780 92.00 93.00 04040 OTHER OUTPATIENT SERVICE COST CENTER 0.000000 93.00 0THER REIMBURSABLE COST CENTERS 99.10 09910 00FF 99.10 99.10 09910 INFERTION 106.00 10600 HEART ACQUISITION 106.00 106.00 10600 HEART ACQUISITION 106.00 109.00 109.00 109.00 111.00 11000 INTESTINAL ACQUISITION 110.00 109.00 109.00 109.00 111.00 11000 INTERST EXPENSE 110.00 110.00 111.00 111.00 113.00 113.00 113.00 113.00 113.00 113.00 109.00 200.00 201.00 200.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>1</td> | | | | | | | 1 |
| 91.00 09100 EMERGENCY 0.466754 91.00 92.00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 1.467780 92.00 93.00 04040 OTHER OUTPATI ENT SERVICE COST CENTER 0.000000 93.00 OTHER REI MBURSABLE COST CENTERS 99.10 09910 OOFF 99.10 99.10 SPECIAL PURPOSE COST CENTERS 99.10 106.00 10600 HEART ACQUI SI TI ON 106.00 109.00 10900 PANCREAS ACQUI SI TI ON 106.00 110.00 11000 INTESTI NAL ACQUI SI TI ON 100.00 111.00 11100 ISLET ACQUI SI TI ON 110.00 111.00 1100 INTERST EXPENSE 113.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00 Less Observation Beds 201.00 201.00 | | | | | | | |
| 92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 1.467780 92.00 93.00 04040 OTHER OUTPATIENT SERVICE COST CENTER 0.000000 93.00 0THER REIMBURSABLE COST CENTERS 0.000000 99.10 99.10 09910 CORF 99.10 SPECIAL PURPOSE COST CENTERS 99.10 106.00 10600 HEART ACQUI SI TI ON 106.00 109.00 10900 PANCREAS ACQUI SI TI ON 106.00 110.00 11000 INTESTI NAL ACQUI SI TI ON 110.00 111.00 11100 ISLET ACQUI SI TI ON 111.00 113.00 11300 INTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 200.00 201.00 | | | | | | | |
| 93.00 04040 OTHER OUTPATIENT SERVICE COST CENTER 0.000000 93.00 OTHER REIMBURSABLE COST CENTERS 09910 CORF 99.10 SPECIAL PURPOSE COST CENTERS 99.10 106.00 10600 HEART ACQUISITION 106.00 100.00 10900 PANCREAS ACQUISITION 106.00 109.00 109.00 109.00 110.00 11000 INTESTINAL ACQUISITION 110.00 110.00 111.00 110.00 110.00 110. | | ON DICTINGT DADT) | | | | | |
| OTHER REI MBURSABLE COST CENTERS 99. 10 99. 10 OOP910 CORF 99. 10 99. 10 99. 10 SPECIAL PURPOSE COST CENTERS 106. 00 106. 00 106. 00 106. 00 109. 00 1000 PANCREAS ACQUI SI TI ON 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 110. 00 111. 00 111. 00 111. 00 111. 00 111. 00 111. 00 113.00 113.00 113. 00 113. 00 113. 00 200. 00 Subtotal (see instructions) 200. 00 201. 00 | | | | | | | |
| 99.10 09910 CORF 99.10 SPECIAL PURPOSE COST CENTERS 106.00 10600 HEART ACQUISITION 106.00 109.00 10900 PANCREAS ACQUISITION 106.00 109.00 110.00 11000 INTESTINAL ACQUISITION 100.00 110.00 111.00 ISLET ACQUISITION 110.00 111.00 11300 INTERST EXPENSE 113.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00 201.00 | | | 0.000000 | | | | 93.00 |
| 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 |
| 106.00 HEART ACQUI SI TI ON 106.00 109.00 10900 PANCREAS ACQUI SI TI ON 109.00 110.00 INTESTI NAL ACQUI SI TI ON 110.00 111.00 ISLET ACQUI SI TI ON 110.00 111.00 ISLET ACQUI SI TI ON 111.00 113.00 INTERST EXPENSE 113.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00 | | EDC | | | | | 99.10 |
| 109.00 PANCREAS ACQUISITION 109.00 110.00 INTESTINAL ACQUISITION 110.00 111.00 INTESTINAL ACQUISITION 110.00 111.00 ISLET ACQUISITION 111.00 113.00 INTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00 | | LNJ | | | | | 106 00 |
| 110.00 INTESTINAL ACQUISITION 110.00 111.00 ISLET ACQUISITION 111.00 113.00 INTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00 | | N | | | | | 1 |
| 111.00 1 SLET ACQUI SITION 111.00 113.00 1 NTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00 | | | | | | | |
| 113.00 INTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00 | | | | | | | |
| 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00 | | | | | | | |
| 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 |
| | | | | | | | |