Health Financia	al Syst	ems	JAY COUNTY HOSE	PI TAL		In Lie	u of Form	CMS-2552-10	0
			g; 42 CFR 413.20(b)). Failu						
payments made	si nce	the beginning of the co	st reporting period being o	deemed overpaymen	ts (42	! USC 1395g).	OMB NO. C)938-0050	
			OST REPORT CERTIFICATION	Provider CCN: 15	1320	Peri od:	Worksheet		
AND SETTLEMENT	SUMMA	RY				From 10/01/2013 To 09/30/2014		Prepared:	
PART I - COST	REPORT	STATUS							
Provi der	1. [X] Electronically filed	cost report			Date: 2/26/20	15 Tim	ie: 9:42 an	n
use only	2. [] Manually submitted co	st report						
	3. [0 4. [F] If this is an amended] Medicare Utilization.	report enter the number o Enter "F" for full or "L"	f times the provi for low.	der re	esubmitted this c	ost report		
Contractor use only	(1) (2) (3)	Settled with Audit		this Provider CC his Provider CCN	11. C	IPR Date: Contractor's Vendo 0]If line 5, co number of tim	olumn 1 is		
	(4)	Reopened							

PART II - CERTIFICATION

(5) Amended

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

CERTIFICATION BY 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 10/01/2013 and ending 09/30/2014 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.

(Si gned)				
	Officer or	Administrator	of Provider(s)	
			• •	
Title				_
11 11 6				
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	28, 438	360, 811	120, 287	-3, 639	1. 00
2.00	Subprovider - IPF	0	0	0		9, 107	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	41, 958	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	70, 396	360, 811	120, 287	5, 468	200. 00

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

Health Financial Systems JAY COUNTY HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 151320 Peri od: Worksheet S-2 From 10/01/2013 Part I 09/30/2014 Date/Time Prepared: 2/25/2015 3:11 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 500 W. VOTAW 1.00 1.00 PO Box: State: IN 2.00 City: PORTLAND Zip Code: 47371-County: JAY 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N)

XVIII XIX Туре Certi fi ed Number Number 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal JAY COUNTY HOSPITAL 151320 99915 01/01/2004 Ν 0 0 3.00 Subprovider - IPF JAY COUNTY 99915 10/01/2005 Р 0 4.00 4.00 15M320 4 Ν HOSPITAL-PSYCH UNIT 5.00 Subprovider - IRF 5.00 Subprovi der - (Other) 6.00 6.00 Swing Beds - SNF JAY COUNTY HOSPITAL 157320 99915 01/01/2004 0 7 00 7 00 N 0 Swing Beds - NF 8.00 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 14.00 Hospi tal -Based Hospi ce 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 16.00 Hospital-Based Health Clinic - FQHC 16.00 Hospital-Based (CMHC) I 17.00 17.00 17. 10 Hospi tal -Based (CORF) I 17.10 18.00 Renal Dialysis 18.00 19.00 Other 19.00 To: From: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 20.00 10/01/2013 09/30/2014 21.00 Type of Control (see instructions) 21.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for disproportionate Ν 22.00 share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y' for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this cost reporting 22.01 period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column Ν 23.00 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method enter "Y" for yes or "N" for no. used in the prior cost reporting period? In column 2, In-State In-State Out-of Out-of Medicaid Other

	Medicaid paid days	Medi cai d el i gi bl e unpai d days	State Medicaid paid days	State Medi cai d el i gi bl e unpai d	HMO days	Medi cai d days	
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24. 00
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0		25. 00

0. od

o. od

61.06

61.04 minus line 61.03). (see instructions) Enter the amount of ACA §5503 award that is being

care or general surgery. (see instructions)

used for cap relief and/or FTEs that are nonprimary

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)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENT		HOSPI TAL	CCN: 151320	Peri o		u of Form CMS Worksheet S	
	IFICATION DATA	Provider	JCN. 151320	From	10/01/2013	Part I	
				То	09/30/2014	Date/Time P 2/25/2015 3	
					1. 00	2. 00	
All Providers					1.00	2.00	
40.00 Are there any related organization or hom	ne office costs as d	lefined in CMS	Pub. 15-1,		Υ		140.
chapter 10? Enter "Y" for yes or "N" for are claimed, enter in column 2 the home of				S			
1.00	2. 00)			3. 00		
If this facility is part of a chain organ				name a	nd address	of the	
home office and enter the home office cor		ontractor numbe					
	ontractor's Name:) Box:		Contrac	tor S	number:		141. 142.
	ate: CA		Zi p Cod	٥.			143.
10. 00 01 13.	071		L. p	<u> </u>			1.10.
						1.00	
44.00 Are provider based physicians' costs incl						Υ	144.
45.00 If costs for renal services are claimed o		e 74, are they	costs for i	npati er	nt	N	145.
services only? Enter "Y" for yes or "N" f	or no.						
					1. 00	2.00	-
46.00 Has the cost allocation methodology chang	ed from the previou	ıslv filed cost	report?		N N	2.00	146.
Enter "Y" for yes or "N" for no in column				5,			
enter the approval date (mm/dd/yyyy) in c							
47.00 Was there a change in the statistical bas					N		147.
48.00 Was there a change in the order of alloca					N		148.
49.00 Was there a change to the simplified cost no.	rinding method? En	iter "Y" for ye	s or "N" To	or	N		149.
J110.		Part A	Part B		Title V	Title XIX	
		1.00	2.00		3. 00	4.00	
Does this facility contain a provider tha							
or charges? Enter "Y" for yes or "N" for	no for each compone			(See			1,55
55.00 Hospi tal 56.00 Subprovi der - IPF		N N	N N		N N	N N	155. 156.
57. 00 Subprovider - TRF		N I	N		N	N	157.
58. 00 SUBPROVI DER							158.
59. 00 SNF		N	N		N	N	159.
60.00 HOME HEALTH AGENCY		N	N		N	N	160.
61. 00 CMHC			N		N	N	161.
61. 10 CORF			N		N	N	161.
						1.00	
Mul ti campus							
65.00 Is this hospital part of a Multicampus ho	spital that has one	e or more campu	ses in diff	erent (CBSAs?	N	165.
Enter "Y" for yes or "N" for no.	Name	County	State Z	ip Code	e CBSA	FTE/Campus	
	0	1. 00	2.00	3. 00	4. 00	5.00	
66.00 f line 165 is yes, for each							00 166.
campus enter the name in column							
0, county in column 1, state in							
column 2, zip code in column 3,							
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in							
column 2, zip code in column 3,							
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in						1.00	
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5							
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 Health Information Technology (HIT) incer 67.00 s this provider a meaningful user under	Section §1886(n)?	Enter "Y" for	yes or "N"	for no.		Y	
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 Health Information Technology (HIT) incer 67.00 is this provider a meaningful user under 68.00 if this provider is a CAH (line 105 is "Y	Section §1886(n)? (") and is a meaning	Enter "Y" for Jful user (line	yes or "N"	for no.		Y	
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 Health Information Technology (HIT) incer 67.00 is this provider a meaningful user under 68.00 if this provider is a CAH (line 105 is "Y reasonable cost incurred for the HIT asse	Section §1886(n)? ") and is a meaning ets (see instruction	Enter "Y" for yful user (line ns)	yes or "N" 167 is "Y"	for no.), ente	er the	Y 184, 8	168.
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 Health Information Technology (HIT) incer 67.00 s this provider a meaningful user under 68.00 f this provider is a CAH (line 105 is "Y reasonable cost incurred for the HIT asse	Section §1886(n)? ") and is a meaning ets (see instruction	Enter "Y" for yful user (line ns)	yes or "N" 167 is "Y"	for no.), ente	er the	Y 184, 8	886 168. (
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 Health Information Technology (HIT) incer 67.00 is this provider a meaningful user under 68.00 if this provider is a CAH (line 105 is "Y reasonable cost incurred for the HIT asse 69.00 if this provider is a meaningful user (li	Section §1886(n)? ") and is a meaning ets (see instruction	Enter "Y" for yful user (line ns)	yes or "N" 167 is "Y"	for no.), ente : "N"),	er the	Y 184, 8 0. Endi ng	167. (886 168. (00 169. (
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 Health Information Technology (HIT) incer 67.00 is this provider a meaningful user under 68.00 if this provider is a CAH (line 105 is "Y reasonable cost incurred for the HIT asse 69.00 if this provider is a meaningful user (li	Section §1886(n)? "") and is a meaning its (see instruction ne 167 is "Y") and	Enter "Y" for gful user (line as) is not a CAH (yes or "N" 167 is "Y" line 105 is	for no.), ente : "N"),	er the	Y 184, 8 0.	00169.

the other adjustments:

made to PS&R Report data for Other? Describe

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provi der CCN: 151320 Peri od: Worksheet S-2 From 10/01/2013 Part II Date/Time Prepared: 09/30/2014 2/25/2015 3:11 pm Part A Part B Description Y/N Date Y/N 0 1.00 2.00 3.00 21.00 Was the cost report prepared only using the Ν 21 00 Ν provider's records? If yes, see . instructions 1.00 COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Capital Related Cost Have assets been relifed for Medicare purposes? If yes, see instructions 22.00 22.00 Ν Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost 23.00 Ν 23.00 reporting period? If yes, see instructions. 24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? Ν 24.00 If ves. see instructions Have there been new capitalized leases entered into during the cost reporting period? If yes, see Ν 25.00 25.00 instructions. 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see Ν 26,00 instructions. 27 00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit Ν 27.00 сору. Interest Expense 28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting N 28.00 period? If yes, see instructions. Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) Υ 29.00 treated as a funded depreciation account? If yes, see instructions Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see Ν 30.00 instructions. 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see Ν 31.00 instructions. Purchased Services 32.00 Have changes or new agreements occurred in patient care services furnished through contractual Υ 32.00 arrangements with suppliers of services? If yes, see instructions. If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If Ν 33.00 33.00 no, see instructions. Provi der-Based Physicians Are services furnished at the provider facility under an arrangement with provider-based physicians? Υ 34.00 If yes, see instructions. Iffine 34 is yes, were there new agreements or amended existing agreements with the provider-based Ν 35.00 physicians during the cost reporting period? If yes, see instructions. Y/N Date 1.00 2.00 Home Office Costs Were home office costs claimed on the cost report? 36, 00 36, 00 N 37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? N 37.00 If yes, see instructions. If line 36 is yes, was the fiscal year end of the home office different from that of N 38.00 the provider? If yes, enter in column 2 the fiscal year end of the home office. If line 36 is yes, did the provider render services to other chain components? If yes, 39.00 39.00 N see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see Ν 40.00 instructions. 1.00 2.00 Cost Report Preparer Contact Information 41.00 Enter the first name, last name and the title/position TI NA SEVERS 41.00 held by the cost report preparer in columns 1, 2, and 3, respecti vel y. Enter the employer/company name of the cost report BLUE & CO., LLC 42.00 42.00 preparer. 43.00 Enter the telephone number and email address of the cost 317-713-7946 TSEVERS@BLUEANDCO. COM 43.00

report preparer in columns 1 and 2, respectively.

1100111	TE THE HOUSE THE HEALTH OTHER RETHINGS CEMENT QUE	STI ONIWII KE	11001461 660. 101626	From 10/01/2013 To 09/30/2014	Part II Date/Time Prep 2/25/2015 3:11	
		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)	01/15/2015				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
20. 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		0. 00			
41. 00	Enter the first name, last name and the title held by the cost report preparer in columns respectively.		NAGER			41. 00
42. 00	Enter the employer/company name of the cost r	report				42. 00
43. 00	preparer. Enter the telephone number and email address report preparer in columns 1 and 2, respective					43. 00

| Peri od: | Worksheet S-3 | From 10/01/2013 | Part I | Date/Time Prepared: |

					''	0 09/30/2014	2/25/2015 3:1	
							I/P Days / 0/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, 125		0	1. 00
	8 exclude Swing Bed, Observation Bed and				,	,		
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2.00
3.00	HMO IPF Subprovider							3.00
4.00	HMO IRF Subprovider							4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF		İ				ol	6.00
7.00	Total Adults and Peds. (exclude observation		İ	25	9, 125	49, 008. 00	ol	7.00
	beds) (see instructions)							
8.00	INTENSIVE CARE UNIT	31. 00	ĺ	0	0	0.00	0	8.00
9.00	CORONARY CARE UNIT		İ					9.00
10.00	BURN INTENSIVE CARE UNIT		İ					10.00
11. 00	SURGICAL INTENSIVE CARE UNIT		İ					11.00
12.00	OTHER SPECIAL CARE (SPECIFY)		İ					12.00
13.00	NURSERY	43.00					ol	13.00
14.00	Total (see instructions)			25	9, 125	49, 008. 00	ol	14.00
15. 00	CAH visits						ol	15.00
16. 00	SUBPROVI DER - I PF	40. 00		10	3, 650		ol	16.00
17. 00	SUBPROVI DER - I RF	41. 00	İ	0	0		ol	17.00
18. 00	SUBPROVI DER	42. 00	İ	O	0		ol	18.00
19. 00	SKILLED NURSING FACILITY		İ					19.00
20. 00	NURSING FACILITY							20.00
21. 00	OTHER LONG TERM CARE		İ					21.00
22. 00	HOME HEALTH AGENCY		İ					22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)							23.00
24. 00	, ,		İ					24.00
24. 10	HOSPICE (non-distinct part)	30. 00	İ					24. 10
25. 00			İ					25.00
25. 10		99. 10	İ				o	25. 10
26. 00		88. 00	İ				ol	26. 00
26. 25		89. 00					ol	26. 25
27. 00				35				27. 00
28. 00	,		İ				ol	28. 00
29. 00								29. 00
30. 00	•							30. 00
31. 00								31. 00
32. 00			i	0	0			32. 00
32. 01				Ĭ	Ĭ			32. 01
52.01	outpatient days (see instructions)							52.01
33. 00	LTCH non-covered days							33. 00
		ı	'	-	•		'	

					'	0 097 307 2014	2/25/2015 3: 1	
			I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents) piii
		Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
		30p01161112			Patients	& Residents	Payrol I	
			6.00	7. 00	8. 00	9, 00	10.00	
1	. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	695	55	1, 883			1. 00
2	. 00	HMO and other (see instructions)	146	o				2. 00
3	. 00	HMO IPF Subprovider	115	o				3. 00
4	. 00	HMO IRF Subprovider	o	o				4. 00
	. 00	Hospital Adults & Peds. Swing Bed SNF	445	0	515			5. 00
	. 00	Hospital Adults & Peds. Swing Bed NF		0	41			6. 00
	. 00	Total Adults and Peds. (exclude observation	1, 140	55	2, 439			7. 00
•	. 00	beds) (see instructions)	.,	0.0	2, 10,			7.00
8	. 00	INTENSIVE CARE UNIT	o	o	0			8. 00
	. 00	CORONARY CARE UNIT						9. 00
	0. 00	BURN INTENSIVE CARE UNIT						10.00
	1. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
	2. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
	3. 00	NURSERY		o	147			13. 00
	4. 00	Total (see instructions)	1, 140	55	2, 586	0.00	263. 71	14. 00
	5. 00	CAH visits	0	0	2, 555	0.00	200.7.	15. 00
	6. 00	SUBPROVI DER - I PF	1, 787	17	2, 115	0.00	15. 46	16. 00
	7. 00	SUBPROVI DER - I RF	.,,,	0	2,0	0.00		17. 00
	8. 00	SUBPROVI DER	0	0	0	0.00		18. 00
	9. 00	SKILLED NURSING FACILITY	٩	Ĭ	· ·	0.00	0.00	19. 00
	0.00	NURSING FACILITY						20. 00
	1. 00	OTHER LONG TERM CARE						21. 00
	2. 00	HOME HEALTH AGENCY						22. 00
	3. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
	4. 00	HOSPI CE						24. 00
	4. 10	HOSPICE (non-distinct part)	0	0	0			24. 10
	5. 00	CMHC - CMHC	٩	Ĭ	O			25. 00
	5. 10	CMHC - CORF	0	0	0	0.00	0. 00	25. 10
	6. 00	RURAL HEALTH CLINIC	0	Ö	0		0.00	26. 00
	6. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	Ö	0			26. 25
	7. 00	Total (sum of lines 14-26)	٥	Ÿ.	O	0.00	279. 17	27. 00
	8. 00	Observation Bed Days		0	62		277.17	28. 00
	9. 00	Ambul ance Tri ps	0	Ÿ.	02			29. 00
	0. 00	Employee discount days (see instruction)	٩		0			30.00
	1. 00	Employee discount days (see l'istruction)			0			31. 00
	2. 00	Labor & delivery days (see instructions)	0	0	0			32.00
	2. 00	Total ancillary labor & delivery room	٥	ď	0			32. 00
3	2.01	outpatient days (see instructions)			0			32.01
3	3. 00		0					33. 00

| Peri od: | Worksheet S-3 | From 10/01/2013 | Part | | To 09/30/2014 | Date/Time Prepared:

					To	09/30/2014	Date/Time Pre 2/25/2015 3:1	
		Full Time			Di scha	arges	2, 20, 20.0 0	, p
		Equi val ents						
	Component	Nonpaid Workers	Title V		Title XVIII	Title XIX	Total All Patients	
		11. 00	12. 00		13.00	14. 00	15. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)			0	216	20	637	1. 00
2. 00 3. 00	HMO IPF Subprovider				39	0		2. 00 3. 00
4.00	HMO IRF Subprovider			1				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF			1				5. 00
6.00	Hospital Adults & Peds. Swing Bed NF			ı				6. 00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)							7. 00
8.00	INTENSIVE CARE UNIT							8. 00
9.00	CORONARY CARE UNIT							9. 00
10.00	BURN INTENSIVE CARE UNIT							10.00
11.00	SURGICAL INTENSIVE CARE UNIT							11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)							12.00
13.00	NURSERY							13.00
14.00	Total (see instructions)	0. 00	1	0	216	20	637	14.00
15. 00	CAH visits							15. 00
16. 00	SUBPROVI DER - I PF	0. 00		0	133	2	176	16. 00
17. 00	SUBPROVI DER - I RF	0. 00	l .	0	0	0	0	17. 00
18. 00	SUBPROVI DER	0. 00	1	0	0	0	0	18. 00
19. 00	SKILLED NURSING FACILITY							19. 00
20.00	NURSING FACILITY							20.00
21.00	OTHER LONG TERM CARE							21. 00
22. 00	HOME HEALTH AGENCY							22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)							23. 00
24. 00	HOSPI CE							24. 00
24. 10	HOSPICE (non-distinct part)							24. 10
25. 00	CMHC - CMHC							25. 00
25. 10	CMHC - CORF	0. 00						25. 10
26. 00	RURAL HEALTH CLINIC	0. 00						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00	l .					26. 25
27.00	Total (sum of lines 14-26)	0. 00	1					27. 00
28. 00	Observation Bed Days							28. 00
29. 00	Ambul ance Trips							29. 00
30.00	Employee discount days (see instruction)							30. 00
31.00	Employee discount days - IRF							31. 00
32.00	Labor & delivery days (see instructions)							32.00
32. 01	Total ancillary labor & delivery room							32. 01
33. 00	outpatient days (see instructions) LTCH non-covered days							33. 00

SPITAL UNCOMPENSATED AND INDIGENT CARE DATA Provi	der CCN: 151320	Peri od: From 10/01/2013	Worksheet S-10	0
		To 09/30/2014	Date/Time Prep 2/25/2015 3:1	
			1. 00	
Uncompensated and indigent care cost computation				
Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided b	y line 202 colum	nn 8)	0. 353680	1.
Medicaid (see instructions for each line)				4
Net revenue from Medicaid			0	
Did you receive DSH or supplemental payments from Medicaid?	nto from Modicai	40		3. 4.
OO If line 3 is "yes", does line 2 include all DSH or supplemental payme OO If line 4 is "no", then enter DSH or supplemental payments from Medic		u?	0	
ON Medicaid charges	ai u		0	
00 Medicaid cost (line 1 times line 6)			o o	
OD Difference between net revenue and costs for Medicaid program (line 7	minus sum of li	nes 2 and 5: if	ő	1
< zero then enter zero)				
State Children's Health Insurance Program (SCHIP) (see instructions for	or each line)			
Net revenue from stand-alone SCHIP			0	
00 Stand-al one SCHIP charges			0	1
OO Stand-alone SCHIP cost (line 1 times line 10)	11 1: 0	: +	0	
00 Difference between net revenue and costs for stand-alone SCHIP (line enter zero)	II minus line 9;	IT < Zero then	0	12
Other state or local government indigent care program (see instruction	ns for each line	7)		
00 Net revenue from state or local indigent care program (Not included o			0	13
00 Charges for patients covered under state or local indigent care progr			o	
10)	•			
00 State or local indigent care program cost (line 1 times line 14)			0	
00 Difference between net revenue and costs for state or local indigent	care program (li	ne 15 minus line	0	16
13; if < zero then enter zero) Uncompensated care (see instructions for each line)				
00 Private grants, donations, or endowment income restricted to funding	charity care		0	17
00 Government grants, appropriations or transfers for support of hospita			0	1
00 Total unreimbursed cost for Medicaid, SCHIP and state and local indi		ams (sum of lines	0	
8, 12 and 16)	g pg	(0.000)	,	
	Uni nsured		Total (col. 1	
	pati ents		+ col . 2)	1
00 Total initial obligation of patients approved for charity care (at fu	1.00	2. 00 150 0	3. 00 631, 150	20
charges excluding non-reimbursable cost centers) for the entire facil		130	031, 130	20
00 Cost of initial obligation of patients approved for charity care (lin		225 0	223, 225	21
times line 20)			,	
00 Partial payment by patients approved for charity care		0 0	0	
00 Cost of charity care (line 21 minus line 22)	223, 2	225 0	223, 225	23
			1. 00	
00 Does the amount in line 20 column 2 include charges for patient days	hevond a Length	of stay limit	1.00	24
imposed on patients covered by Medicaid or other indigent care progra		o. oray iriii t		-
00 If line 24 is "yes," charges for patient days beyond an indigent car		gth of stay limit	0	25
00 Total bad debt expense for the entire hospital complex (see instruction	ons)	•	0	26
00 Medicare bad debts for the entire hospital complex (see instructions)			352, 008	
00 Non-Medicare and non-reimbursable Medicare bad debt expense (line 26	,		-352, 008	
00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times lir	ne 28)	-124, 498	29
Ook Cost of uncompensated care (line 23 column 3 plus line 29) Total unreimbursed and uncompensated care cost (line 19 plus line 30)			98, 727 98, 727	

Heal th	Financial Systems	JAY COUNTY H	OSPI TAL		In Lie	eu of Form CMS-	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C)F EXPENSES	Provi der		Peri od:	Worksheet A	
					From 10/01/2013 To 09/30/2014		nared:
					10 09/30/2014	2/25/2015 3: 1	
	Cost Center Description	Sal ari es	Other	Total (col. 1	Reclassi fi cati	Recl assi fi ed	
				+ col . 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
						col . 4)	
	OFNEDAL CEDIU OF COST OFNITEDS	1.00	2. 00	3.00	4. 00	5. 00	
2. 00	GENERAL SERVICE COST CENTERS O0200 NEW CAP REL COSTS-MVBLE EQUIP		2 020 040	2, 039, 84	8 0	2 020 040	2 00
2. 00	00201 NEW CAP REL COSTS-MVBLE EQUIP MOB		2, 039, 848 23, 258				2. 00 2. 01
2. 02	00202 NEW CAP REL COSTS-MVBLE EQUI P-POB		104, 018			104, 018	
2. 03	00203 NEW CAP REL COSTS-MVBLE EQUIP- WJ		5, 275			5, 275	
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	o	5, 283, 308			5, 283, 308	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	2, 023, 694	4, 908, 515			6, 932, 209	5. 00
7.00	00700 OPERATION OF PLANT	343, 947	825, 951	1, 169, 89	-16, 511	1, 153, 387	7. 00
7. 01	00701 OPERATION OF PLANT-MOB	0	37, 790	37, 79	0 5, 917	43, 707	7. 01
7.02	00702 OPERATION OF PLANT-POB	0	98, 376	98, 37			
7.03	00703 OPERATION OF PLANT-WJ	0	0		0 1, 311		1
8.00	00800 LAUNDRY & LINEN SERVICE	23, 741	16, 463				1
9.00	00900 HOUSEKEEPI NG	302, 676	60, 677			363, 353	1
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	322, 903	250, 712	573, 61			1
13.00	01300 NURSI NG ADMI NI STRATI ON	898, 586	22, 051	920, 63	0 336, 367	336, 367 920, 637	1
14. 00	01400 CENTRAL SERVICES & SUPPLY	65, 875	-1, 140	1		64, 735	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	353, 252	60, 196			l	1
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	000, 202	00, 170	110, 11	<u> </u>	110, 110	10.00
30.00	03000 ADULTS & PEDIATRICS	1, 242, 657	119, 649	1, 362, 30	6 -147, 686	1, 214, 620	30.00
31.00	03100 INTENSIVE CARE UNIT	0	0		0 0	0	31. 00
40.00	04000 SUBPROVI DER - I PF	629, 541	449, 309	1, 078, 85	0 0	1, 078, 850	40.00
41.00	04100 SUBPROVI DER - I RF	0	0)	0 0	0	41. 00
42.00	04200 SUBPROVI DER	0	0		0	0	42. 00
43. 00	04300 NURSERY	0	0		0 128, 757	128, 757	43. 00
F0 00	ANCILLARY SERVICE COST CENTERS	004 044	707.00/	4 500 04	7 40.000	4 544 044	F0 00
50.00	05000 OPERATING ROOM	821, 211	707, 006 0	1			
52. 00 53. 00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	217, 041	722, 612		0 18, 929 3 0		
54. 00	05400 RADI OLOGY-DI AGNOSTI C	786, 883	596, 404			1, 383, 287	
57. 00	05700 CT SCAN	700,003	370, 404	1, 303, 20	0 0	1, 303, 207	57.00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	o	0		o o	Ö	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	o	0		0 0	0	59. 00
60.00	06000 LABORATORY	627, 312	1, 083, 416	1, 710, 72	8 0	1, 710, 728	60.00
60. 01	06001 BLOOD LABORATORY	o	0		0 0	0	60. 01
65.00	06500 RESPI RATORY THERAPY	0	356, 837			356, 837	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	704, 166	704, 16	6 0	704, 166	1
68. 00	06800 SPEECH PATHOLOGY	0	0		0 0		68. 00
69. 00	06900 ELECTROCARDI OLOGY	180, 908	142, 356	323, 26	4 0	323, 264	1
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS		0		0 13, 903	13, 903	71. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	361, 015	1, 003, 914	1, 364, 92		l	
73.00	OUTPATIENT SERVICE COST CENTERS	301,013	1,003,714	1, 304, 72	7 0	1, 304, 727	73.00
88. 00		0	0		0 0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	89. 00
90.00	09000 CLI NI C	474, 523	179, 598	654, 12	1 0	654, 121	90.00
90. 01	09001 FAMILY PRACTICE OF JAY COUNTY	1, 500, 223	228, 469	1, 728, 69	2 0	1, 728, 692	90. 01
	09002 JAY FAMILY MEDICINE	919, 849	152, 362			1, 072, 211	90. 02
91. 00	09100 EMERGENCY	1, 729, 408	556, 987	2, 286, 39	5 0	2, 286, 395	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		_			_	92. 00
93. 00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0		0 0	0	93.00
00 10	OTHER REIMBURSABLE COST CENTERS			ı			00 10
99. 10	O9910 CORF SPECIAL PURPOSE COST CENTERS	0	0	1	0 0	0	99. 10
106.00	10600 HEART ACQUISITION	0	0		ol o	0	106. 00
	10900 PANCREAS ACQUISITION	0	0		o o		109.00
	11000 INTESTINAL ACQUISITION	o	0		o o		110.00
	11100 SLET ACQUISITION	o	0		0 0	0	111. 00
113.00	11300 INTEREST EXPENSE		0		0 0		113. 00
118.00		13, 825, 245	20, 738, 383	34, 563, 62	8 0	34, 563, 628	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	I	0		190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0		192.00
	19300 NONPAID WORKERS 07950 MOB		1 214	1 21	0		193.00
	07950 MOB 07951 POB		1, 314	1, 31	0 0		194. 00 194. 01
	07951 POB 07952 WEST JAY CLINIC	419, 368	76, 705	496, 07	3 0	496, 073	
	07956 TRI COUNTY	177, 587	1, 307, 401			l	1
200.00		14, 422, 200	22, 123, 803			1	1
		. '		•	•		

	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (JAY COUNTY		CCN: 151320	In Lieu of Form Period: Worksheet	
RECLAS	STRICATION AND ADJUSTMENTS OF TRIAL BALANCE (UF EXPENSES	Provider	CCN. 131320	From 10/01/2013	
						Prepared: 3:11 pm
	Cost Center Description	Adjustments	Net Expenses			
		(See A-8) 6.00	For Allocation 7.00	<u> </u>		
	GENERAL SERVICE COST CENTERS					
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	-473, 042				2.00
2. 01	00201 NEW CAP REL COSTS MVBLE EQUIP MOB		23, 258	1		2. 01
2. 02 2. 03	O0202 NEW CAP REL COSTS-MVBLE EQUI P-POB O0203 NEW CAP REL COSTS-MVBLE EQUI P- WJ		1			2. 02 2. 03
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-162, 847		1		4. 00
5. 00	00500 ADMI NI STRATI VE & GENERAL	-2, 232, 147		1		5. 00
7.00	00700 OPERATION OF PLANT		1, 153, 387	1		7. 00
7. 01	00701 OPERATION OF PLANT-MOB	C	43, 707	'		7. 01
7. 02	00702 OPERATION OF PLANT-POB	C	107, 659	1		7. 02
7.03	00703 OPERATION OF PLANT-WJ		1, 311			7. 03
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE		40, 204	1		8. 00 9. 00
10.00	00900 HOUSEKEEPI NG 01000 DI ETARY		1,	1		10.00
11. 00	01100 CAFETERI A	-138, 705		1		11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	-10, 608				13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	C	64, 735	i		14. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	-15, 086	398, 362	2		16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			.1		
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT		1,,			30. 00 31. 00
40. 00	04000 SUBPROVI DER - I PF		1			40. 00
41. 00	04100 SUBPROVI DER - I RF		1, -, -, -, -	1		41. 00
42.00	04200 SUBPROVI DER	d	o			42.00
43.00	04300 NURSERY	C	128, 757	,		43. 00
F0 00	ANCILLARY SERVICE COST CENTERS	T	4 544 044			
50. 00 52. 00	O5000 OPERATING ROOM O5200 DELIVERY ROOM & LABOR ROOM					50. 00 52. 00
53. 00	05300 ANESTHESI OLOGY	-939, 653				53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	, , , , , , , , , , , , , , , , , , ,	1	,		54.00
57.00	05700 CT SCAN	C	0			57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	C	0			58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	(7.22	1 (42 20))		59.00
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	-67, 332	1, 643, 396			60. 00
65. 00	06500 RESPIRATORY THERAPY		356, 837	;		65. 00
66. 00	06600 PHYSI CAL THERAPY	-112, 981		1		66. 00
68. 00	06800 SPEECH PATHOLOGY	C	0			68. 00
69. 00	06900 ELECTROCARDI OLOGY	-12, 880	1			69. 00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS		13, 903	2		71. 00 72. 00
	07300 DRUGS CHARGED TO PATIENTS	-86, 678		1		73. 00
70.00	OUTPATIENT SERVICE COST CENTERS		, 1,2,0,20.	1		70.00
	08800 RURAL HEALTH CLINIC	C	0)		88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	C	0			89. 00
	09000 CLINIC	-444, 987		1		90.00
	09001 FAMILY PRACTICE OF JAY COUNTY 09002 JAY FAMILY MEDICINE	-1, 320, 409 -820, 712	1			90. 01
	09100 EMERGENCY	-1, 432, 237		1		91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)					92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	C	0			93. 00
00.46	OTHER REIMBURSABLE COST CENTERS	T -	\			00.45
99. 10	O9910 CORF SPECIAL PURPOSE COST CENTERS	C) 0	η		99. 10
106. 00	10600 HEART ACQUISITION					106. 00
	10900 PANCREAS ACQUISITION		Ί "	•		109. 00
	11000 INTESTINAL ACQUISITION	C	0			110. 00
	11100 SLET ACQUISITION		0	1		111. 00
113. 00 118. 00	11300 INTEREST EXPENSE	0 270 204	0 26 202 224	1		113. 00 118. 00
110.UL	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	-8, 270, 304	26, 293, 324	1		118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		0			190. 00
	19200 PHYSICIANS' PRIVATE OFFICES			1		192. 00
	19300 NONPALD WORKERS		0	1		193. 00
	07950 MOB		1, 314	1		194. 00
	07951 POB 07952 WEST JAY CLINIC		0 496, 073	1		194. 01 194. 02
	07956 TRI COUNTY		1	1		194. 02
200.00		-8, 270, 304		1		200. 00
				1		1

						2/25/2015 3:	11 pm
		Increases					
	Cost Center	Li ne #	Sal ary	0ther			
	2. 00	3. 00	4. 00	5.00			
	A - NURSERY						
1.00	NURSERY	43.00	121, 085	7, 672			1. 00
	TOTALS	- $ 1$	121, 085				
	B - DELIVERY & LABOR RECLASS						
1.00	DELIVERY ROOM & LABOR ROOM	52. 00	17, 838	1, 091			1. 00
	TOTALS		17, 838	1, 091			
	C - CAFETERIA	•	<u> </u>				
1.00	CAFETERI A	11. 00	189, 350	147, 017			1. 00
	TOTALS		189, 350	147, 017			
	D - MOB & POB MAINTENANCE REC	CLASS	<u> </u>				Ī
1.00	OPERATION OF PLANT-MOB	7. 01	5, 917	0			1. 00
2.00	OPERATION OF PLANT-POB	7. 02	9, 283	0			2. 00
3.00	OPERATION OF PLANT-WJ	7. 03	1, 311	0			3. 00
	TOTALS	- $ 1$	16, 511	₀			
	E - IMPLANTABLE DEVICES		·				1
1.00	IMPL. DEV. CHARGED TO	72.00	0	13, 903			1. 00
	PATI ENTS						
	TOTALS			13, 903			
500.00	Grand Total: Increases		344, 784	169, 683			500.00

					10	09/30/2014 Date/IIme Pr 2/25/2015 3:	
		Decreases		<u> </u>		, , , , , , , , , , , , , , , , , , , ,	
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
	A - NURSERY						
1.00	ADULTS & PEDIATRICS	30.00	121, 085	<u>7, 6</u> 72	2 0		1. 00
	TOTALS		121, 085	7, 672)		
	B - DELIVERY & LABOR RECLASS						
1.00	ADULTS & PEDIATRICS	30. 00	1 <u>7, 8</u> 38		0		1. 00
	TOTALS		17, 838	1, 091			
	C - CAFETERIA						
1.00	DI ETARY	1000	18 <u>9, 3</u> 50	147, 017	0		1. 00
	TOTALS		189, 350	147, 017	'		
	D - MOB & POB MAINTENANCE REC	LASS					
1.00	OPERATION OF PLANT	7.00	16, 511	0	0		1. 00
2.00		0.00	0	0	0		2. 00
3.00		0.00	0_	0	0		3. 00
	TOTALS		16, 511	0)		
	E - IMPLANTABLE DEVICES						
1.00	OPERATING ROOM	50.00	0_	1 <u>3, 9</u> 03	S O		1. 00
	TOTALS		0	13, 903			1
500.00	Grand Total: Decreases		344, 784	169, 683	3		500.00

Provider CCN: 151320 | Period: | Worksheet A-7 | From 10/01/2013 | Part | ITAL | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part

					To 09/30/2014	Date/Time Pre	
						2/25/2015 3:1	1 pm
				Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE					Г	
1.00	Land	220, 245	0		0	0	1. 00
2.00	Land Improvements	915, 689	20, 520		0 20, 520	•	2. 00
3.00	Buildings and Fixtures	22, 769, 259	568, 310		0 568, 310	0	3. 00
4.00	Building Improvements	0	0		0	0	4. 00
5.00	Fi xed Equipment	3, 105, 733	0		0	0	5. 00
6.00	Movable Equipment	10, 895, 386	562, 654		0 562, 654	0	6. 00
7.00	HIT designated Assets	0	0		0 0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	37, 906, 312	1, 151, 484		0 1, 151, 484	0	8. 00
9.00	Reconciling Items	0	o		0 0	0	9. 00
10.00	Total (line 8 minus line 9)	37, 906, 312	1, 151, 484		0 1, 151, 484	0	10.00
		Ending Balance	Fully				
			Depreciated				
			Assets				
		6.00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	T BALANCES					
1.00	Land	220, 245	0				1. 00
2.00	Land Improvements	936, 209	o				2. 00
3.00	Buildings and Fixtures	23, 337, 569	ol				3. 00
4.00	Building Improvements	o	ol				4. 00
5.00	Fixed Equipment	3, 105, 733	o				5. 00
6.00	Movable Equipment	11, 458, 040	o				6. 00
7. 00	HIT designated Assets	0	o				7. 00
8.00	Subtotal (sum of lines 1-7)	39, 057, 796	0				8. 00
9. 00	Reconciling I tems	0,,55,,7,0	0				9. 00
10. 00	Total (line 8 minus line 9)	39, 057, 796	o				10.00
13.00	Trotal (Trie o milias Trie 7)	37,037,770	٥Į				1 .0.00

Heal th	Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
RECONC	ELLIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 151320	Peri od: From 10/01/2013 To 09/30/2014	Worksheet A-7 Part II Date/Time Pre 2/25/2015 3:1	pared:
			Sl	JMMARY OF CAP	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 WORL	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2, 039, 848	0		0 0	0	2. 00
2.01	NEW CAP REL COSTS-MVBLE EQUIP MOB	23, 258	0		0 0	0	2. 01
2.02	NEW CAP REL COSTS-MVBLE EQUIP-POB	104, 018	0		0 0	0	2. 02
2.03	NEW CAP REL COSTS-MVBLE EQUIP- WJ	5, 275	0		0 0	0	2. 03
3.00	Total (sum of lines 1-2)	2, 172, 399	0		0 0	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					

		This tructions)			1	
		14.00	15. 00			
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	IN 2, LINES 1 a	nd 2		
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	2, 039, 848		2. 00	
2.01	NEW CAP REL COSTS-MVBLE EQUIP MOB	0	23, 258		2. 01	
2.02	NEW CAP REL COSTS-MVBLE EQUIP-POB	0	104, 018		2. 02	
2.03	NEW CAP REL COSTS-MVBLE EQUIP- WJ	0	5, 275		2. 03	
3.00	Total (sum of lines 1-2)	0	2, 172, 399		3. 00	

	Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS			F	Period: From 10/01/2013 To 09/30/2014	Date/Time Prep 2/25/2015 3:11	
		COMPUTATION OF RATIOS			ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi talized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C						
2.00	NEW CAP REL COSTS-MVBLE EQUIP	39, 057, 796	0				2. 00
2. 01	NEW CAP REL COSTS-MVBLE EQUIP MOB	0	0	(0.00000		2. 01
2. 02	NEW CAP REL COSTS-MVBLE EQUIP-POB	0	0	(2. 02
2.03	NEW CAP REL COSTS-MVBLE EQUIP- WJ	0	0	(0. 000000		2. 03
3.00	Total (sum of lines 1-2)	39, 057, 796		39, 057, 796			3. 00
		ALLOCA	TION OF OTHER (CAPITAL	SUMMARY C	OF CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate	cols. 5			
			d Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI	ENTERS		1			
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	`	1,000,000		2. 00
2.01	NEW CAP REL COSTS-MVBLE EQUIP MOB	0	0	(20, 200		2. 01
2.02	NEW CAP REL COSTS-MVBLE EQUIP-POB	0	0	(,		2. 02
2.03	NEW CAP REL COSTS-MVBLE EQUIP- WJ	0	0		-,		2. 03
3.00	Total (sum of lines 1-2)	0		(., ,	0	3. 00
			50	JMMARY OF CAPI	IAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
	,		instructions)		Capi tal -Rel ate		
			ĺ	ĺ	d Costs (see	through 14)	
					instructions)		
		11.00	12.00	13. 00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI						
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	٧ -		1	1, 566, 806	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP MOB	0	0	`	-	23, 258	2. 01
2.02	NEW CAP REL COSTS-MVBLE EQUIP-POB	0	0	1		,	2. 02
2.03	NEW CAP REL COSTS-MVBLE EQUIP- WJ	0	0	(1	5, 275	2. 03
3.00	Total (sum of lines 1-2)	0	0) (0	1, 699, 357	3. 00

Health Financial Systems JAY COUNTY HOSPITAL In Lieu of Form CMS-2552-10 Provi der CCN: 151320 ADJUSTMENTS TO EXPENSES Peri od: Worksheet A-8 From 10/01/2013 09/30/2014 Date/Time Prepared: 2/25/2015 3:11 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Amount Cost Center Line # Wkst. A-7 Ref. 2.00 3.00 4.00 5.00 1.00 Investment income - CAP REL Cost Center Deleted *** 1. 00 1.00 COSTS-BLDG & FIXT (chapter 2) 2.00 Investment income - NEW CAP ONEW CAP REL COSTS-MVBLE 2.00 2.00 REL COSTS-MVBLE EQUIP (chapter EQUI P 2.01 Investment income - NEW CAP ONEW CAP REL COSTS-MVBLE 2.01 2.01 REL COSTS-MVBLE EQUIP MOB EQUIP MOB (chapter 2) ONEW CAP REL COSTS-MVBLE 2 02 Investment income - NEW CAP 2.02 2.02 REL COSTS-MVBLE EQUIP-POB EQUI P-POB (chapter 2) ONEW CAP REL COSTS-MVBLE 2.03 Investment income - NEW CAP 2.03 REL COSTS-MVBLE EQUIP- WJ EQUIP- WJ (chapter 2) 3.00 Investment income - other 0.00 Λ (chapter 2) Trade, quantity, and time 4.00 0.00 discounts (chapter 8) 5.00 Refunds and rebates of 0.00 expenses (chapter 8) 6.00 Rental of provider space by 0.00 suppliers (chapter 8) 7.00 Tel ephone services (pay 0.00 stations excluded) (chapter 21) 8.00 Tel evi si on and radio servi ce 0.00 (chapter 21) 9 00 Parking lot (chapter 21) 0.00 Provi der-based physician -4, 078, 729 10.00 A-8-2 adjustment Sale of scrap, waste, etc. (chapter 23) 11.00 0.00 12.00 Related organization A-8-1 -106, 483 transactions (chapter 10) 13.00 Laundry and linen service 0.00 Cafeteria-employees and guests В -140, 917 CAFETERI A 14.00 11.00 0

Provi der CCN: 151320 Peri od: Worksheet A-8 From 10/01/2013 | To 09/30/2014 | Date/Time Prepared:

					09/30/2014	2/25/2015 3:1	
				Expense Classification on	Worksheet A	2,20,2010 011	
				To/From Which the Amount is			
					,		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1.00	2. 00	3. 00	4. 00	5. 00	
27. 03	Depreciation - NEW CAP REL		0	NEW CAP REL COSTS-MVBLE	2. 03	0	27. 03
	COSTS-MVBLE EQUIP- WJ			EQUIP- WJ			
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00
29. 00	Physicians' assistant		0		0.00	0	29. 00
30.00	Adjustment for occupational	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
	therapy costs in excess of						
	limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
	instructions)						
31.00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
	pathology costs in excess of						
	limitation (chapter 14)						
32.00	CAH HIT Adjustment for		0		0.00	0	32.00
	Depreciation and Interest						
33.00	JEMS RENTAL	В	-6, 000	ADMINISTRATIVE & GENERAL	5. 00	0	33. 00
33. 01	SUPPY REBATES AND DISCOUNTS	В	-19, 289	ADMINISTRATIVE & GENERAL	5.00	0	33. 01
33. 02	OTHER REVENUE	В	-30, 374	ADMINISTRATIVE & GENERAL	5. 00	0	33. 02
33. 03	OTHER REVENUE-DIABETIC	В	-10, 608	NURSING ADMINISTRATION	13.00	0	33. 03
	COUNSELI NG						
33.04	CRNA OFFSET	A	-939, 653	ANESTHESI OLOGY	53.00	0	33. 04
33. 05	PHYSICIAN RECRUITMENT	A	-68, 922	ADMINISTRATIVE & GENERAL	5. 00	0	33. 05
33.06	ADVERTISING EXPENSE	A	-82, 218	ADMINISTRATIVE & GENERAL	5. 00	0	33. 06
33.07	SENI OR PROGRAM	A	-14, 775	ADMINISTRATIVE & GENERAL	5.00	0	33. 07
33. 08	SWITCHBOARD SALARY	A	-7, 869	ADMINISTRATIVE & GENERAL	5. 00	0	33. 08
33. 09	SWITCHBOARD EH&W	A	-2, 565	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33. 09
33. 10	PAT TELEPHONE EXPENSE	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 10
33. 11	PAT TELEPHONE DEPRECIATION	l A	· ·	NEW CAP REL COSTS-MVBLE	2.00		33. 11
			-,	EQUI P			
33. 12	HEALTH EDUCATION	В	-130, 989	ADMINISTRATIVE & GENERAL	5. 00	0	33. 12
33. 13	VENDING MACHINE REVENUE	В		CAFETERI A	11. 00	0	33. 13
33. 14	PHARMACY EMPLOYEE SALES	В	· ·	DRUGS CHARGED TO PATIENTS	73. 00	0	33. 14
33. 15	PENSION EXPENSE	A		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 15
33. 16	THA AND AHA DUES	A	· ·	ADMINISTRATIVE & GENERAL	5. 00	0	33. 16
33. 17	CLINIC RENTAL	В		ELECTROCARDI OLOGY	69.00	0	1
33. 18	FLU SHOT	В		ADMINISTRATIVE & GENERAL	5. 00	0	33. 18
33. 19	CONFERENCE ROOM RENTAL	В		ADMINISTRATIVE & GENERAL	5. 00		
33. 20	VENDOR/CONTRACT REV	B		ADMINISTRATIVE & GENERAL	5. 00	o o	•
33. 21	OTHER REVENUE	В	· ·	LABORATORY	60.00	1	33. 21
33. 22	OTHER REVENUE	B	· ·	FAMILY PRACTICE OF JAY	90. 01	0	
JJ. ZZ	OTHER REVENUE		-2, 520	COUNTY	70.01		33. 22
33. 23	OTHER REVENUE	В	-1 560	JAY FAMILY MEDICINE	90. 02	0	33. 23
33. 24	EHR DEPRECIATION	В	· ·	NEW CAP REL COSTS-MVBLE	2.00		33. 24
JJ. 24	LIN DEI REGIATION	ا د	-407, 040	EQUIP	2.00	9	JJ. 24
33. 25	HAF(HOSPITAL ASSESSMENT FEE)	A	_1 844 014	ADMINISTRATIVE & GENERAL	5. 00	0	33. 25
50. 00	TOTAL (sum of lines 1 thru 49)		-8, 270, 304	1	3.00		50.00
50.00	(Transfer to Worksheet A,		-0, 270, 304				30.00
	column 6, line 200.)						
(4) 5	COLUMN 0, TITLE 200.)			0110 D 1 15 1			

⁽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.

* 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.

0

35, 137

0

141,620

4.00

5.00

 p	cor anno i aria, or 2, tho amoun				
			Related Organization(s) and/	or Home Office	
Symbol (1)	Name	Percentage of	Name	Percentage of	
		Ownershi p		Ownershi p	
1. 00	2. 00	3. 00	4. 00	5. 00	
B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HO	ME 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	0.00	6. 00
7.00			0.00	0.00	7.00
8.00			0.00	0.00	8.00
9.00			0.00	0.00	9.00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or				100.00
	non-financial) specify:				

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

0.00

TOTALS (sum of lines 1-4).

Transfer column 6, line 5 to Worksheet A-8, column 2,

- 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.

4.00

5.00

line 12.

Heal th	Financial Syste	ems		JAY CC	OUNTY HOSP	I TAL				In Lie	u of Form CMS	-2552-10
STATEME	NT OF COSTS OF	SERVICES FROM	RELATED	ORGANI ZATI ONS AND	HOME	Provi der	CCN: 1	51320	Peri od:		Worksheet A	-8-1
OFFICE	COSTS									/01/2013 /30/2014	Date/Time Pi	epared:
											2/25/2015 3:	11 pm
	Net	Wkst. A-7 Ref.										
	Adjustments											
	(col. 4 minus											
	col. 5)*											
	6. 00	7. 00										
	A. COSTS INCUR	RED AND ADJUSTI	MENTS REC	QUI RED AS A RESULT	OF TRANS	ACTIONS W	/I TH REI	LATED C	RGANI ZAT	IONS OR (CLAI MED	
	HOME OFFICE CO	STS:										
1.00	-106, 483	0										1.00
2.00	0	0	i									2.00
3.00	0	0	i									3.00
4.00	0	0										4.00
5.00	-106, 483											5. 00
* The	amounts on line	es 1-4 (and sub	scripts	as appropriate) a	re transf	erred in o	detai I	to Wor	ksheet A	col umn	6 lines as	<u>'</u>
				and negative amoun								t which
				4 1/ 6 11								

has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

Related Organization(s) and/or Home Office

Type of Business

6.00

B. INTERRELATIONSHIP TO 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		6. 00
7.00		7. 00
8.00		8. 00 9. 00
9.00		9. 00
10.00		10.00
7. 00 8. 00 9. 00 10. 00 100. 00		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.
- 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.

			From To	09/30/2014	Date/Time Pro 2/25/2015 3:1	

						07,007,201	2/25/2015 3: 1	1 pm
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
				·	·		Hours	
	1. 00	2. 00	3.00	4. 00	5. 00	6. 00	7. 00	
1.00	60. 00	LABORATORY	64, 464	64, 464	0	0	0	1. 00
2.00	90. 00	CLINIC	444, 987	444, 987	0	0	0	2.00
3.00	90. 01	FAMILY PRACTICE OF JAY	1, 317, 889	1, 317, 889	0	0	0	3.00
		COUNTY						
4.00	90. 02	JAY FAMILY MEDICINE	819, 152	819, 152	0	0	0	4.00
5.00	91. 00	EMERGENCY	1, 665, 392	1, 432, 237	233, 155	0	o	5.00
6.00	0. 00		0	0	0	0	o	6. 00
7. 00	0. 00		0	0	0	0	o	7. 00
8. 00	0. 00		0	0	0	0	o	8. 00
9. 00	0. 00		l o	0	0	0	o	9. 00
10. 00	0. 00		0	0	0	0	0	10.00
200.00			4, 311, 884	4, 078, 729	233, 155		o	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		Identifier	Limit		Memberships &	Component	of Mal practice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	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		CLINIC	0	0	0	0	o	2. 00
3. 00		FAMILY PRACTICE OF JAY	0	0	0	0	0	3. 00
0.00		COUNTY						0.00
4. 00	90. 02	JAY FAMILY MEDICINE	0	0	0	0	o	4. 00
5. 00		EMERGENCY	0	0	0	0	0	5. 00
6. 00	0. 00		0	0	0	0	0	6. 00
7. 00	0. 00		0	0	0	0	Ö	7. 00
8.00	0. 00		0	0	0	0	0	8. 00
9. 00	0. 00		0	l o	0	0	0	9. 00
10.00	0. 00		١	0	0	0	Ö	10. 00
200.00	0.00		١	0	0	0		200. 00
200.00	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	0	200.00
	WKSt. A LINE #	I denti fi er	Component	Limit	Di sal I owance	Auj us tilicit		
		racittifici	Share of col.	Limit	Di Sai i Owanee			
			14					
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00		
1. 00		LABORATORY	0		0			1. 00
2. 00		CLI NI C	0	· ·	_			2. 00
3. 00		FAMILY PRACTICE OF JAY	١	0		1, 317, 889		3. 00
3.00	70.01	COUNTY	٥		0	1, 317, 007		3. 00
4. 00	90 02	JAY FAMILY MEDICINE	0	0	0	819, 152		4. 00
5. 00		EMERGENCY		0	0	1, 432, 237		5. 00
6.00	0.00			0	0	1, 432, 237		6. 00
7.00	0.00							7. 00
8. 00	0.00			0	0			8. 00
9. 00	0.00							9. 00
10. 00	0.00				0			10. 00
	0.00					4 070 700		
200.00			l 0	l 0	1	4, 078, 729		200.00

	Financial Systems ABLE COST DETERMINATION FOR THERAPY SERVICES	JAY COUNTY		CCN: 151320		worksheet A-8	
	E SUPPLIERS	FURINI SHED BY	Provider	JUN: 151320	Peri od: From 10/01/2013	Parts I-VI	
					To 09/30/2014	Date/Time Pre 2/25/2015 3:1	
					Physical Therapy		
						1. 00	
	PART I - GENERAL INFORMATION						
1. 00 2. 00	Total number of weeks worked (excluding aides Line 1 multiplied by 15 hours per week	s) (see instruc	tions)			52 780	1
3. 00	Number of unduplicated days in which supervis	sor or therapis	t was on provid	ler site (see	e instructions)	260	
4.00	Number of unduplicated days in which therapy		on provider sit	e but neithe	er supervi sor	0	4. 00
5. 00	nor therapist was on provider site (see instr Number of unduplicated offsite visits - super	ructions) rvisors or ther	apists (see ins	structions)		0	5. 00
6.00	Number of unduplicated offsite visits - thera	apy assistants	(include only v	visits made b		0	
	assistant and on which supervisor and/or ther instructions)	rapist was not	present during	the visit(s)) (see		
7. 00	Standard travel expense rate					5. 50	7. 00
8. 00	Optional travel expense rate per mile		· T		A: 1	0.00	8.00
		Supervi sors 1.00	Therapi sts 2.00	Assi stants 3.00	Ai des 4. 00	Trai nees 5.00	
9. 00	Total hours worked	2, 152. 00	4, 379. 00	2, 164. (0.00	0.00	1
	AHSEA (see instructions) Standard travel allowance (columns 1 and 2,	36. 94 36. 95	73. 89 36. 95	40. ⁹ 20. ⁴		0.00	10.00
11.00	one-half of column 2, line 10; column 3,	30. 95	30. 95	20. 4			11.00
40.00	one-half of column 3, line 10)						40.00
	Number of travel hours (provider site) Number of travel hours (offsite)	0	0		0		12. 00 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	
	Part II - SALARY EQUIVALENCY COMPUTATION	10)				70.405	
14.00	Supervisors (column 1, line 9 times column 1, Therapists (column 2, line 9 times column 2,					79, 495 323, 564	
16. 00	Assistants (column 3, line 9 times column 3,	line10)				88, 616	16. 00
17. 00	Subtotal allowance amount (sum of lines 14 ar others)	nd 15 for respi	ratory therapy	or lines 14-	·16 for all	491, 675	17. 00
18. 00	Aides (column 4, line 9 times column 4, line	10)				0	18. 00
19. 00	Trainees (column 5, line 9 times column 5, li			47 140	6 11 11)	0	
20. 00	Total allowance amount (sum of lines 17-19 for If the sum of columns 1 and 2 for respiratory					491, 675 hology or	20.00
	occupational therapy, line 9, is greater than	ıline 2, make ı					
21. 00	the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra	<u>lines 21-23.</u> ainees (line 17	divided by sur	of columns	1 and 2. line 9	0.00	21. 00
	for respiratory therapy or columns 1 thru 3,	line 9 for all	others)		,		
22.00	Weighted allowance excluding aides and traine Total salary equivalency (see instructions)	ees (line 2 tim	es line 21)			0 491, 675	
23.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW	ANCE AND TRAVE	EXPENSE COMPL	ITATION - PRO	OVI DER SITE	471,073	25.00
24.00	Standard Travel Allowance					0 (07	1 24 00
24. 00 25. 00	Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11)					9, 607	1
26. 00	Subtotal (line 24 for respiratory therapy or					9, 607	1
27. 00	Standard travel expense (line 7 times line 3 others)	for respirator	y therapy or su	ım of lines 3	and 4 for all	1, 430	27. 00
28. 00	Total standard travel allowance and standard	travel expense	at the provide	er site (sum	of lines 26 and	11, 037	28. 00
	27) Optional Travel Allowance and Optional Travel	Fynansa					-
29. 00	Therapists (column 2, line 10 times the sum of		d 2, line 12)			0	29. 00
30.00	Assistants (column 3, line 10 times column 3,					0	
31. 00 32. 00	Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns				or sum of	0 0	
02.00	columns 1-3, line 13 for all others)	o i una 2, iiilo	TO TOT TOSPITE	reory therapy	, or sam or		02.00
33.00	Standard travel allowance and standard travel			. 21)		11, 037	1
34. 00 35. 00	Optional travel allowance and standard travel Optional travel allowance and optional travel					0 0	1
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA				ICES OUTSIDE PRO		1
36. 00	Standard Travel Expense Therapists (line 5 times column 2, line 11)					I 0	36.00
36.00	Assistants (line 6 times column 3, line 11)					0	1
38. 00	Subtotal (sum of lines 36 and 37)	-				0	38. 00
39. 00	Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel		a 6)			0	39. 00
40. 00	Therapists (sum of columns 1 and 2, line 12.0	01 times column	2, line 10)			0	1
41.00	Assistants (column 3, line 12.01 times column	2 lino 10)				0	41.00

40. 00 41. 00

0 44.00

0 45.00

0 42.00

0 43.00

42.00

43.00

Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)

or 46, as appropriate.
44.00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)

45.00 Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)

Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45,

Subtotal (sum of lines 40 and 41)

	ABLE COST DETERMINATION FOR THERAPY SERVICES F E SUPPLIERS	FURNI SHED BY	Provi der		Period: From 10/01/2013 To 09/30/2014 Physical Therapy	Date/Time Pre 2/25/2015 3:1	pared:
						1.00	
46. 00	Optional travel allowance and optional travel	expense (sum o	f lines 42 an	d 43 - see in	structions)		46. 00
		Therapi sts	Assi stants	Ai des	Trai nées	Total	
	DART W. OVERTIME COMPUTATION	1.00	2. 00	3. 00	4. 00	5. 00	
47. 00	PART V - OVERTIME COMPUTATION Overtime hours worked during reporting	0.00	0.00	0.0	0.00	0.00	47. 00
47.00	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)	0.00	0.00	0.0	0.00	0.00	47.00
48. 00	Overtime rate (see instructions)	0. 00	0.00				48. 00
49. 00	Total overtime (including base and overtime	0. 00	0. 00	0.0	0.00		49. 00
	allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT					İ	-
50. 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. 00
51. 00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions) DETERMINATION OF OVERTIME ALLOWANCE	0. 00	0.00	0.0	0.00	0.00	51.00
52. 00	Adjusted hourly salary equivalency amount	73. 89	40. 95	0.0	0.00		52. 00
53. 00	(see instructions) Overtime cost limitation (line 51 times line	0	0		0 0		53. 00
54. 00	52) Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0		0 0		54. 00
55. 00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0		0 0		55. 00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	O	0		0 0	0	56. 00
	Total art others.					1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST A	ADJUSTMENT			1.00	
	Salary equivalency amount (from line 23)				ļ	491, 675	
58. 00 59. 00 60. 00 61. 00 62. 00 63. 00	Travel allowance and expense - provider site Travel allowance and expense - Offsite service Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) Total allowance (sum of lines 57-62))		11, 037 0 0 0 0 0 502, 712	59. 00 60. 00 61. 00 62. 00
64. 00	Total cost of outside supplier services (from	your records)				509, 210	
	Excess over limitation (line 64 minus line 63		enter zero)			6, 498	
	LINE 33 CALCULATION						
100.01	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				others		100. 00 100. 01
.00.02	LINE 34 CALCULATION					117007	1.00.02
	Line 27 = line 7 times line 3 for respiratory				others		101. 00
	Line 31 = line 29 for respiratory therapy or	sum of lines 29	and 30 for a	II others			101. 01
	Line 34 = sum of lines 27 and 31					1, 430	101. 02
101.02	ILLINE 33 CALCULATION						
102.00	LINE 35 CALCULATION Line 31 = line 29 for respiratory therapy or Line 32 = line 8 times columns 1 and 2, line				mns 1-3, line		102. 00 102. 01

	ADLE COCT DETERMINATION FOR THERAPY CERVICES FURNICHED BY	ITY HOSPITAL		ieu of Form CMS-2	
	ABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY E SUPPLIERS	Provi der CCN: 1	51320 Peri od: From 10/01/201 To 09/30/201		pared
			Respi ratory Therapy	Cost	Гріп
			тнег ару	1.00	
	PART I - GENERAL INFORMATION				
1.00 2.00	Total number of weeks worked (excluding aides) (see inst Line 1 multiplied by 15 hours per week	ructions)		52 780	1
3. 00 1. 00	Number of unduplicated days in which supervisor or thera Number of unduplicated days in which therapy assistant w			260	1
5. 00	nor therapist was on provider site (see instructions) Number of unduplicated offsite visits - supervisors or t	herapists (see instruct	i ons)	0	5. (
. 00	Number of unduplicated offsite visits - therapy assistan assistant and on which supervisor and/or therapist was n			0	6.
. 00	instructions) Standard travel expense rate			5. 50	7.
3. 00	Optional travel expense rate per mile			0.00	
	Supervi sor 1.00		stants Ai des	Trai nees 5. 00	
9. 00	Total hours worked 1,872.	00 5, 636. 00	0.00 1,791.0	0.00	
10. 00 11. 00	AHSEA (see instructions) 72. Standard travel allowance (columns 1 and 2, 29.		29. 04 0. 0 14. 52	0.00	10. (
11.00	one-half of column 2, line 10; column 3,	27.04	14. 32		' ' '
12. 00	one-half of column 3, line 10) Number of travel hours (provider site)	0 0	0		12. (
12. 00	Number of travel hours (offsite)		o o		12.
13.00	Number of miles driven (provider site)	0 0	0		13.
13. 01	Number of miles driven (offsite)				13.
	T			1.00	
4. 00	Part II - SALARY EQUIVALENCY COMPUTATION Supervisors (column 1, line 9 times column 1, line 10)			135, 346	1 14
5. 00	Therapists (column 2, line 9 times column 2, line 10)			327, 339	1
6. 00	Assistants (column 3, line 9 times column 3, line10)		44.47.6	0	
7. 00	Subtotal allowance amount (sum of lines 14 and 15 for re others)	spiratory therapy or li	nes 14-16 for all	462, 685	17.
8. 00	Aides (column 4, line 9 times column 4, line 10)			0	18.
9. 00	Trainees (column 5, line 9 times column 5, line 10)	+1 1: 17	10 <i>E</i> - -+	0	1
20. 00	Total allowance amount (sum of lines 17-19 for respirato If the sum of columns 1 and 2 for respiratory therapy or				20.
	occupational therapy, line 9, is greater than line 2, mal	ke no entries on lines			
21. 00	the amount from line 20. Otherwise complete lines 21-23 Weighted average rate excluding aides and trainees (line		olumns 1 and 2 line	9 0.00	21.
- 1. 00	for respiratory therapy or columns 1 thru 3, line 9 for	all others)	oranins rana 2, rrne	, 0.00	
22. 00	Weighted allowance excluding aides and trainees (line 2	times line 21)			
2 00				0	l
23. 00	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TR.	AVEL EXPENSE COMPUTATIO	N - PROVIDER SITE	462, 685	l
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TR. Standard Travel Allowance	AVEL EXPENSE COMPUTATIO	N - PROVIDER SITE	462, 685	23.
24. 00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TR Standard Travel Allowance Therapists (line 3 times column 2, line 11)	AVEL EXPENSE COMPUTATIO	N - PROVIDER SITE	462, 685 7, 550	23.
24. 00 25. 00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TR. Standard Travel Allowance			462, 685	23. 24. 25.
24. 00 25. 00 26. 00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TR Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or sum of line Standard travel expense (line 7 times line 3 for respira	s 24 and 25 for all oth	ers)	7, 550 0	24. 25. 26.
24. 00 25. 00 26. 00 27. 00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TR Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or sum of line	s 24 and 25 for all oth tory therapy or sum of	ers) lines 3 and 4 for all	7, 550 0 7, 550 1, 430	24. 25. 26. 27.
24. 00 25. 00 26. 00 27. 00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TR. Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or sum of line Standard travel expense (line 7 times line 3 for respira others) Total standard travel allowance and standard travel expe 27)	s 24 and 25 for all oth tory therapy or sum of	ers) lines 3 and 4 for all	7, 550 0 7, 550 1, 430	24. 25. 26. 27.
24. 00 25. 00 26. 00 27. 00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TR. Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or sum of line Standard travel expense (line 7 times line 3 for respira others) Total standard travel allowance and standard travel expe 27) Optional Travel Allowance and Optional Travel Expense	s 24 and 25 for all oth tory therapy or sum of nse at the provider sit	ers) lines 3 and 4 for all	7, 550 0 7, 550 1, 430 d 8, 980	24. 25. 26. 27.
24. 00 25. 00 26. 00 27. 00 28. 00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TR. Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or sum of line Standard travel expense (line 7 times line 3 for respira others) Total standard travel allowance and standard travel expe 27)	s 24 and 25 for all oth tory therapy or sum of nse at the provider sit	ers) lines 3 and 4 for all	7, 550 0 7, 550 1, 430	24. 25. 26. 27. 28.
24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 31. 00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TR. Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or sum of line Standard travel expense (line 7 times line 3 for respira others) Total standard travel allowance and standard travel expe 27) Optional Travel Allowance and Optional Travel Expense Therapists (column 2, line 10 times the sum of columns 1 Assistants (column 3, line 10 times column 3, line 12) Subtotal (line 29 for respiratory therapy or sum of line	s 24 and 25 for all oth tory therapy or sum of nse at the provider sit and 2, line 12) s 29 and 30 for all oth	ers) lines 3 and 4 for all e (sum of lines 26 an ers)	7, 550 0 7, 550 1, 430 d 8, 980	24. 25. 26. 27. 28. 29. 30. 31.
24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 31. 00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRANSTANDARD TRAVEL ALLOWANCE AND TRANSTANDARD TRAVEL ALLOWANCE AND TRANSTANDARD TRAVEL ALLOWANCE AND	s 24 and 25 for all oth tory therapy or sum of nse at the provider sit and 2, line 12) s 29 and 30 for all oth	ers) lines 3 and 4 for all e (sum of lines 26 an ers)	7, 550 0 7, 550 1, 430 d 8, 980	24. 25. 26. 27. 28. 29. 30. 31.
24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TR. Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or sum of line Standard travel expense (line 7 times line 3 for respira others) Total standard travel allowance and standard travel expe 27) Optional Travel Allowance and Optional Travel Expense Therapists (column 2, line 10 times the sum of columns 1 Assistants (column 3, line 10 times column 3, line 12) Subtotal (line 29 for respiratory therapy or sum of line Optional travel expense (line 8 times columns 1 and 2, l columns 1-3, line 13 for all others) Standard travel allowance and standard travel expense (l	s 24 and 25 for all oth tory therapy or sum of nse at the provider sit and 2, line 12) s 29 and 30 for all oth ine 13 for respiratory ine 28)	ers) lines 3 and 4 for all e (sum of lines 26 an ers)	7, 550 0 7, 550 1, 430 d 8, 980 0 0 0 0 8, 980	24. 25. 26. 27. 28. 29. 30. 31. 32.
24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 34. 00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TR. Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or sum of line Standard travel expense (line 7 times line 3 for respira others) Total standard travel allowance and standard travel expe 27) Optional Travel Allowance and Optional Travel Expense Therapists (column 2, line 10 times the sum of columns 1 Assistants (column 3, line 10 times column 3, line 12) Subtotal (line 29 for respiratory therapy or sum of line Optional travel expense (line 8 times columns 1 and 2, l columns 1-3, line 13 for all others) Standard travel allowance and standard travel expense (l Optional travel allowance and standard travel expense (s	s 24 and 25 for all oth tory therapy or sum of use at the provider sit and 2, line 12) s 29 and 30 for all oth ine 13 for respiratory ine 28) um of lines 27 and 31)	ers) lines 3 and 4 for all e (sum of lines 26 an ers)	7, 550 0 7, 550 1, 430 d 8, 980 0 0 0 8, 980	23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34.
4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 00 1. 00 2. 00 4. 00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TR. Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or sum of line Standard travel expense (line 7 times line 3 for respira others) Total standard travel allowance and standard travel expe 27) Optional Travel Allowance and Optional Travel Expense Therapists (column 2, line 10 times the sum of columns 1 Assistants (column 3, line 10 times column 3, line 12) Subtotal (line 29 for respiratory therapy or sum of line Optional travel expense (line 8 times columns 1 and 2, l columns 1-3, line 13 for all others) Standard travel allowance and standard travel expense (l	s 24 and 25 for all oth tory therapy or sum of nse at the provider sit and 2, line 12) s 29 and 30 for all oth ine 13 for respiratory ine 28) um of lines 27 and 31) um of lines 31 and 32)	ers) lines 3 and 4 for all e (sum of lines 26 an ers) therapy or sum of	7, 550 0 7, 550 1, 430 d 8, 980 0 0 0 8, 980	23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34.
44. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 00 11. 00 2. 00 4. 00 5. 00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TR. Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or sum of line Standard travel expense (line 7 times line 3 for respira others) Total standard travel allowance and standard travel expe 27) Optional Travel Allowance and Optional Travel Expense Therapists (column 2, line 10 times the sum of columns 1 Assistants (column 3, line 10 times column 3, line 12) Subtotal (line 29 for respiratory therapy or sum of line Optional travel expense (line 8 times columns 1 and 2, l columns 1-3, line 13 for all others) Standard travel allowance and standard travel expense (soptional travel allowance and standard travel expense (soptional travel allowance and optional travel expense (separt IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRASTANDARD TRAVEL Expense	s 24 and 25 for all oth tory therapy or sum of nse at the provider sit and 2, line 12) s 29 and 30 for all oth ine 13 for respiratory ine 28) um of lines 27 and 31) um of lines 31 and 32)	ers) lines 3 and 4 for all e (sum of lines 26 an ers) therapy or sum of	7, 550 0 7, 550 1, 430 d 8, 980 0 0 8, 980 0 0 ROVI DER SITE	23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35.
4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TR. Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or sum of line Standard travel expense (line 7 times line 3 for respira others) Total standard travel allowance and standard travel expe 27) Optional Travel Allowance and Optional Travel Expense Therapists (column 2, line 10 times the sum of columns 1 Assistants (column 3, line 10 times column 3, line 12) Subtotal (line 29 for respiratory therapy or sum of line Optional travel expense (line 8 times columns 1 and 2, l columns 1-3, line 13 for all others) Standard travel allowance and standard travel expense (I Optional travel allowance and standard travel expense (Soptional travel allowance and optional travel expense (Separt IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAYSTANDARD TRAYSTANDARD STANDARD	s 24 and 25 for all oth tory therapy or sum of nse at the provider sit and 2, line 12) s 29 and 30 for all oth ine 13 for respiratory ine 28) um of lines 27 and 31) um of lines 31 and 32)	ers) lines 3 and 4 for all e (sum of lines 26 an ers) therapy or sum of	7, 550 0 7, 550 1, 430 d 8, 980 0 0 0 8, 980 0 0 ROVI DER SITE	23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35.
14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TR. Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or sum of line Standard travel expense (line 7 times line 3 for respira others) Total standard travel allowance and standard travel expe 27) Optional Travel Allowance and Optional Travel Expense Therapists (column 2, line 10 times the sum of columns 1 Assistants (column 3, line 10 times column 3, line 12) Subtotal (line 29 for respiratory therapy or sum of line Optional travel expense (line 8 times columns 1 and 2, l columns 1-3, line 13 for all others) Standard travel allowance and standard travel expense (soptional travel allowance and standard travel expense (soptional travel allowance and optional travel expense (separt IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRASTANDARD TRAVEL Expense	s 24 and 25 for all oth tory therapy or sum of nse at the provider sit and 2, line 12) s 29 and 30 for all oth ine 13 for respiratory ine 28) um of lines 27 and 31) um of lines 31 and 32)	ers) lines 3 and 4 for all e (sum of lines 26 an ers) therapy or sum of	7, 550 0 7, 550 1, 430 d 8, 980 0 0 8, 980 0 0 ROVI DER SITE	23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35.
24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TR. Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or sum of line Standard travel expense (line 7 times line 3 for respira others) Total standard travel allowance and standard travel expe 27) Optional Travel Allowance and Optional Travel Expense Therapists (column 2, line 10 times the sum of columns 1 Assistants (column 3, line 10 times column 3, line 12) Subtotal (line 29 for respiratory therapy or sum of line Optional travel expense (line 8 times columns 1 and 2, l columns 1-3, line 13 for all others) Standard travel allowance and standard travel expense (l Optional travel allowance and standard travel expense (s Optional travel allowance and optional travel expense (s Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAYSTANDARD STA	s 24 and 25 for all oth tory therapy or sum of use at the provider sit and 2, line 12) s 29 and 30 for all oth ine 13 for respiratory ine 28) um of lines 27 and 31) um of lines 31 and 32) VEL EXPENSE COMPUTATION	ers) lines 3 and 4 for all e (sum of lines 26 an ers) therapy or sum of	7, 550 0, 7, 550 1, 430 d 8, 980 0 0 0 8, 980 0 0 ROVI DER SITE	23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38.
24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TR. Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or sum of line Standard travel expense (line 7 times line 3 for respira others) Total standard travel allowance and standard travel expe 27) Optional Travel Allowance and Optional Travel Expense Therapists (column 2, line 10 times the sum of columns 1 Assistants (column 3, line 10 times column 3, line 12) Subtotal (line 29 for respiratory therapy or sum of line Optional travel expense (line 8 times columns 1 and 2, l columns 1-3, line 13 for all others) Standard travel allowance and standard travel expense (l Optional travel allowance and standard travel expense (s Optional travel allowance and optional travel expense (s Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAYStandard 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 Expense	s 24 and 25 for all oth tory therapy or sum of nse at the provider sit and 2, line 12) s 29 and 30 for all oth ine 13 for respiratory ine 28) um of lines 27 and 31) um of lines 31 and 32) VEL EXPENSE COMPUTATION and 6)	ers) lines 3 and 4 for all e (sum of lines 26 an ers) therapy or sum of	7, 550 0 7, 550 1, 430 d 8, 980 0 0 0 8, 980 0 0 0 ROVI DER SITE	23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39.
23. 00 24. 00 25. 00 26. 00 27. 00 28. 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	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TR. Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or sum of line Standard travel expense (line 7 times line 3 for respira others) Total standard travel allowance and standard travel expe 27) Optional Travel Allowance and Optional Travel Expense Therapists (column 2, line 10 times the sum of columns 1 Assistants (column 3, line 10 times column 3, line 12) Subtotal (line 29 for respiratory therapy or sum of line Optional travel expense (line 8 times columns 1 and 2, l columns 1-3, line 13 for all others) Standard travel allowance and standard travel expense (l Optional travel allowance and standard travel expense (s Optional travel allowance and optional travel expense (s Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAYSTANDARD STA	s 24 and 25 for all oth tory therapy or sum of nse at the provider sit and 2, line 12) s 29 and 30 for all oth ine 13 for respiratory ine 28) um of lines 27 and 31) um of lines 31 and 32) VEL EXPENSE COMPUTATION and 6) umn 2, line 10)	ers) lines 3 and 4 for all e (sum of lines 26 an ers) therapy or sum of	7, 550 0, 7, 550 1, 430 d 8, 980 0, 0 8, 980 0, 0 ROVI DER SITE	23. 24. 25. 25. 26. 27. 28. 30. 31. 32. 33. 34. 35. 35. 39. 39. 40. 40.
24. 00 25. 00 26. 00 27. 00 28. 00 28. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TR. Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or sum of line Standard travel expense (line 7 times line 3 for respira others) Total standard travel allowance and standard travel expe 27) Optional Travel Allowance and Optional Travel Expense Therapists (column 2, line 10 times the sum of columns 1 Assistants (column 3, line 10 times column 3, line 12) Subtotal (line 29 for respiratory therapy or sum of line Optional travel expense (line 8 times columns 1 and 2, l columns 1-3, line 13 for all others) Standard travel allowance and standard travel expense (l Optional travel allowance and standard travel expense (spart IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRASISTANTS (line 5 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum of lines 5 Optional Travel Allowance and Optional Travel Expense Therapists (sum of lines 36 and 37) Standard travel expense (line 7 times the sum of lines 5 Optional Travel Allowance and Optional Travel Expense Therapists (sum of columns 1 and 2, line 12.01 times col Assistants (column 3, line 10 Subtotal (sum of lines 40 and 41)	s 24 and 25 for all oth tory therapy or sum of nse at the provider sit and 2, line 12) s 29 and 30 for all oth ine 13 for respiratory ine 28) um of lines 27 and 31) um of lines 31 and 32) VEL EXPENSE COMPUTATION and 6) umn 2, line 10)	ers) lines 3 and 4 for all e (sum of lines 26 an ers) therapy or sum of	7, 550 0, 7, 550 1, 430 d 8, 980 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	23. 24. 25. 26. 27. 28. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42.
4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 00 1. 00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TR. Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or sum of line Standard travel expense (line 7 times line 3 for respira others) Total standard travel allowance and standard travel expe 27) Optional Travel Allowance and Optional Travel Expense Therapists (column 2, line 10 times the sum of columns 1 Assistants (column 3, line 10 times column 3, line 12) Subtotal (line 29 for respiratory therapy or sum of line Optional travel expense (line 8 times columns 1 and 2, l columns 1-3, line 13 for all others) Standard travel allowance and standard travel expense (I Optional travel allowance and standard travel expense (s Optional travel allowance and optional travel expense (s Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRASISTANTS (line 5 times column 2, line 11) Assistants (line 6 times column 2, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum of lines 5 Optional Travel Allowance and Optional Travel Expense Therapists (sum of columns 1 and 2, line 12.01 times col Assistants (column 3, line 12.01 times column 3, line 10	s 24 and 25 for all oth tory therapy or sum of nse at the provider sit and 2, line 12) s 29 and 30 for all oth ine 13 for respiratory ine 28) um of lines 27 and 31) um of lines 31 and 32) VEL EXPENSE COMPUTATION and 6) umn 2, line 10))	ers) lines 3 and 4 for all e (sum of lines 26 an ers) therapy or sum of - SERVICES OUTSIDE P	7, 550 0, 7, 550 1, 430 d 8, 980 0, 0 0, 0 0, 0 0, 0 0, 0 0, 0 0, 0 0,	23. 24. 25. 26. 27. 28. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42.

מופוטנ	Financial Systems ABLE COST DETERMINATION FOR THERAPY SERVICES I E SUPPLIERS	JAY COUNTY FURNI SHED BY		CCN: 151320	Peri od: From 10/01/2013 To 09/30/2014	wof Form CMS-2 Worksheet A-8 Parts I-VI Date/Time Pre	-3
					Respiratory	2/25/2015 3:1 Cost	1 pm
					Therapy		
						1. 00	
	Optional travel allowance and standard travel					0	
16.00	Optional travel allowance and optional travel	expense (sum of Therapists	Assistants	d 43 - see ir Aides	Trai nees	0 Total	46. 00
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART V - OVERTIME COMPUTATION						
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	140. 00	0. 00	12.0	0.00	152. 00	47.0
8. 00	column of line 56) Overtime rate (see instructions)	87. 12	43. 56	0. 0	0.00		48. 00
9. 00	Total overtime (including base and overtime	12, 196. 80	0.00				49.00
	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)	92. 11	0. 00	7.8	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, 915. 89	0.00	164. 1	1 0.00	2, 080. 00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE Adjusted hourly salary equivalency amount	58. 08	0.00	0.0	0. 00		52. 0
2. 00	(see instructions)	30.00	0.00	0.0	0.00		32.0
3. 00	Overtime cost limitation (line 51 times line 52)	111, 275	0		0 0		53.0
4. 00	Maximum overtime cost (enter the lesser of line 49 or line 53)	12, 197	0		0 0		54.0
5. 00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	8, 131	0		0 0		55.00
6. 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	4, 066	0		0 0	4, 066	56. 0
	respiratory therapy and columns 1 through 3 for all others.)						
						1. 00	
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST	ADJUSTMENT				
						462, 685 8, 980	
7. 00	Salary equivalency amount (from line 23) Travel allowance and expense - provider site	(from lines 33	34 or 35))			0, 700	1
7. 00 3. 00	Travel allowance and expense - provider site Travel allowance and expense - Offsite service	•	. , ,)		0	59.0
7. 00 8. 00 9. 00 0. 00	Travel allowance and expense - provider site Travel allowance and expense - Offsite servic Overtime allowance (from column 5, line 56)	•	. , ,)		0 4, 066	60.0
7. 00 3. 00 9. 00 0. 00 1. 00	Travel allowance and expense - provider site Travel allowance and expense - Offsite servic Overtime allowance (from column 5, line 56) Equipment cost (see instructions)	•	. , ,)		4, 066 0	60. C
7. 00 3. 00 9. 00 0. 00 1. 00 2. 00	Travel allowance and expense - provider site Travel allowance and expense - Offsite servic Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions)	•	. , ,)		4, 066 0 0	60. C 61. C 62. C
7. 00 3. 00 9. 00 0. 00 1. 00 2. 00 3. 00	Travel allowance and expense - provider site Travel allowance and expense - Offsite servic Overtime allowance (from column 5, line 56) Equipment cost (see instructions)	es (from lines	. , ,)		4, 066 0	60. 0 61. 0 62. 0 63. 0
7. 00 8. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00	Travel allowance and expense - provider site Travel allowance and expense - Offsite service Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63)	es (from lines	44, 45, or 46)		4, 066 0 0 475, 731	60. 0 61. 0 62. 0 63. 0 64. 0
7. 00 8. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00	Travel allowance and expense - provider site Travel allowance and expense - Offsite service Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) Total allowance (sum of lines 57-62) Total cost of outside supplier services (from	es (from lines your records) - if negative,	44, 45, or 46			4, 066 0 0 475, 731 348, 628	60. 0 61. 0 62. 0 63. 0 64. 0 65. 0
7. 00 8. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 00. 01	Travel allowance and expense - provider site Travel allowance and expense - Offsite service Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) 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	your records) - if negative, sum of lines 24	enter zero) 4 and 25 for a	II others	others	4, 066 0 0 475, 731 348, 628 0	60. 0 61. 0 62. 0 63. 0 64. 0 65. 0
7. 00 8. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 00. 01 00. 02 01. 00	Travel allowance and expense - provider site Travel allowance and expense - Offsite service Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) 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	your records) - if negative, sum of lines 24 therapy or sur	enter zero) 4 and 25 for an of lines 3 an of lines 3 and 10 lines	II others nd 4 for all nd 4 for all		4, 066 0 0 475, 731 348, 628 0 7, 550 1, 430 8, 980	60. 0 61. 0 62. 0 63. 0 64. 0 65. 0 100. 0 100. 0
7. 00 8. 00 9. 00 0. 00 1. 00 12. 00 3. 00 4. 00 5. 00 00. 01 00. 02 01. 00 01. 01 01. 01	Travel allowance and expense - provider site Travel allowance and expense - Offsite service Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) 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	your records) - if negative, sum of lines 24 therapy or sur	enter zero) 4 and 25 for an of lines 3 an of lines 3 and 10 lines	II others nd 4 for all nd 4 for all		4, 066 0 0 475, 731 348, 628 0 7, 550 1, 430 8, 980	61. 0 62. 0 63. 0 64. 0 65. 0 100. 0 100. 0 101. 0
7. 00 8. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 00. 01 00. 02 01. 00 01. 01 01. 02	Travel allowance and expense - provider site Travel allowance and expense - Offsite service Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) 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 Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31	your records) 3 - if negative, sum of lines 24 therapy or sur therapy or sur sum of lines 24 sum of lines 24	enter zero) 4 and 25 for an of lines 3 and 30 for an and 30 for an an and 30 for an and 30 for an and 30 for an and 30 for an and 30 for an and 30 for an and 30 for an and 30 for an and 30 for an and 30 for an and 30 for an and 30 for an analysis analysis and 30 for an analysis and 30 for an analysis and 30 for an analysis and 30 for an analysis and 30 for an analysis and 30 for an analysis and 30 for an analysis and 30 for an analysis analysis and 30 for an analysis and 30 for an analysis and 30 for an analysis and 30 for an analysis and 30 for an analysis analysis analysis and 30 for an analysis analysis analysis and 30 for an analysis	II others nd 4 for all nd 4 for all II others	others	4, 066 0 0 475, 731 348, 628 0 7, 550 1, 430 8, 980 1, 430 0 1, 430	60. 0 61. 0 62. 0 63. 0 64. 0 65. 0 100. 0 100. 0 101. 0

| Peri od: | Worksheet B | From 10/01/2013 | Part | To 09/30/2014 | Date/Time Prepared: | 2/25/2015 3:11 pm Provi der CCN: 151320

					077 307 2014	2/25/2015 3:1	1 pm
				CAPITAL REL	ATED COSTS		
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A	NEW MVBLE EQUIP	NEW MVBLE EQUIP MOB	NEW MVBLE EQUI P-POB	NEW MVBLE EQUIP- WJ	
		col . 7)	2.00	2.01	2.02	2.02	
	GENERAL SERVICE COST CENTERS	0	2. 00	2. 01	2. 02	2. 03	
2. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP	1, 566, 806	1, 566, 806				2. 00
2. 01	00201 NEW CAP REL COSTS-MVBLE EQUIP MOB	23, 258	1, 300, 000	23, 258			2. 01
2. 02	00202 NEW CAP REL COSTS MVBLE EQUI P-POB	104, 018	0	23, 230	104, 018		2. 02
2. 03	00203 NEW CAP REL COSTS-MVBLE EQUIP- WJ	5, 275	0	0	0	5, 275	2. 03
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	5, 120, 461	O	0	0	0	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	4, 700, 062	187, 020	4, 950	2, 908	0	5. 00
7.00	00700 OPERATION OF PLANT	1, 153, 387	97, 451	0	0	0	7. 00
7. 01	00701 OPERATION OF PLANT-MOB	43, 707	0	0	0	0	7. 01
7. 02	00702 OPERATION OF PLANT-POB	107, 659	0	0	0	0	7. 02
7. 03	00703 OPERATION OF PLANT-WJ	1, 311	0	0	0	0	7. 03
8.00	00800 LAUNDRY & LINEN SERVICE	40, 204	10, 540	0	0	0	8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	363, 353 237, 248	8, 386 49, 035	0 845	0	0	9. 00 10. 00
11. 00	01100 CAFETERI A	197, 662	47, 033 47, 087	045	0	0	11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	910, 029	33, 385	0	0	0	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	64, 735	46, 285	0	o	0	14. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	398, 362	32, 423	0	0	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS		,				
30.00	03000 ADULTS & PEDIATRICS	1, 214, 620	306, 699	0	0	0	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	1, 078, 850	106, 227	0	0	0	40. 00
41. 00	04100 SUBPROVI DER – I RF	0	0	0	0	0	41.00
42.00	04200 SUBPROVI DER	100 757	0 (70	0	0	0	42.00
43. 00	04300 NURSERY	128, 757	23, 670	0	0	0	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS O5000 OPERATING ROOM	1, 514, 314	146, 647	0	49, 526	0	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	18, 929	2, 910	0	47, 320	0	52. 00
53. 00	05300 ANESTHESI OLOGY	10, 727	2, 710	0	0	0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 383, 287	143, 324	0	o	0	54.00
57.00	05700 CT SCAN	0	o	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	1, 643, 396	54, 993	0	0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	356, 837	6, 416	0	0	0	65. 00
68. 00	06800 SPEECH PATHOLOGY	591, 185	0	0	0	0	66. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	310, 384	22, 914	0	0	0	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	22, 714	0	0	0	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	13, 903	o	0	o	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 278, 251	25, 434	0	0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	0	0	0	0	0	
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	
90.00	09000 CLINIC	209, 134	96, 237	0	51 504	0	90.00
90. 01 90. 02	09001 FAMILY PRACTICE OF JAY COUNTY	408, 283 251, 499	0	0	51, 584	0	90. 01 90. 02
90. 02	09002 JAY FAMILY MEDICINE 09100 EMERGENCY	854, 158	106, 548	0	0	0	
92. 00		654, 156	100, 546	U	o o	U	92.00
93. 00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	
70.00	OTHER REIMBURSABLE COST CENTERS	<u> </u>	٥,	<u> </u>	<u> </u>		70.00
99. 10	09910 CORF	0	0	0	0	0	99. 10
	SPECIAL PURPOSE COST CENTERS	<u> </u>	'				
106.00	10600 HEART ACQUISITION	0	0	0	0	0	106. 00
	10900 PANCREAS ACQUISITION	0	0	0	0		109. 00
	11000 INTESTINAL ACQUISITION	0	0	0	0		110. 00
	11100 SLET ACQUI SITION	0	0	0	0	0	111. 00
113.00	11300 INTEREST EXPENSE	24 202 224	1 550 (21	E 70E	104 010	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	26, 293, 324	1, 553, 631	5, 795	104, 018	0	118. 00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	n	13, 175	0	0	n	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES		13, 175	n	0		190.00
	19300 NONPALD WORKERS		o	Ö	ol		193.00
194.00	07950 MOB	1, 314	ō	17, 463	o		194. 00
	07951 POB	0	o	0	О		194. 01
	07952 WEST JAY CLINIC	496, 073	o	0	O		194. 02
	07956 TRI COUNTY	1, 484, 988	0	0	O		194. 06
200.00	Cross Foot Adjustments						200. 00

Health Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Peri od:	Worksheet B	
				From 10/01/2013 To 09/30/2014		pared:
			CAPITAL R	ELATED COSTS	1 27 207 2010 011	, jo
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	NEW MVBLE EQUIP	NEW MVBLE EQUIP MOB	NEW MVBLE EQUI P-POB	NEW MVBLE EQUIP- WJ	
	0	2.00	2. 01	2. 02	2. 03	
201.00 Negative Cost Centers		0		0	0	201. 00
202.00 TOTAL (sum lines 118-201)	28, 275, 699	1, 566, 806	23, 25	8 104, 018	5, 275	202. 00

Provi der CCN: 151320

					0 07/30/2014	2/25/2015 3:1	
	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	
	GENERAL SERVICE COST CENTERS						
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	00202 NEW CAP REL COSTS-MVBLE EQUIP-POB						2. 02
2.03	00203 NEW CAP REL COSTS-MVBLE EQUIP- WJ						2. 03
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	5, 120, 461					4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	729, 470	5, 624, 410	5, 624, 410			5. 00
7. 00	00700 OPERATION OF PLANT	118, 029	1, 368, 867				7. 00
7. 00	00701 OPERATION OF PLANT-MOB	2, 133	45, 840		1, 700, 702	57, 222	7. 01
7. 01	00702 OPERATION OF PLANT-NOB	1			0	0	7. 01
	1	3, 346	111, 005		0		1
7. 03	00703 OPERATION OF PLANT-WJ	473	1, 784		4.4.045	0	7. 03
8.00	00800 LAUNDRY & LINEN SERVICE	8, 558	59, 302			l e	8. 00
9.00	00900 HOUSEKEEPI NG	109, 104	480, 843				
10. 00	01000 DI ETARY	48, 141	335, 269		65, 341	2, 640	
11. 00	01100 CAFETERI A	68, 254	313, 003			i e	11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	323, 909	1, 267, 323		44, 487	0	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	23, 746	134, 766	33, 463	61, 677	0	14. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	127, 335	558, 120	138, 583	43, 205	0	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	397, 857	1, 919, 176	476, 539	408, 686	0	30. 00
31.00	03100 INTENSIVE CARE UNIT	O	C	0	0	0	31.00
40.00	04000 SUBPROVI DER - I PF	226, 927	1, 412, 004	350, 606	141, 552	0	40.00
41. 00	04100 SUBPROVI DER - I RF	0		0	0	0	41. 00
42. 00	04200 SUBPROVI DER	0	Ċ	0	0	Ō	42. 00
43. 00	04300 NURSERY	43, 647	196, 074	48, 686	31, 541	0	43. 00
10.00	ANCI LLARY SERVI CE COST CENTERS	10,017	170,071	10,000	01,011		10.00
50. 00	05000 OPERATING ROOM	296, 018	2, 006, 505	498, 230	195, 413	0	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	6, 430	28, 269			l .	
		0, 430	20, 209	7,019	3,070		
53. 00	05300 ANESTHESI OLOGY	١	4 040 055	140 404	100 005		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	283, 644	1, 810, 255	449, 494	190, 985	0	54.00
57. 00	05700 CT SCAN	0	C	0	0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	C	0	0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	C	0	0	0	59. 00
60.00	06000 LABORATORY	226, 124	1, 924, 513	477, 864	73, 280	0	60.00
60. 01	06001 BLOOD LABORATORY	0	C	0	0	0	60. 01
65.00	06500 RESPI RATORY THERAPY	0	363, 253	90, 197	8, 549	0	65.00
66.00	06600 PHYSI CAL THERAPY	O	591, 185	146, 794	0	0	66. 00
68.00	06800 SPEECH PATHOLOGY	0	C	0	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	65, 211	398, 509	98, 951	30, 533	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o		0	0	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	13, 903	3, 452	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	130, 133	1, 433, 818		33, 892	0	73. 00
70.00	OUTPATIENT SERVICE COST CENTERS	100, 100	1, 100, 010	, 300, 020	00, 072		70.00
88. 00	08800 RURAL HEALTH CLINIC	0		1	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER				0	Ö	1
90. 00	09000 CLINIC	171, 049	476, 420	118, 297	128, 240	l e	
90. 00	09001 FAMILY PRACTICE OF JAY COUNTY	540, 778	1, 000, 645				
	1						
	09002 JAY FAMILY MEDICINE	331, 573	583, 072			0	
91.00	09100 EMERGENCY	623, 391	1, 584, 097	393, 338	141, 980	0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		C)	_	_	92. 00
93. 00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	C	0	0	0	93. 00
	OTHER REIMBURSABLE COST CENTERS						
99. 10	09910 CORF	0	C	0	0	0	99. 10
	SPECIAL PURPOSE COST CENTERS						
106.00	10600 HEART ACQUISITION	0	C	0	0	0	106. 00
109.00	10900 PANCREAS ACQUISITION	0	C	0	0	0	109. 00
110.00	11000 INTESTINAL ACQUISITION	0	C	0	0	0	110.00
111.00	11100 SLET ACQUISITION	0	C	0	0	0	111. 00
	11300 NTEREST EXPENSE						113. 00
118.00		4, 905, 280	26, 042, 230	5, 069, 832	1, 691, 205	2 640	118. 00
	NONREI MBURSABLE COST CENTERS	1,700,200	20/012/200	0,007,002	1,071,200	270.0	
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	nl	13, 175	3, 271	17, 557	0	190. 00
	19200 PHYSI CLANS' PRI VATE OFFICES	0	10, 170	0, 2, 1	.,, 557		192. 00
	19300 NONPALD WORKERS				0		
	07950 MOB		18, 777	4, 662	0	l e	193.00
	07951 POB		10, ///	4,002	0		
		151 1/3	/E0 E1E	142 022	0		194. 01
	07952 WEST JAY CLINIC	151, 167	652, 515			l e	194. 02
	07956 TRI COUNTY	64, 014	1, 549, 002	384, 623	0	0	194. 06
200.00	1 1		C		_	_	200. 00
201.00		0	00.075.155	J	0		201. 00
202.00	TOTAL (sum lines 118-201)	5, 120, 461	28, 275, 699	5, 624, 410	1, 708, 762	57, 222	202. 00

Provi der CCN: 151320

					2/25/2015 3:1	1 pm
Cost Center Description	OPERATION OF	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	PLANT-POB	PLANT-WJ	LINEN SERVICE			
	7. 02	7. 03	8. 00	9. 00	10.00	
GENERAL SERVICE COST CENTERS	7.02	7.00	0.00	7. 00	10.00	
2. 00 00200 NEW CAP REL COSTS-MVBLE EQUI P			1			2. 00
2.01 O0201 NEW CAP REL COSTS-MVBLE EQUIP MOB						2. 01
2. 02 00202 NEW CAP REL COSTS-MVBLE EQUIP-POB						2. 02
2.03 OO203 NEW CAP REL COSTS-MVBLE EQUIP- WJ						2.03
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00 00500 ADMINISTRATIVE & GENERAL						5. 00
7.00 00700 OPERATION OF PLANT						7. 00
7.01 00701 OPERATION OF PLANT-MOB						7. 01
7.02 00702 OPERATION OF PLANT-POB	138, 568					7. 02
7. 03 00703 OPERATION OF PLANT-WJ	0	l .				7. 03
	0	2, 227				
8.00 00800 LAUNDRY & LINEN SERVICE	0	0	88, 072			8.00
9. 00 00900 HOUSEKEEPI NG	0	0	10, 469	621, 882		9.00
10. 00 01000 DI ETARY	0	0	2, 443	16, 411	505, 353	10.00
11. 00 01100 CAFETERI A	0	١	1 2,	15, 759	0	11. 00
	0	0				
13.00 O1300 NURSING ADMINISTRATION	0	0	0	11, 173	0	13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	0	0	15, 491	0	14. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0	0	10, 851	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS		-			_	
		0	21 222	102 (4)	220, 001	20.00
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	21, 232	102, 646	238, 001	30. 00
31.00 03100 INTENSIVE CARE UNIT	0	0	0	0	0	31. 00
40. 00 04000 SUBPROVIDER - IPF	0	0	8, 515	35, 552	267, 352	40.00
41. 00 04100 SUBPROVI DER - I RF	0	0	0	0	0	41.00
42. 00 04200 SUBPROVI DER	1	j -	آ آ	١	0	42. 00
1 1		0	175	7 022		
43. 00 04300 NURSERY	0	0	475	7, 922	0	43. 00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	67, 874	0	19, 873	91, 525	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	974	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	j -	آ آ		0	53. 00
		0	F 170	47 0/7		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	5, 178	47, 967	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	l n	١	n	0	59.00
		٥	١	10 405		
60. 00 06000 LABORATORY	0	0		18, 405	0	60.00
60. 01 06001 BL00D LABORATORY	0	0	0	0	0	60. 01
65. 00 06500 RESPIRATORY THERAPY	0	0	0	2, 147	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	l o	1, 576	n	0	66.00
68. 00 06800 SPEECH PATHOLOGY		٥	1, 5, 5	0	0	68. 00
	0	0		7	- 1	
69. 00 06900 ELECTROCARDI OLOGY	0	0	2, 146	7, 669	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	l n	0	8, 512	0	73.00
			1 0	0, 312		73.00
OUTPATIENT SERVICE COST CENTERS				ام		
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 CLI NI C	0	0	0	32, 208	0	90.00
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY	70, 694	,	آ آ	44, 210	0	90. 01
		0		44, 210		
90. 02 09002 JAY FAMILY MEDICINE	0	0	0	U	0	90. 02
91. 00 09100 EMERGENCY	0	0	16, 165	35, 659	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS		ı	ı	٦	- J	70.00
			1 0	ما		00 40
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	o	0	109. 00
110. 00 11000 NTESTI NAL ACQUI SI TI ON	٥	١	ا آ	0		110.00
	0	0		0		
111.00 11100 1 SLET ACQUI SI TI ON	0	0	0	0	0	111. 00
113. 00 11300 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	138, 568	0	88, 072	505, 081	505, 353	118. 00
NONREI MBURSABLE COST CENTERS					,	
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		^	_	4 400		100 00
	0	l	0	4, 409		190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0	0	193.00
194. 00 07950 MOB	n	n	n	68, 182		194. 00
194. 01 07951 POB				44, 210		194. 01
		1 222	1	44, 210		
194. 02 07952 WEST JAY CLINIC	0	2, 227	0	0		194. 02
194. 06 07956 TRI COUNTY	0	[0	0	0	0	194. 06
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	n	n	n	n	n	201. 00
202.00 TOTAL (sum lines 118-201)	138, 568	2, 227	88, 072	621, 882		
202.00 TOTAL (SUIII TITIES TTO-201)	130, 308	2, 221	1 00,072	021,082	505, 553	ZUZ. UU

Provi der CCN: 151320

				To	09/30/2014	Date/Time Pre 2/25/2015 3:1	
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES & SUPPLY	MEDI CAL RECORDS & LI BRARY	Subtotal	, j
		11.00	13. 00	14. 00	16. 00	24. 00	
	GENERAL SERVICE COST CENTERS						
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	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	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 7. 00	OO5OO ADMINISTRATIVE & GENERAL OO7OO OPERATION OF PLANT						5. 00 7. 00
7. 00	00701 OPERATION OF PLANT-MOB						7. 00
7. 01	00702 OPERATION OF PLANT-NOB						7. 01
7. 02	00703 OPERATION OF PLANT-WJ						7. 02
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A	469, 228					11. 00
13.00	01300 NURSING ADMINISTRATION	34, 702	1, 672, 366				13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	5, 684	o	251, 081			14. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	25, 428	0	397	776, 584		16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	66, 815	586, 718	12, 535	37, 843	3, 870, 191	30. 00
31. 00	03100 INTENSI VE CARE UNI T	0	0	0	0	0	31.00
40. 00	04000 SUBPROVI DER - I PF	38, 541	338, 458	3, 774	16, 073	2, 612, 427	40.00
41. 00	04100 SUBPROVI DER - I RF	0	0	0	0	0	41.00
42. 00 43. 00	04200 SUBPROVI DER 04300 NURSERY	6, 930	60, 861	0	1, 330	0 353, 819	42. 00 43. 00
43.00	ANCI LLARY SERVI CE COST CENTERS	0, 730	00, 80 1	U	1, 330	333, 617	43.00
50. 00	05000 OPERATING ROOM	34, 652	304, 305	78, 368	131, 185	3, 427, 930	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	773	6, 787	0	1, 383	49, 083	52. 00
53. 00	05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	36, 572	o	15, 872	272, 550	2, 828, 873	54.00
57.00	05700 CT SCAN	0	o	0	0	0	57. 00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	o	0	0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00
60.00	06000 LABORATORY	37, 519	0	71, 701	173, 795	2, 777, 077	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
65. 00	06500 RESPI RATORY THERAPY	0	0	961	8, 072	473, 179	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0	985	20, 791	761, 331	1
68. 00 69. 00	O6800 SPEECH PATHOLOGY O6900 ELECTROCARDI OLOGY	11, 916	0	3, 345	12 274	0 566, 345	68. 00 69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	11, 910		3, 343	13, 276	0 0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	1, 370	18, 725	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	14, 733	o	1, 226	37, 905	1, 886, 109	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 CLI NI C	26, 999	0	7, 698	2, 086	791, 948	90. 00
	09001 FAMILY PRACTICE OF JAY COUNTY	51, 480		22, 766	6, 819	1, 445, 078	
90. 02	09002 JAY FAMILY MEDICINE	30, 464	l .	9, 479	3, 743	771, 537	1
91.00	09100 EMERGENCY	46, 020	375, 237	13, 959	48, 363	2, 654, 818	1
92. 00 93. 00	O9200 OBSERVATION BEDS (NON-DISTINCT PART) O4040 OTHER OUTPATIENT SERVICE COST CENTER	0	o	0	0	0	92. 00 93. 00
73.00	OTHER REIMBURSABLE COST CENTERS	0	l ol	U	υ		73.00
99. 10	09910 CORF	0	O	0	0	0	99. 10
	SPECIAL PURPOSE COST CENTERS		- 1	- 1	-1		
106.00	10600 HEART ACQUISITION	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	0	111. 00
	11300 I NTEREST EXPENSE		4 (70 0//	0.40 0.44		05 000 170	113. 00
118. 00	SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	469, 228	1, 672, 366	243, 066	776, 584	25, 288, 470] 118.00
100 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1		0	ام	30 /12	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0		0	0		192. 00
	19300 NONPALD WORKERS	0	ا م	0	ol O		193. 00
	07950 MOB	0		Ö	o	146, 203	1
	07951 P0B	0	0	0	o		194. 01
	07952 WEST JAY CLINIC	0	0	4, 410	o	821, 174	
	07956 TRI COUNTY	0	0	3, 605	0	1, 937, 230	
200.00	1 1						200. 00
201.00		140 220	1 472 244	0	77/ 504		201.00
202.00	TOTAL (sum lines 118-201)	469, 228	1, 672, 366	251, 081	776, 584	28, 275, 699	J∠U∠. UU

| Peri od: | Worksheet B | From 10/01/2013 | Part | | To 09/30/2014 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 151320

			To 09/30/2014 Date/lime 2/25/2015	
Cost Center Description	Intern & Residents Cost	Total		
	& Post			
	Stepdown			
	Adjustments 25.00	26. 00		
GENERAL SERVICE COST CENTERS				
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				4. 00
5.00 00500 ADMINISTRATIVE & GENERAL				5. 00
7. 00 00700 OPERATION OF PLANT				7. 00
7. 01 00701 OPERATION OF PLANT-MOB 7. 02 00702 OPERATION OF PLANT-POB				7. 01 7. 02
7. 03 00703 OPERATION OF PLANT-WJ				7. 02
8.00 00800 LAUNDRY & LINEN SERVICE				8. 00
9. 00 00900 HOUSEKEEPI NG				9. 00
10. 00 01000 DI ETARY				10.00
11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON				11. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY				14. 00
16.00 01600 MEDICAL RECORDS & LIBRARY				16. 00
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS	0	3, 870, 191		30.00
31. 00 03100 I NTENSI VE CARE UNI T 40. 00 04000 SUBPROVI DER - I PF	0	0 2, 612, 427		31. 00 40. 00
41. 00 04100 SUBPROVI DER		0		41.00
42. 00 04200 SUBPROVI DER	O	0		42. 00
43. 00 04300 NURSERY	0	353, 819		43. 00
ANCI LLARY SERVI CE COST CENTERS		2 427 020		F0.00
50.00 05000 OPERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	0	3, 427, 930 49, 083		50. 00 52. 00
53. 00 05300 ANESTHESI OLOGY	o o	0		53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	2, 828, 873		54.00
57.00 05700 CT SCAN	0	0		57. 00
58. 00 05800 MAGNETI C RESONANCE I MAGING (MRI)	0	0		58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	0	2, 777, 077		59. 00 60. 00
60. 01 06001 BLOOD LABORATORY	0	0		60. 01
65. 00 06500 RESPIRATORY THERAPY	0	473, 179		65. 00
66. 00 06600 PHYSI CAL THERAPY	0	761, 331		66. 00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0	0 566, 345		68. 00 69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	s o	0		71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	18, 725		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	1, 886, 109		73. 00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		88. 00 89. 00
90. 00 09000 CLINIC		791, 948		90.00
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	O	1, 445, 078		90. 01
90. 02 09002 JAY FAMILY MEDICINE	0	771, 537		90. 02
91. 00 09100 EMERGENCY	0	2, 654, 818		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 93.00 04040 OTHER OUTPATIENT SERVICE COST CENTE		o		92. 00 93. 00
OTHER REIMBURSABLE COST CENTERS	it j	0		75.00
99. 10 09910 CORF	0	0		99. 10
SPECIAL PURPOSE COST CENTERS		-1		
106. 00 10600 HEART ACQUISITION 109. 00 10900 PANCREAS ACQUISITION	0	0		106. 00 109. 00
110.00 11000 NTESTINAL ACQUISITION		0		1109.00
111. 00 11100 SLET ACQUISITION	0	Ö		111.00
113.00 11300 INTEREST EXPENSE				113. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	25, 288, 470		118. 00
NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		30 112		190. 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	38, 412 0		190.00
193. 00 19300 NONPALD WORKERS	Ŏ	ŏ		193. 00
194. 00 07950 MOB	0	146, 203		194. 00
194. 01 07951 POB	0	44, 210		194. 01
194. 02 07952 WEST JAY CLINIC	0	821, 174		194. 02
194.06 07956 TRI COUNTY 200.00 Cross Foot Adjustments	0	1, 937, 230 0		194. 06 200. 00
201. 00 Negative Cost Centers	o o	ŏ		201. 00
202.00 TOTAL (sum lines 118-201)	o	28, 275, 699		202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

			To		Date/Time Pre 2/25/2015 3:1	
			CAPITAL REL	ATED COSTS		
Cost Center Description	Directly	NEW MVBLE	NEW MVBLE	NEW MVBLE	NEW MVBLE	
	Assigned New Capital	EQUI P	EQUIP MOB	EQUI P-POB	EQUIP- WJ	
	Related Costs					
GENERAL SERVICE COST CENTERS	0	2. 00	2. 01	2. 02	2. 03	
2.00 OO200 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 EQUIP-POB						2. 02
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	
5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT	0	187, 020 97, 451	4, 950	2, 908	0	
7. 01 00701 OPERATION OF PLANT-MOB	0	97, 431	0	0	0	1
7. 02 00702 OPERATION OF PLANT-POB	0	О	0	0	0	
7. 03 00703 OPERATION OF PLANT-WJ 8. 00 00800 LAUNDRY & LINEN SERVICE	0	0 10, 540	0	0	0	
9. 00 00900 HOUSEKEEPI NG	0	8, 386	0	0	0	1
10. 00 01000 DI ETARY	0	49, 035	845	0	0	
11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON	0	47, 087 33, 385	0	0	0	1
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	46, 285	0	o	0	
16. 00 01600 MEDICAL RECORDS & LIBRARY	0	32, 423	0	0	0	16. 00
30. 00 03000 ADULTS & PEDI ATRI CS	0	306, 699	0	O	0	30.00
31. 00 03100 INTENSIVE CARE UNIT	o o	0	0	o	0	
40. 00 04000 SUBPROVI DER - 1 PF	0	106, 227	0	0	0	1
41. 00 04100 SUBPROVI DER - I RF 42. 00 04200 SUBPROVI DER	0	0	0	0	0	
43. 00 04300 NURSERY	0	23, 670	0	Ö	0	1
ANCILLARY SERVICE COST CENTERS	T al					
50.00 05000 OPERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	0	146, 647 2, 910	0	49, 526 0	0	1
53. 00 05300 ANESTHESI OLOGY	0	0	0	Ö	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	143, 324	0	0	0	
57. 00 05700 CT SCAN 58. 00 05800 MAGNETIC RESONANCE MAGING (MRI)	0	0	0	0	0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	Ö	0	Ö	0	
60. 00 06000 LABORATORY	0	54, 993	0	0	0	
60. 01 06001 BL00D LABORATORY 65. 00 06500 RESPI RATORY THERAPY	0	6, 416	0	0	0	
66. 00 06600 PHYSI CAL THERAPY	0	0	0	0	0	
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0	0 22, 914	0	0	0	1
69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	22, 914	0	0	0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	O	O	0	0	0	72. 00
73. 00 O7300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	25, 434	0	0	0	73. 00
88. 00 08800 RURAL HEALTH CLINIC	0	ol	0	0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	O	0	0	0	89. 00
90.00 09000 CLINIC 90.01 09001 FAMILY PRACTICE OF JAY COUNTY	0	96, 237	0	0 51, 584	0	
90. 02 09002 JAY FAMILY MEDICINE	0	0	0	0	0	1
91. 00 09100 EMERGENCY	0	106, 548	0	0	0	
92. 00 09200 0BSERVATI ON 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	J O	<u> </u>	O ₁	<u> </u>	0	73.00
99. 10 09910 CORF	0	0	0	0	0	99. 10
SPECIAL PURPOSE COST CENTERS 106. 00 10600 HEART ACQUI SI TI ON	0	ol	0	ol	0	106. 00
109. 00 10900 PANCREAS ACQUISITION	0	o	0	0		100.00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110. 00
111. 00 11100 SLET ACQUI SI TI ON 113. 00 11300 NTEREST EXPENSE	0	O	0	0	0	111. 00 113. 00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	0	1, 553, 631	5, 795	104, 018	0	118. 00
NONREI MBURSABLE COST CENTERS			_	-1		
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSICIANS' PRIVATE OFFICES	0	13, 175 0	0	0		190. 00 192. 00
193. 00 19300 NONPALD WORKERS		ol	0	0		192.00
194. 00 07950 MOB	0	О	17, 463	o		194. 00
194. 01 07951 POB 194. 02 07952 WEST JAY CLINIC	0	0	0	0		194. 01 194. 02
194. 06 07956 TRI COUNTY		ol	0	ol		194. 02
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	1	이	0	0	0	201. 00

Health Financial Systems	JAY COUNTY	HOSPI TAL		In Lieu of Form CMS-2		
ALLOCATION OF CAPITAL RELATED COSTS	From 10/01/2013 To 09/30/2014					
		CAPITAL RELATED COSTS				
Cost Center Description	Directly Assigned New Capital Related Costs	NEW MVBLE EQUIP	NEW MVBLE EQUIP MOB	NEW MVBLE EQUI P-POB	NEW MVBLE EQUIP- WJ	
	0	2.00	2. 01	2. 02	2. 03	
202.00 TOTAL (sum lines 118-201)	0	1, 566, 806	23, 25	8 104, 018	5, 275	202. 00

			'	0 09/30/2014	2/25/2015 3:1	
Cost Center Description	Subtotal	EMPLOYEE BENEFITS	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT-MOB	
		DEPARTMENT	& GENERAL	T EANT		
GENERAL SERVICE COST CENTERS	2A	4. 00	5. 00	7. 00	7. 01	
2. 00 O0200 NEW CAP REL COSTS-MVBLE EQUIP						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. 02
2.03 O0203 NEW CAP REL COSTS-MVBLE EQUIP- WJ 4.00 O0400 EMPLOYEE BENEFITS DEPARTMENT	0	ſ				2. 03 4. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL	194, 878	(194, 878			5.00
7.00 00700 OPERATION OF PLANT	97, 451	(11, 776			7. 00
7. 01 00701 OPERATION OF PLANT-MOB	0	(394		394	7. 01
7.02 00702 OPERATION OF PLANT-POB 7.03 00703 OPERATION OF PLANT-WJ	0	(955 15		0	7. 02 7. 03
8.00 00800 LAUNDRY & LINEN SERVICE	10, 540	(510		0	8.00
9. 00 00900 HOUSEKEEPI NG	8, 386	(4, 137	714	0	9. 00
10. 00 01000 DI ETARY	49, 880	(2, 884		18	1
11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMINI STRATI ON	47, 087 33, 385	(2, 693 10, 903		0	11. 00 13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	46, 285	(1		ł	14. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	32, 423	(0	16. 00
INPATIENT ROUTINE SERVICE COST CENTERS	1 004 400		1 4, 544	0, 10,1		
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 NTENSIVE CARE UNIT	306, 699	(16, 511	26, 124	0	30. 00 31. 00
40. 00 04000 SUBPROVI DER - PF	106, 227	(12, 147	9, 048	0	40.00
41. 00 04100 SUBPROVI DER - I RF	0	(0	0	0	41.00
42. 00 04200 SUBPROVI DER	0	(0	0	0	42. 00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	23, 670	(1, 687	2, 016	0	43.00
50. 00 05000 OPERATING ROOM	196, 173	(17, 270	12, 491	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	2, 910	(243		0	52. 00
53. 00 05300 ANESTHESI OLOGY	0	(0	0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	143, 324	(15, 574	12, 208	0	54.00
57. 00 05700 CT SCAN 58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	(0	0	57. 00 58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	O	(o o	0	Ö	59. 00
60. 00 06000 LABORATORY	54, 993	(16, 557	4, 684	0	60.00
60. 01 06001 BLOOD LABORATORY	0	(0	0	0	60. 01
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	6, 416	(3, 125 5, 086		0 0	65. 00 66. 00
68. 00 06800 SPEECH PATHOLOGY	0	(0	0	Ö	68. 00
69. 00 06900 ELECTROCARDI OLOGY	22, 914	(3, 428	1, 952	0	69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	(0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0 25, 434	() 120 12, 335		0	72. 00 73. 00
OUTPATIENT SERVICE COST CENTERS	20, 101		72,000	2, 100		7 5. 55
88. 00 08800 RURAL HEALTH CLINIC	0	(1	0		88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0 0 227	(0	0 107	0	89. 00
90.00 09000 CLINIC 90.01 09001 FAMILY PRACTICE OF JAY COUNTY	96, 237 51, 584	(4, 099 8, 609		0	
90. 02 09002 JAY FAMILY MEDICINE	0	(5, 016		Ö	
91. 00 09100 EMERGENCY	106, 548	(13, 628	9, 076	0	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTER OTHER REIMBURSABLE COST CENTERS	0	(0	U	0	93.00
99. 10 09910 CORF	0	(0	0	0	99. 10
SPECIAL PURPOSE COST CENTERS						
106. 00 10600 HEART ACQUISITION	0	(0	0		106.00
109. 00 10900 PANCREAS ACQUISITION 110. 00 11000 INTESTINAL ACQUISITION	0	(0	l e	109. 00 110. 00
111. 00 11100 SLET ACQUISITION	0	(0		111.00
113.00 11300 INTEREST EXPENSE						113. 00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	1, 663, 444	(175, 663	108, 105	18	118. 00
NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	13, 175	(113	1, 122	0	190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	13, 173	(0		192.00
193. 00 19300 NONPALD WORKERS	0	Ć	0	o	0	193. 00
194. 00 07950 MOB	17, 463	(162	0		194.00
194. 01 07951 POB 194. 02 07952 WEST JAY CLINIC	5, 275	(0 5, 614	0		194. 01 194. 02
194.06 07956 TRI_COUNTY	0,275	(13, 326			194. 02
200.00 Cross Foot Adjustments	0					200. 00
201.00 Negative Cost Centers	0	(0	0		201. 00
202.00 TOTAL (sum lines 118-201)	1, 699, 357	(194, 878	109, 227	394	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 151320 Peri od: From 10/01/3

			'	0 077 007 2011	2/25/2015 3:1	1 pm
Cost Center Description	OPERATION OF	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	PLANT-POB	PLANT-WJ	LINEN SERVICE			
	7. 02	7. 03	8. 00	9. 00	10.00	
GENERAL SERVICE COST CENTERS						
2.00 OO200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2. 01 00201 NEW CAP REL COSTS-MVBLE EQUIP MOB						2. 01
2. 02 00202 NEW CAP REL COSTS-MVBLE EQUIP-POB						2. 02
2.03 00203 NEW CAP REL COSTS-MVBLE EQUIP- WJ						2. 03
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL						5. 00
7. 00 00700 OPERATION OF PLANT						7. 00
7. 01 00701 OPERATION OF PLANT-MOB	0.55					7. 01
7. 02 00702 0PERATI ON OF PLANT-POB	955					7. 02
7.03 OPERATION OF PLANT-WJ	0	15				7. 03
8.00 00800 LAUNDRY & LINEN SERVICE	0	0	11, 948	l l		8. 00
9. 00 00900 HOUSEKEEPI NG	0	0	1, 420	14, 657		9. 00
10. 00 01000 DI ETARY	0	0	331	387	57, 677	10.00
11. 00 01100 CAFETERIA	0	0	0	371	0	11.00
13.00 01300 NURSING ADMINISTRATION	o	0	0	263	0	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	o	0	0	365	0	14.00
16.00 01600 MEDICAL RECORDS & LIBRARY	ol	0	0	256	0	16. 00
INPATIENT ROUTINE SERVICE COST CENTERS	-1	-		1		
30. 00 03000 ADULTS & PEDIATRICS	0	0	2, 882	2, 418	27, 164	30. 00
31. 00 03100 INTENSIVE CARE UNIT	ol	0	2,002	2,	0	31. 00
40. 00 04000 SUBPROVI DER - PF		0	1, 155	838	30, 513	40. 00
41. 00 04100 SUBPROVI DER	0	0	1, 133	030	0	41. 00
	0	0	1	0		
42. 00 04200 SUBPROVI DER	0	0	0	107	0	42.00
43. 00 04300 NURSERY	0	Ü	64	187	0	43. 00
ANCI LLARY SERVI CE COST CENTERS		_				
50. 00 05000 OPERATI NG ROOM	468	0	2, 696		0	50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	23	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	702	1, 131	0	54.00
57. 00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	o	0	0	o	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	ol	0	0	ol	0	59. 00
60. 00 06000 LABORATORY	o	0	0	434	0	60.00
60. 01 06001 BLOOD LABORATORY	0	0	l o	0	0	60. 01
65. 00 06500 RESPIRATORY THERAPY		0	0	51	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	214	31	0	66. 00
	0	0		0	-	
68. 00 06800 SPEECH PATHOLOGY	0	0	0	101	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	291	181	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	201	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 CLI NI C	ol	0	0	759	0	90.00
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	487	0	0	1, 042	0	90. 01
90.02 09002 JAY FAMILY MEDICINE	ol	0	0	l ' '	0	90. 02
91. 00 09100 EMERGENCY	ol	0	2, 193	840	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		_	_,		-	92. 00
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	ام	0	93. 00
OTHER REIMBURSABLE COST CENTERS	<u> </u>	O		<u> </u>		73.00
99. 10 09910 CORF	0	0	0	0	0	99. 10
	<u> </u>	U		U U	0	77. 10
SPECIAL PURPOSE COST CENTERS		0				10/ 00
106. 00 10600 HEART ACQUISITION	0	0	0			106. 00
109. 00 10900 PANCREAS ACQUISITION	0	0	0	١		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0		110. 00
111.00 11100 I SLET ACQUI SI TI ON	0	0	0	0	0	111. 00
113.00 11300 INTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	955	0	11, 948	11, 904	57, 677	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	104	0	190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	o	0	0	ol	0	192. 00
193. 00 19300 NONPALD WORKERS	o	0	0	o		193. 00
194. 00 07950 MOB	ا م	n	l	1, 607		194. 00
194. 01 07951 POB	١	0		1, 042		194. 01
194. 02 07952 WEST JAY CLINIC		15		1, 072		194. 01
194. 06 07956 TRI COUNTY		13				194. 02
200.00 Cross Foot Adjustments	"	U	l	١	Ü	200. 00
			_		^	200.00
	0	0	11 040	14 4 5 7		
202.00 TOTAL (sum lines 118-201)	955	15	11, 948	14, 657	57, 677	ZUZ. UU

| Peri od: | Worksheet B | From 10/01/2013 | Part | I | To 09/30/2014 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 151320

				To	09/30/2014	Date/Time Pre 2/25/2015 3:1	
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES & SUPPLY	MEDI CAL RECORDS & LI BRARY	Subtotal	.
		11.00	13. 00	14.00	16. 00	24.00	
2. 00 2. 01	GENERAL SERVI CE COST CENTERS 00200 NEW CAP REL COSTS-MVBLE EQUI P 00201 NEW CAP REL COSTS-MVBLE EQUI P MOB						2. 00 2. 01
2. 02 2. 03	00202 NEW CAP REL COSTS-MVBLE EQUI P-POB 00203 NEW CAP REL COSTS-MVBLE EQUI P- WJ						2. 02 2. 03
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4. 00 5. 00
7. 00 7. 01	00700 OPERATION OF PLANT						7. 00 7. 01
7. 02	00702 OPERATION OF PLANT-POB						7. 02
7. 03 8. 00	OO7O3 OPERATION OF PLANT-WJ OO8O0 LAUNDRY & LINEN SERVICE						7. 03 8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY						9. 00 10. 00
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	54, 162 4, 006					11. 00 13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY 01600 MEDICAL RECORDS & LI BRARY	656		52, 408	42 241		14. 00
16. 00	INPATIENT ROUTINE SERVICE COST CENTERS	2, 935		83	43, 261		16. 00
30. 00 31. 00	03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T	7,713	18, 032 0	2, 616 0	2, 109 0	412, 268 0	30. 00 31. 00
40. 00 41. 00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF	4, 449 0	10, 403 0	788 0	896 0	176, 464 0	40. 00 41. 00
42. 00 43. 00	04200 SUBPROVI DER 04300 NURSERY	0 800	0 1, 871	0	0 74	0 30, 369	42. 00 43. 00
	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM			51			
50. 00 52. 00	05200 DELIVERY ROOM & LABOR ROOM	4, 000 89	209	16, 357 0	7, 310 77	268, 275 3, 799	52. 00
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY - DI AGNOSTI C	0 4, 221	0	3, 313	15, 175	0 195, 648	53. 00 54. 00
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0 0	0	0	0	0	57. 00 58. 00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0 4, 331	0	0 14, 966	0 9, 684	0 105, 649	59. 00 60. 00
60. 01 65. 00	06001 BLOOD LABORATORY 06500 RESPIRATORY THERAPY	0	0	0 201	0 450	10, 789	60. 01 65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0	206	1, 158	6, 664	66. 00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	1, 375	0	0 698	740	0 31, 579	
71. 00 72. 00	O7100 MEDICAL SUPPLIES CHARGED TO PATIENTS O7200 IMPL. DEV. CHARGED TO PATIENTS	0 0	0	0 0	0 76	0 196	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	1, 701	0	256	2, 112	44, 205	73. 00
88. 00 89. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	88. 00 89. 00
90.00	09000 CLI NI C	3, 116	O	1, 607	116	114, 131	90. 00
90. 02	09001 FAMILY PRACTICE OF JAY COUNTY 09002 JAY FAMILY MEDICINE	5, 942 3, 516	0	4, 752 1, 979	380 209	10, 720	
91. 00 92. 00	O9100 EMERGENCY O9200 OBSERVATION BEDS (NON-DISTINCT PART)	5, 312	11, 533	2, 914	2, 695	154, 739	92. 00
93. 00	O4040 OTHER OUTPATIENT SERVICE COST CENTER OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	93. 00
99. 10	09910 CORF SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	99. 10
	10600 HEART ACQUISITION 10900 PANCREAS ACQUISITION	0	0	0	0		106. 00 109. 00
110.00	11000 INTESTINAL ACQUISITION	0	O	0	0	0	110. 00
113.00	11100 SLET ACQUISITION 11300 NTEREST EXPENSE	0		0	0		111. 00 113. 00
118. 00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	54, 162	51, 401	50, 736	43, 261	1, 638, 291	118. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		190. 00 192. 00
193.00	19300 NONPALD WORKERS 07950 MOB	0	0	0	0	0	193. 00 194. 00
194. 01	07951 POB	0	0	0	0	1, 042	194. 01
194.06	07952 WEST JAY CLINIC 07956 TRI COUNTY	0	0	920 752	0	14, 078	194. 02 194. 06
200. 00 201. 00	Negative Cost Centers	0	o	0	0	0	200. 00 201. 00
202. 00	TOTAL (sum lines 118-201)	54, 162	51, 401	52, 408	43, 261	1, 699, 357	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 151320

			2/25/2015 3: 1	
Cost Center Description	Intern &	Total		
	Residents Cost			
	& Post			
	Stepdown			
	Adjustments 25.00	26. 00		
GENERAL SERVICE COST CENTERS	25.00	20.00		
2.00 OO200 NEW CAP REL COSTS-MVBLE EQUIP				2. 00
2.01 00201 NEW CAP REL COSTS-MVBLE EQUIP MOB				2. 01
2.02 00202 NEW CAP REL COSTS-MVBLE EQUIP-POB				2. 02
2.03 OO203 NEW CAP REL COSTS-MVBLE EQUIP- WJ				2. 03
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT				4. 00
5.00 00500 ADMINISTRATIVE & GENERAL				5. 00
7.00 O0700 OPERATION OF PLANT				7. 00
7.01 OO701 OPERATION OF PLANT-MOB				7. 01
7. 02 00702 OPERATION OF PLANT-POB				7. 02
7. 03 00703 OPERATION OF PLANT-WJ				7. 03
8. 00 00800 LAUNDRY & LINEN SERVICE				8. 00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY				9. 00 10. 00
11. 00 01100 CAFETERI A				11. 00
13. 00 01300 NURSING ADMINISTRATION				13. 00
14. 00 01400 CENTRAL SERVI CES & SUPPLY				14. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY				16. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS	0	412, 268		30. 00
31.00 03100 INTENSIVE CARE UNIT	0	O		31.00
40. 00 04000 SUBPROVI DER - 1 PF	0	176, 464		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	0	30, 369		43. 00
ANCILLARY SERVICE COST CENTERS		2/0 275		FO 00
50. 00 05000 OPERATING ROOM	0	268, 275 3, 799		50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	0	3, 799		52. 00 53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	195, 648		54. 00
57. 00 05700 CT SCAN	0	175, 040		57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0		58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	o	o		59. 00
60. 00 06000 LABORATORY	0	105, 649		60.00
60. 01 06001 BLOOD LABORATORY	0	o		60. 01
65. 00 06500 RESPI RATORY THERAPY	0	10, 789		65.00
66. 00 06600 PHYSI CAL THERAPY	0	6, 664		66. 00
68. 00 06800 SPEECH PATHOLOGY	0	0		68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	31, 579		69. 00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0	l	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	196		72.00
73. 00 O7300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	44, 205		73. 00
88. 00 08800 RURAL HEALTH CLINIC	0	0		88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	o	o	l l	89. 00
90. 00 09000 CLI NI C	o	114, 131		90.00
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	O	72, 796		90. 01
90.02 09002 JAY FAMILY MEDICINE	0	10, 720		90. 02
91. 00 09100 EMERGENCY	0	154, 739		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0		93. 00
OTHER REIMBURSABLE COST CENTERS		21		00 10
99. 10 09910 CORF SPECI AL PURPOSE COST CENTERS	0	0		99. 10
106.00 10600 HEART ACQUI SI TI ON	O	0		106. 00
109. 00 10900 PANCREAS ACQUISITION		0	1	100.00
110. 00 11000 NTESTINAL ACQUISITION	o	ol		110. 00
111.00 11100 I SLET ACQUI SI TI ON	0	o		111. 00
113.00 11300 INTEREST EXPENSE				113. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	1, 638, 291		118. 00
NONREI MBURSABLE COST CENTERS				
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	14, 514		190.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0		192.00
193. 00 19300 NONPALD WORKERS	0	0		193. 00
194. 00 07950 MOB	0	19, 608		194. 00
194. 01 07951 POB	U	1, 042		194. 01
194. 02 07952 WEST JAY CLINIC 194. 06 07956 TRI COUNTY	U	11, 824		194. 02 194. 06
200.00 Cross Foot Adjustments	0	14, 078 0		200. 00
201.00 Negative Cost Centers		0		200.00
202.00 TOTAL (sum lines 118-201)		1, 699, 357		201.00
	<u>1</u>			

COST A	LLOCATION - STATISTICAL BASIS		Provi der	CCN: 151320	Peri od:	Worksheet B-1	
					From 10/01/2013 To 09/30/2014	Date/Time Pre 2/25/2015 3:1	
			CAPI TAL REL	_ATED COSTS		2/23/2013 3.1	i piii
	Cost Center Description	NEW MVBLE	NEW MVBLE	NEW MVBLE	NEW MVBLE	EMPLOYEE	
		EQUI P	EQUIP MOB	EQUI P-POB	EQUIP- WJ	BENEFI TS	
		(SQUARE FEET)	(SQUARE FEET)	(SQUARE FEET)	(SQUARE FEET)	DEPARTMENT (GROSS	
		,		Í	, i	SALARI ES)	
	GENERAL SERVICE COST CENTERS	2.00	2. 01	2. 02	2. 03	4. 00	
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	68, 379					2. 00
2. 01	00201 NEW CAP REL COSTS-MVBLE EQUIP MOB	O	11, 841				2. 01
2. 02 2. 03	00202 NEW CAP REL COSTS-MVBLE EQUI P-POB 00203 NEW CAP REL COSTS-MVBLE EQUI P- WJ	0	0	11, 62	0 3, 300		2. 02 2. 03
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	o o	0		0 0,300	14, 205, 159	
5.00	00500 ADMINISTRATIVE & GENERAL	8, 162	2, 520	32	1	2, 023, 694	
7. 00 7. 01	OO7OO OPERATION OF PLANT OO7O1 OPERATION OF PLANT-MOB	4, 253	0		0 0	327, 436 5, 917	
7.02	00702 OPERATION OF PLANT-POB	o	0		0 0	9, 283	7. 02
7. 03 8. 00	OO7O3 OPERATION OF PLANT-WJ OO8OO LAUNDRY & LINEN SERVICE	0 460	0		0 0	1, 311	
9. 00	00900 HOUSEKEEPING	366	0		0 0	23, 741 302, 676	
10.00	01000 DI ETARY	2, 140	430		0 0	133, 553	
11. 00 13. 00	O1100 CAFETERI A O1300 NURSI NG ADMI NI STRATI ON	2, 055 1, 457	0		0 0	189, 350 898, 586	
14. 00	01400 CENTRAL SERVICES & SUPPLY	2, 020	0		0 0	65, 875	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	1, 415	0		0 0	353, 252	16. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	13, 385	0		0 0	1, 103, 734	30.00
31.00	03100 INTENSIVE CARE UNIT	O	0		0 0	0	31.00
40. 00 41. 00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF	4, 636	0		0 0	629, 541 0	1
41.00	04200 SUBPROVI DER	0	0		0 0	0	1
43. 00	04300 NURSERY	1, 033	0		0 0	121, 085	43. 00
50. 00	ANCI LLARY SERVI CE COST CENTERS O5000 OPERATI NG ROOM	6, 400	0	5, 53	.5 O	821, 211	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	127	0	-,	0 0	17, 838	1
53.00	05300 ANESTHESI OLOGY	0	0		0 0	70/ 002	
54. 00 57. 00	05400 RADI OLOGY-DI AGNOSTI C 05700 CT SCAN	6, 255	0		0 0	786, 883 0	1
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	O	0		0 0	0	58. 00
59. 00 60. 00	O5900 CARDI AC CATHETERI ZATI ON O6000 LABORATORY	2, 400	0		0 0	0 627, 312	
60. 01	06001 BLOOD LABORATORY	2,400	0		0 0	027, 312	1
65.00	06500 RESPIRATORY THERAPY	280	0		0 0	0	
66. 00 68. 00	06600 PHYSI CAL THERAPY 06800 SPEECH PATHOLOGY		0		0 0	0	
69. 00	06900 ELECTROCARDI OLOGY	1, 000	0		0 0	180, 908	
	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	1, 110	0		0 0	361, 015	
	OUTPATIENT SERVICE COST CENTERS		_			_	ļ
88. 00 89. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	
90.00	09000 CLINIC	4, 200	0		0 0	474, 523	
90. 01	09001 FAMILY PRACTICE OF JAY COUNTY	0	0	5, 76	0	1, 500, 223	1
	09002 JAY FAMILY MEDICINE 09100 EMERGENCY	4, 650	0		0 0	919, 849 1, 729, 408	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,7000				1,727,100	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	O	0		0 0	0	99. 10
	SPECIAL PURPOSE COST CENTERS						
	10600 HEART ACQUISITION 10900 PANCREAS ACQUISITION	0	0		0 0		106. 00 109. 00
	11000 INTESTINAL ACQUISITION	o o	0		0 0		110. 00
	11100 SLET ACQUI SI TI ON	0	0		0	0	111.00
113.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1-117)	67, 804	2, 950	11, 62	25 0	13, 608, 204	113.00
	NONREI MBURSABLE COST CENTERS	07,001	2, 700	11,02	.0	10, 000, 201	110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	575	0		0 0		190.00
	19200 PHYSICIANS PRIVATE OFFICES 19300 NONPALD WORKERS		0				192. 00 193. 00
194.00	07950 MOB	0	8, 891		0 0	0	194. 00
	07951	0	0		0 0 3, 300		194. 01
	07956 TRI COUNTY		0		0 0	177, 587	
200.00		<u> </u>					200. 00

Heal th Fina	ncial Systems	JAY COUNTY	HOSPI TAL		In Lieu of Form CMS-2552-10		
COST ALLOCA	ATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
					From 10/01/2013 To 09/30/2014		
			CAPITAL RELATED COSTS				
	Cost Center Description	NEW MVBLE	NEW MVBLE	NEW MVBLE	NEW MVBLE	EMPLOYEE	
		EQUI P	EQUIP MOB	EQUI P-POB	EQUIP- WJ	BENEFI TS	
		(SQUARE	(SQUARE	(SQUARE	(SQUARE	DEPARTMENT	
		FEET)	FEET)	FEET)	FEET)	(GROSS	
						SALARI ES)	
		2.00	2. 01	2. 02	2. 03	4. 00	
201.00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	1, 566, 806	23, 258	104, 01	5, 275	5, 120, 461	202. 00
203.00	Unit cost multiplier (Wkst. B, Part I)	22. 913555	1. 964192	8. 94778	1. 598485	0. 360465	203.00
204.00	Cost to be allocated (per Wkst. B,					0	204. 00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part					0. 000000	205.00
	11)						
· ·				•			•

Heal th Financial Systems

OST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151320

Period:
From 10/01/2013
To 09/30/2014

Reconciliation ADMINISTRATIVE OPERATION OF OPERATION O

					0 09/30/2014	2/25/2015 3: 1	
	Cost Center Description	Reconciliation			OPERATION OF	OPERATION OF PLANT-POB	
			& GENERAL (ACCUM.	PLANT (SQUARE	PLANT-MOB (SQUARE	(SQUARE	
			COST)	FEET)	FEET)	FEET)	
		5A	5. 00	7. 00	7. 01	7. 02	
	GENERAL SERVICE COST CENTERS	1		1			
2. 00 2. 01	OO200 NEW CAP REL COSTS-MVBLE EQUIP OO201 NEW CAP REL COSTS-MVBLE EQUIP MOB						2. 00 2. 01
2.01	00201 NEW CAP REL COSTS-MVBLE EQUIP MOB						2.01
2. 02	00203 NEW CAP REL COSTS-MVBLE EQUIP- WJ						2. 02
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	-5, 624, 410	22, 651, 289				5. 00
7.00	00700 OPERATION OF PLANT	0	1, 368, 867				7. 00
7.01	00701 OPERATION OF PLANT-MOB	0	45, 840	0	9, 321		7. 01
7.02	00702 OPERATION OF PLANT-POB	0	111, 005	0	0	11, 300	7. 02
7. 03	00703 OPERATION OF PLANT-WJ	0	1, 784		0	0	7. 03
8.00	00800 LAUNDRY & LINEN SERVICE	0	59, 302	•	0	0	8. 00
9.00	00900 HOUSEKEEPI NG	0	480, 843	•	120	0	9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	0	335, 269 313, 003		430		10. 00 11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON		1, 267, 323		0	0	13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	Ö	134, 766		0	Ö	14. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	558, 120		0	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDIATRICS	0	1, 919, 176	13, 385	0	1	30. 00
31. 00	03100 I NTENSI VE CARE UNI T	0	0		0	1	31. 00
40. 00	04000 SUBPROVIDER - I PF	0	1, 412, 004	4, 636	0	0	40.00
41. 00	04100 SUBPROVI DER - I RF	0	0	0	0	0	41.00
42. 00 43. 00	04200 SUBPROVI DER 04300 NURSERY	0	196, 074	1, 033	0	0	42. 00 43. 00
43.00	ANCI LLARY SERVI CE COST CENTERS	J U	190, 074	1,033	0	0	43.00
50.00	05000 OPERATI NG ROOM	0	2, 006, 505	6, 400	0	5, 535	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	28, 269		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	1, 810, 255	6, 255	0	0	54.00
57. 00	05700 CT SCAN	0	0	0	0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE MAGING (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	1, 924, 513	2, 400	0	0	60.00
60. 01 65. 00	06001 BL00D LABORATORY 06500 RESPIRATORY THERAPY	0	363, 253	280	0		60. 01 65. 00
66. 00	06600 PHYSI CAL THERAPY	0	591, 185		0	0	66.00
68. 00	06800 SPEECH PATHOLOGY	Ö	071,100	Ö	0	Ö	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	398, 509	1, 000	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	13, 903		0		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	1, 433, 818	1, 110	0	0	73. 00
00.00	OUTPATIENT SERVICE COST CENTERS		^	1			00.00
88. 00 89. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		88. 00 89. 00
90.00	09000 CLINIC	0	476, 420			1	90.00
	09001 FAMILY PRACTICE OF JAY COUNTY		1, 000, 645		0	5, 765	
90. 02	09002 JAY FAMILY MEDICINE	o	583, 072		0	0,700	90. 02
91. 00	09100 EMERGENCY	0	1, 584, 097		0	Ō	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93. 00
	OTHER REIMBURSABLE COST CENTERS						
99. 10	09910 CORF	0	0	0	0	0	99. 10
10/ 00	SPECIAL PURPOSE COST CENTERS	0	0	0	0		10/ 00
	10600 HEART ACQUISITION 10900 PANCREAS ACQUISITION	0	0	0	0		106. 00 109. 00
	11000 NTESTINAL ACQUISITION	0	0	0	0	l e	1109.00
	11100 I SLET ACQUI SI TI ON	0	0	0	0		111.00
	11300 NTEREST EXPENSE				9	J	113. 00
118.00		-5, 624, 410	20, 417, 820	55, 389	430	11, 300	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13, 175	575	0		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192. 00
	19300 NONPALD WORKERS	0	0	0	0		193. 00
	07950 MOB	0	18, 777	0	8, 891	•	194. 00
	07951 POB 07952 WEST JAY CLINIC		652, 515		0	•	194. 01 194. 02
	07956 TRI COUNTY		1, 549, 002		0	l	194. 02
200.00			1, 347, 002		0		200.00
201.00							201. 00
202. 00			5, 624, 410	1, 708, 762	57, 222	138, 568	
	Part I)	1			•		

Health Fina	ncial Systems	JAY COUNTY	HOSPI TAL		In Lieu of Form CMS-2552-10		
COST ALLOCA	TION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
					rom 10/01/2013 o 09/30/2014	Date/Time Pre 2/25/2015 3:1	
	Cost Center Description	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	
203.00	Unit cost multiplier (Wkst. B, Part I)		0. 248304	30. 533236	6. 139041	12. 262655	203. 00
204.00	Cost to be allocated (per Wkst. B,		194, 878	109, 227	394	955	204. 00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part		0. 008603	1. 951737	0. 042270	0. 084513	205. 00
	[11]						

	LLOCATION - STATISTICAL BASIS	JAT COUNTY		CCN: 151320 P	eri od: rom 10/01/2013	Worksheet B-1	
				T		2/25/2015 3:1	pared: 1 pm
	Cost Center Description	OPERATION OF PLANT-WJ (SQUARE FEET)	LAUNDRY & LI NEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (MEALS SERVED)	CAFETERI A (FTE' S)	
	OFFICIAL CERVILOR COCT OFFICE	7. 03	8.00	9. 00	10.00	11. 00	
2. 00 2. 01 2. 02 2. 03	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						2. 00 2. 01 2. 02 2. 03
4. 00 5. 00 7. 00 7. 01	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00701 OPERATION OF PLANT-MOB						4. 00 5. 00 7. 00 7. 01
7. 02 7. 03 8. 00	00702 OPERATION OF PLANT-POB 00703 OPERATION OF PLANT-WJ 00800 LAUNDRY & LINEN SERVICE	3, 300	1				7. 02 7. 03 8. 00
9. 00 10. 00 11. 00	00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A	000000000000000000000000000000000000000	5, 400 1, 260 0		15, 530	18, 822	9. 00 10. 00 11. 00
13. 00 14. 00 16. 00	01300 NURSI NG ADMINI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01600 MEDI CAL RECORDS & LI BRARY	0	0 0	1, 457 2, 020 1, 415	0	1, 392 228 1, 020	13. 00 14. 00
30. 00 31. 00		0		13, 385	7, 314 0	2, 680	1 .
40. 00 41. 00 42. 00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 04200 SUBPROVI DER	0	4, 392 0	4, 636 0	8, 216 0 0	1, 546 0 0	41.00
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM				0	278	43. 00
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0	0 0	127 0	0	1, 390 31 0	52. 00 53. 00
54. 00 57. 00 58. 00	O5400 RADI OLOGY-DI AGNOSTI C O5700 CT SCAN O5800 MAGNETI C RESONANCE MAGING (MRI)	0	2, 671 0 0	6, 255 0 0	0 0 0	1, 467 0 0	57. 00 58. 00
59. 00 60. 00 60. 01	O5900 CARDI AC CATHETERI ZATI ON O6000 LABORATORY O6001 BLOOD LABORATORY	0	0 0	2, 400 0	0	0 1, 505 0	60. 00 60. 01
65. 00 66. 00 68. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06800 SPEECH PATHOLOGY	0	813	0	0	0	66. 00 68. 00
69. 00 71. 00 72. 00	O6900 ELECTROCARDIOLOGY O7100 MEDICAL SUPPLIES CHARGED TO PATIENTS O7200 IMPL. DEV. CHARGED TO PATIENTS	000000000000000000000000000000000000000	1, 107 0 0	0	0	478 0 0	71. 00 72. 00
73. 00 88. 00	O7300 DRUGS CHARGED TO PATIENTS	0	0	1, 110	0	591	88. 00
89. 00 90. 00 90. 01	O8900 FEDERALLY QUALIFIED HEALTH CENTER O9000 CLINIC O9001 FAMILY PRACTICE OF JAY COUNTY	0000	0 0	0 4, 200 5, 765		0 1, 083 2, 065	90.00
91. 00	09002 JAY FAMILY MEDICINE 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0 8, 338	0 4, 650	0	1, 222 1, 846	
93. 00	04040 OTHER OUTPATIENT SERVICE COST CENTER OTHER REIMBURSABLE COST CENTERS 09910 CORF			0		0	93. 00 99. 10
	SPECIAL PURPOSE COST CENTERS		-				
109. 00 110. 00	10600 HEART ACQUISITION 10900 PANCREAS ACQUISITION 11000 INTESTINAL ACQUISITION 11100 ISLET ACQUISITION	0	0	0 0	1	0	106. 00 109. 00 110. 00 111. 00
	11300 INTEREST EXPENSE	0	45, 429	65, 863	15, 530		113. 00 118. 00
192.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CIANS' PRIVATE OFFICES 19300 NONPAID WORKERS	0	0 0	575 0	l	0	190. 00 192. 00 193. 00
194. 00 194. 01	07950 MOB 07951 POB 07952 WEST JAY CLINIC	3,300		8, 891 5, 765	0 0	0	194. 00 194. 01 194. 02
	07956 TRI COUNTY Cross Foot Adjustments	0,300	o	o	O		194. 06 200. 00 201. 00
202.00		2, 227	88, 072	621, 882	505, 353	469, 228	

Health Fina	ncial Systems	JAY COUNTY	HOSPI TAL		In Lieu of Form CMS-2552-10		
COST ALLOCA	TION - STATISTICAL BASIS		Provi der		Peri od: From 10/01/2013	Worksheet B-1	
					To 09/30/2014	Date/Time Pre 2/25/2015 3:1	
	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	
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 674848	1. 938674	7. 66865	6 32. 540438	24. 929763	203. 00
204. 00	Cost to be allocated (per Wkst. B,	15	11, 948	14, 65	7 57, 677	54, 162	204. 00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 004545	0. 263004	0. 18074	1 3. 713909	2. 877590	205. 00
	[11]						

Peri od: Worksheet B-1 From 10/01/2013 To 09/30/2014 Date/Time Prepared: 2/25/2015 3:11 pm

				' '	2/25/2015 3:1	
	Cost Center Description	NURSI NG	CENTRAL	MEDI CAL		
		ADMI NI STRATI ON		RECORDS &		
		(DI RECT	SUPPLY (SUPPLY COST)	LI BRARY (GROSS		
		NRSING FTE)	(3011 E1 6031)	CHARGES)		
		13. 00	14. 00	16. 00		
	RAL SERVICE COST CENTERS					
	NEW CAP REL COSTS-MVBLE EQUIP					2. 00
	NEW CAP REL COSTS-MVBLE EQUIP MOB					2. 01
	12 NEW CAP REL COSTS-MVBLE EQUI P-POB					2. 02
	3 NEW CAP REL COSTS-MVBLE EQUIP- WJ O EMPLOYEE BENEFITS DEPARTMENT					2. 03 4. 00
	O ADMINISTRATIVE & GENERAL					5. 00
	O OPERATION OF PLANT					7. 00
	1 OPERATION OF PLANT-MOB					7. 01
	2 OPERATION OF PLANT-POB					7. 02
7. 03 0070	3 OPERATION OF PLANT-WJ					7. 03
	O LAUNDRY & LINEN SERVICE					8. 00
	O HOUSEKEEPI NG					9. 00
	O DI ETARY					10.00
	O CAFETERIA	7 (20				11.00
	IO NURSING ADMINISTRATION IO CENTRAL SERVICES & SUPPLY	7, 639				13. 00 14. 00
	O MEDICAL RECORDS & LIBRARY	0		71, 519, 393		16.00
	TIENT ROUTINE SERVICE COST CENTERS		3,043	71, 517, 575		10.00
	O ADULTS & PEDIATRICS	2, 680	95, 970	3, 485, 285		30.00
1	O INTENSIVE CARE UNIT	0	0	0		31.00
40.00 0400	O SUBPROVIDER - IPF	1, 546	28, 896	1, 480, 260		40.00
41.00 0410	O SUBPROVIDER - IRF	0	0	0		41. 00
1	O SUBPROVI DER	0		0		42. 00
	O NURSERY	278	0	122, 518		43. 00
	LLARY SERVICE COST CENTERS	1 000	F00 075	40 004 040		
•	OOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOO	1, 390 31	1	12, 081, 913		50. 00 52. 00
1	O ANESTHESI OLOGY	0	0	127, 334		53. 00
1	O RADI OLOGY-DI AGNOSTI C		•	25, 098, 781		54.00
1	O CT SCAN	0	.=.,	20, 0,0, ,01		57. 00
	O MAGNETIC RESONANCE IMAGING (MRI)	0	o	0		58. 00
	O CARDI AC CATHETERI ZATI ON	0	0	0		59. 00
	O LABORATORY	0	548, 942	16, 006, 138		60.00
	1 BLOOD LABORATORY	0	0	0		60. 01
	O RESPI RATORY THERAPY	0	7, 359			65. 00
	O PHYSI CAL THERAPY	0	7, 540	1, 914, 826		66.00
	IO SPEECH PATHOLOGY IO ELECTROCARDI OLOGY	0	25, 612	0 1, 222, 686		68. 00 69. 00
	O MEDICAL SUPPLIES CHARGED TO PATIENTS			1, 222, 000		71. 00
	O IMPL. DEV. CHARGED TO PATIENTS		1	126, 215		72.00
	DRUGS CHARGED TO PATIENTS	Ö		3, 491, 003		73. 00
	ATIENT SERVICE COST CENTERS					
	O RURAL HEALTH CLINIC	0	0	0		88. 00
	FEDERALLY QUALIFIED HEALTH CENTER	0		-		89. 00
	O CLINIC	0				90.00
	FAMILY PRACTICE OF JAY COUNTY	0		627, 980		90. 01
	12 JAY FAMILY MEDICINE 10 EMERGENCY	0	,	344, 711		90. 02
	O OBSERVATION BEDS (NON-DISTINCT PART)	1, 714	106, 874	4, 454, 157		91.00
	O OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		93. 00
	R REIMBURSABLE COST CENTERS			<u> </u>		70.00
99. 10 0991		0	0	0		99. 10
SPEC	I AL PURPOSE COST CENTERS					
•	O HEART ACQUISITION	0	0	0		106. 00
	O PANCREAS ACQUISITION	0		0		109. 00
	O INTESTINAL ACQUISITION	0	1	0		110.00
	O ISLET ACQUISITION O INTEREST EXPENSE	0	U	0		111.00
118. 00	SUBTOTALS (SUM OF LINES 1-117)	7, 639	1, 860, 921	71, 519, 393		113. 00 118. 00
	EIMBURSABLE COST CENTERS	1,039	1,000,921	71, 517, 575		1118.00
	O GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190. 00
	O PHYSICIANS' PRIVATE OFFICES	0		0		192. 00
	NONPALD WORKERS	0		0		193. 00
194. 00 0795		0	0	0		194. 00
194. 01 0795	l .	0	0	0		194. 01
	2 WEST JAY CLINIC	0	33, 762	0		194. 02
	6 TRI COUNTY	0	27, 597	0		194. 06
200. 00 201. 00	Cross Foot Adjustments					200. 00 201. 00
201.00	Negative Cost Centers	1	I			1201.00

Health Financial Systems	JAY COUNTY	HOSPI TAL			In Lie	u of Form (CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi de	r CCN: 151320	Peri		Worksheet	B-1	
					1 10/01/2013		Descr	norod.
				lo	09/30/2014	2/25/2015		
Cost Center Description	NURSI NG	CENTRAL	MEDI CAL			27 207 2010	0. 1	, p
· ·	ADMI NI STRATI ON							
		SUPPLY	LI BRARY					
	(DI RECT	(SUPPLY COST	(GROSS					
	NRSING FTE)		CHARGES)					
	13.00	14.00	16. 00					

1, 672, 366

218. 924728 51, 401

6. 728760

776, 584

0. 010858 43, 261

0.000605

251, 081

0. 130616 52, 408

0. 027263

202.00

203. 00 204. 00

205. 00

Cost to be allocated (per Wkst. B, Part I)

Unit cost multiplier (Wkst. B, Part I)
Cost to be allocated (per Wkst. B,

Unit cost multiplier (Wkst. B, Part

202.00

203. 00 204. 00

205.00

Part II)

11)

				'	0 09/30/2014	2/25/2015 3:1	
			Ti tl	e XVIII	Hospi tal	Cost	
	·		·		Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	·	(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	3, 870, 191		3, 870, 191	0	3, 870, 191	30. 00
31.00	03100 INTENSIVE CARE UNIT	0		(0	0	31. 00
40.00	04000 SUBPROVI DER - I PF	2, 612, 427		2, 612, 427	0	2, 612, 427	40. 00
41.00	04100 SUBPROVI DER - I RF	0		(0	0	41.00
42.00	04200 SUBPROVI DER	0		(0	0	42.00
43.00	04300 NURSERY	353, 819		353, 819	0	353, 819	43. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	3, 427, 930		3, 427, 930	0	3, 427, 930	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	49, 083		49, 083	0	49, 083	1
53.00	05300 ANESTHESI OLOGY	0		(0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 828, 873		2, 828, 873	0	2, 828, 873	54.00
57. 00	05700 CT SCAN	0		(0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		(0	0	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0		(0	0	07.00
60.00	06000 LABORATORY	2, 777, 077		2, 777, 077	0	2, 777, 077	
60. 01	06001 BLOOD LABORATORY	0		(0	0	
65. 00	06500 RESPI RATORY THERAPY	473, 179		1		473, 179	
66. 00	06600 PHYSI CAL THERAPY	761, 331	6, 498	767, 829	이	767, 829	1
68. 00	06800 SPEECH PATHOLOGY	0	0	(0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	566, 345		566, 345	0	566, 345	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		(0	0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	18, 725		18, 725		18, 725	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 886, 109		1, 886, 109	0	1, 886, 109	73. 00
	OUTPATIENT SERVICE COST CENTERS			1			
88. 00	08800 RURAL HEALTH CLINIC	0			0	0	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0			이	0	89. 00
90.00	09000 CLI NI C	791, 948		791, 948		791, 948	1
90. 01	09001 FAMILY PRACTICE OF JAY COUNTY	1, 445, 078		1, 445, 078		1, 445, 078	1
90. 02	09002 JAY FAMILY MEDICINE	771, 537		771, 537		771, 537	•
91.00	09100 EMERGENCY	2, 654, 818		2, 654, 818		2, 654, 818	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	97, 411		97, 411		97, 411	
93. 00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0		(0	0	93. 00
	OTHER REIMBURSABLE COST CENTERS	_		1			
99. 10	09910 CORF	0		()	0	99. 10
10/ 00	SPECIAL PURPOSE COST CENTERS			1 /	, I	0	10/ 00
	10600 HEART ACQUISITION 10900 PANCREAS ACQUISITION	0					106. 00 109. 00
		0					1109.00
	111000 I NTESTI NAL ACQUI SI TI ON				(111.00
	11100 SLET ACQUI SITION	0			ή	Ü	113.00
200.00	11300 INTEREST EXPENSE Subtotal (see instructions)	25 205 001	0	25 202 270	o	25, 392, 379	
200.00	, ,	25, 385, 881 97, 411	0	25, 392, 379 97, 411		25, 392, 379 97, 411	
201.00		25, 288, 470	О			25, 294, 968	
202. UL	lintal (see Histinctions)	25, 200, 470	ı	y 25, 274, 900	·l 이	25, 274, 708	1202. UU

					0 077 007 2011	2/25/2015 3:1	1 pm
			Ti tl	e XVIII	Hospi tal	Cost	
	·		Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	·	·	·	+ col. 7)	Ratio	Inpati ent	
						Ratio	
		6.00	7. 00	8.00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	3, 423, 395		3, 423, 395			30. 00
31.00	03100 INTENSIVE CARE UNIT	0		0			31.00
40.00	04000 SUBPROVI DER - I PF	1, 480, 260		1, 480, 260			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	122, 518		122, 518			43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	2, 892, 328	9, 189, 585	12, 081, 913	0. 283724	0.000000	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	127, 334	0	127, 334	0. 385467	0.000000	52. 00
53.00	05300 ANESTHESI OLOGY	o	0	0	0.000000	0.000000	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 308, 804	23, 789, 977	25, 098, 781	0. 112710	0.000000	54. 00
57.00	05700 CT SCAN	o	0	0	0.000000	0.000000	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	o	0	0	0. 000000	0. 000000	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	o	0	0	0.000000	0. 000000	
60.00	06000 LABORATORY	1, 772, 008	14, 234, 130	16, 006, 138		0. 000000	
60. 01	06001 BLOOD LABORATORY	0	0	_	0. 000000	0. 000000	
65. 00	06500 RESPIRATORY THERAPY	505, 596	237, 829	743, 425		0. 000000	
66. 00	06600 PHYSI CAL THERAPY	533, 694	1, 381, 132			0. 000000	
68. 00	06800 SPEECH PATHOLOGY	0	0	0	0. 000000	0. 000000	
69. 00	06900 ELECTROCARDI OLOGY	89, 149	1, 133, 537	1, 222, 686		0. 000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0. 000000	0. 000000	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	31, 318	94, 897	126, 215		0. 000000	
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 111, 855	2, 379, 148			0. 000000	1
	OUTPATIENT SERVICE COST CENTERS	.,		27 1117 222			
88. 00	08800 RURAL HEALTH CLINIC	0	0	0			88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				89. 00
90.00	09000 CLI NI C	0	192, 161	192, 161	4. 121273	0. 000000	
90. 01	09001 FAMILY PRACTICE OF JAY COUNTY		627, 980			0. 000000	1
90. 02	09002 JAY FAMILY MEDICINE		344, 711			0. 000000	
91. 00	09100 EMERGENCY	130, 940	4, 323, 217			0. 000000	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	100, 710	61, 890			0. 000000	
93. 00	04040 OTHER OUTPATIENT SERVICE COST CENTER		01,070			0. 000000	
70.00	OTHER REIMBURSABLE COST CENTERS	<u>۷</u>			0.00000	0.000000	70.00
99. 10	09910 CORF	O	0	0			99. 10
, , , 10	SPECIAL PURPOSE COST CENTERS	<u> </u>					//. 10
106.00	10600 HEART ACQUISITION	0	0	0			106. 00
	10900 PANCREAS ACQUISITION		0				109.00
	11000 INTESTINAL ACQUISITION		0				110.00
	11100 I SLET ACQUISITION		0				111.00
	11300 I NTEREST EXPENSE		0	١			113. 00
200.00		13, 529, 199	57, 990, 194	71, 519, 393			200. 00
201.00	, ,	13, 327, 177	57, 770, 174	71, 317, 373			201.00
202.00	i i	13, 529, 199	57, 990, 194	71, 519, 393			202.00
202.00	Total (See Histi detions)	10, 527, 177	37, 770, 174	1 11, 517, 575	1	I	1202.00

Heal th Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES

A Provider CCN: 151320

Provider CCN: 151320

Provider CCN: 151320

Provider CCN: 151320

Part I

Date/Time Prepared:

2/25/2015 3:11 pm Title XVIII Hospi tal Cost PPS Inpatient Cost Center Description Ratio 11 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 31.00 03100 INTENSIVE CARE UNIT 31.00 40. 00 | 04000 | SUBPROVI DER - I PF 40.00 41.00 04100 SUBPROVIDER - IRF 41.00 42.00 04200 SUBPROVI DER 42.00 43.00 04300 NURSERY 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 283724 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.385467 52.00 53. 00 | 05300 | ANESTHESI OLOGY 53 00 0.000000 54. 00 | 05400 | RADI OLOGY-DI AGNOSTI C 0. 112710 54.00 57.00 05700 CT SCAN 0.000000 57.00 58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0.000000 58.00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0.000000 59.00 60.00 06000 LABORATORY 0.173501 60.00 06001 BLOOD LABORATORY 0.000000 60.01 60.01 0. 636485 06500 RESPIRATORY THERAPY 65.00 65.00 06600 PHYSI CAL THERAPY 0.400992 66.00 66.00 68.00 06800 SPEECH PATHOLOGY 0.000000 68.00 06900 ELECTROCARDI OLOGY 69.00 0.463197 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 148358 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.540277 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88 00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 09000 CLI NI C 90.00 90.00 4. 121273 09001 FAMILY PRACTICE OF JAY COUNTY 90.01 90.01 2. 301153 09002 JAY FAMILY MEDICINE 90.02 2. 238214 90.02 91.00 09100 EMERGENCY 0.596032 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1. 573938 92.00 92.00 04040 OTHER OUTPATIENT SERVICE COST CENTER 93.00 0.000000 93.00 OTHER REIMBURSABLE COST CENTERS 99. 10 09910 CORF 99. 10 SPECIAL PURPOSE COST CENTERS 106.00 10600 HEART ACQUISITION 106.00 109. 00 109.00 10900 PANCREAS ACQUISITION 110.00 11000 INTESTINAL ACQUISITION 110.00 111.00 11100 I SLET ACQUISITION 111 00 113.00 11300 INTEREST EXPENSE 113. 00 200.00 Subtotal (see instructions) 200. 00 201.00 Less Observation Beds 201.00

202.00

202.00

Total (see instructions)

						2/25/2015 3:1	1 pm
			Ti t	le XIX	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	·	(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.	,				
		26)					
		1.00	2. 00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	3, 870, 191		3, 870, 191	0	3, 870, 191	30.00
31. 00	03100 NTENSI VE CARE UNI T	0,0,0,1,1		0,0,0,1,1		0,070,171	1
	04000 SUBPROVI DER - I PF	2, 612, 427		2, 612, 427	0	2, 612, 427	1
41. 00	04100 SUBPROVI DER – I RF	2,012,427		2,012,427	0	2,012,427	41.00
	04200 SUBPROVI DER	0			0	0	42.00
		252 010		0 010	-		1
43. 00	04300 NURSERY	353, 819		353, 819	U	353, 819	43. 00
	ANCILLARY SERVICE COST CENTERS	0 407 000				0 107 000	
50. 00	05000 OPERATI NG ROOM	3, 427, 930		3, 427, 930		3, 427, 930	1
52.00	05200 DELIVERY ROOM & LABOR ROOM	49, 083		49, 083		49, 083	
53.00	05300 ANESTHESI OLOGY	0		0	0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 828, 873		2, 828, 873	0	2, 828, 873	
57.00	05700 CT SCAN	0		0	0	0	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0		0	0	0	59. 00
60.00	06000 LABORATORY	2, 777, 077		2, 777, 077	0	2, 777, 077	60.00
60.01	06001 BLOOD LABORATORY	0		0	0	0	60. 01
65.00	06500 RESPI RATORY THERAPY	473, 179	0	473, 179	0	473, 179	65. 00
66.00	06600 PHYSI CAL THERAPY	761, 331	0	761, 331	0	761, 331	66. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	0	0	0	1
69. 00	06900 ELECTROCARDI OLOGY	566, 345	_	566, 345	0	566, 345	•
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	000, 010		000, 010	0	0	1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	18, 725		18, 725	o	18, 725	
	07300 DRUGS CHARGED TO PATIENTS	1, 886, 109		1, 886, 109		1, 886, 109	•
73.00	OUTPATIENT SERVICE COST CENTERS	1,000,109		1,000,109	l o	1, 000, 109	73.00
88. 00	08800 RURAL HEALTH CLINIC	0		0	0	0	88. 00
		0					1
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	701 010		704 040		701 040	89. 00
90.00	09000 CLI NI C	791, 948		791, 948		791, 948	
90. 01	09001 FAMILY PRACTICE OF JAY COUNTY	1, 445, 078		1, 445, 078		1, 445, 078	1
	09002 JAY FAMILY MEDICINE	771, 537		771, 537		771, 537	
91. 00	09100 EMERGENCY	2, 654, 818		2, 654, 818	0	2, 654, 818	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	97, 411		97, 411		97, 411	
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	93. 00
	OTHER REIMBURSABLE COST CENTERS						
99. 10	09910 CORF	0		0		0	99. 10
	SPECIAL PURPOSE COST CENTERS						1
106.00	10600 HEART ACQUISITION	0		0		0	106. 00
	10900 PANCREAS ACQUISITION	0		l o			109. 00
	11000 INTESTINAL ACQUISITION	0		0			110.00
	11100 SLET ACQUISITION	0		0			111. 00
	11300 NTEREST EXPENSE			Ĭ			113. 00
200.00		25, 385, 881	0	25, 385, 881	0	25, 385, 881	1
201.00	,	97, 411	0	97, 411			201.00
201.00		25, 288, 470	0		0		
202.00	Total (See Histiactions)	23, 200, 470	0	25, 200, 470	١	23, 200, 470	1202.00

					0 077 007 2011	2/25/2015 3:1	1 pm
			Ti t	le XIX	Hospi tal	Cost	
	·		Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	·	·	·	+ col. 7)	Ratio	Inpati ent	
						Rati o	
		6.00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	3, 423, 395		3, 423, 395			30. 00
31.00	03100 INTENSIVE CARE UNIT	0		C			31.00
40.00	04000 SUBPROVI DER - I PF	1, 480, 260		1, 480, 260			40.00
41.00	04100 SUBPROVI DER - I RF	0		C			41.00
42.00	04200 SUBPROVI DER	0		C			42. 00
43.00	04300 NURSERY	122, 518		122, 518			43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	2, 892, 328	9, 189, 585	12, 081, 913	0. 283724	0.000000	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	127, 334	0	127, 334	0. 385467	0.000000	52. 00
53.00	05300 ANESTHESI OLOGY	o	0	C	0.000000	0.000000	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 308, 804	23, 789, 977	25, 098, 781	0. 112710	0.000000	54. 00
57.00	05700 CT SCAN	o	0	C	0.000000	0.000000	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	o	0	l c	0. 000000	0. 000000	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	o	0	l c	0.000000	0. 000000	
60.00	06000 LABORATORY	1, 772, 008	14, 234, 130	16, 006, 138		0. 000000	
60. 01	06001 BLOOD LABORATORY	0	0	C	0. 000000	0. 000000	
65. 00	06500 RESPIRATORY THERAPY	505, 596	237, 829	743, 425		0. 000000	
66. 00	06600 PHYSI CAL THERAPY	533, 694	1, 381, 132			0. 000000	
68. 00	06800 SPEECH PATHOLOGY	0	0	0	0. 000000	0. 000000	
69. 00	06900 ELECTROCARDI OLOGY	89, 149	1, 133, 537	1, 222, 686		0. 000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0. 000000	0. 000000	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	31, 318	94, 897	126, 215		0. 000000	
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 111, 855	2, 379, 148			0. 000000	1
	OUTPATIENT SERVICE COST CENTERS	.,					
88. 00	08800 RURAL HEALTH CLINIC	0	0	C	0.000000	0.000000	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0			0. 000000	
90.00	09000 CLI NI C	0	192, 161	192, 161		0. 000000	
90. 01	09001 FAMILY PRACTICE OF JAY COUNTY	0	627, 980			0. 000000	
90. 02	09002 JAY FAMILY MEDICINE	0	344, 711			0. 000000	
91. 00	09100 EMERGENCY	130, 940	4, 323, 217			0. 000000	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	61, 890			0. 000000	
93. 00	04040 OTHER OUTPATIENT SERVICE COST CENTER		0.,070			0. 000000	
70.00	OTHER REIMBURSABLE COST CENTERS	<u>۷</u>			0.00000	0.000000	70.00
99. 10	09910 CORF	O	0	С			99. 10
, , , 10	SPECIAL PURPOSE COST CENTERS	<u> </u>					//. 10
106 00	10600 HEART ACQUISITION	0	0	C			106. 00
	10900 PANCREAS ACQUISITION	0	0				109. 00
	11000 INTESTINAL ACQUISITION		0	Ö			110.00
	11100 I SLET ACQUISITION		0	l o			111.00
	11300 I NTEREST EXPENSE		O				113. 00
200.00		13, 529, 199	57, 990, 194	71, 519, 393			200.00
201.00	, ,	.5,527,177	5.,,,,,,,,,,	1.,017,070			201. 00
202.00	i i	13, 529, 199	57, 990, 194	71, 519, 393			202.00
202.00	1.514. (555 1.151. 4611 6115)		3., ,,,,,,,,,,	1, 017, 070	1	1	,_02.00

Heal th Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151320
Period: From 10/01/2013 To 09/30/2014
Part I Date/Time Prepared: 2/25/2015 3:11 pm

					2/25/2015 3:11	pm
			Title XIX	Hospi tal	Cost	
	Cost Center Description	PPS Inpatient				
	·	Ratio				
		11. 00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDI ATRI CS				3	30. 00
31. 00	03100 INTENSIVE CARE UNIT					31. 00
40. 00	04000 SUBPROVI DER - I PF				•	40. 00
41. 00	04100 SUBPROVI DER - I RF				•	41. 00
42. 00	04200 SUBPROVI DER				· · · · · · · · · · · · · · · · · · ·	42. 00
43. 00	04300 NURSERY				l	43. 00
43.00	ANCILLARY SERVICE COST CENTERS				7	45. 00
50.00	05000 OPERATING ROOM	0. 000000			F	50. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52. 00
53. 00	05300 ANESTHESI OLOGY	0. 000000				53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54. 00
57. 00	05700 CT SCAN	0. 000000				57. 00
		1				
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000				58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0.000000			· · · · · · · · · · · · · · · · · · ·	59.00
60.00	06000 LABORATORY	0. 000000			•	60.00
60. 01	06001 BLOOD LABORATORY	0. 000000				60. 01
65. 00	06500 RESPI RATORY THERAPY	0. 000000				65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 000000			•	66. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000				68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000			•	69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			•	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000			l l	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000			7	73. 00
	OUTPATIENT SERVICE COST CENTERS					
88. 00	08800 RURAL HEALTH CLINIC	0. 000000			8	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000			8	89. 00
90.00	09000 CLI NI C	0. 000000			9	90. 00
90. 01	09001 FAMILY PRACTICE OF JAY COUNTY	0. 000000			9	90. 01
90.02	09002 JAY FAMILY MEDICINE	0. 000000			9	90. 02
91.00	09100 EMERGENCY	0. 000000			9	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			9	92. 00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0. 000000			9	93. 00
	OTHER REIMBURSABLE COST CENTERS	·				
99. 10	09910 CORF				9	99. 10
	SPECIAL PURPOSE COST CENTERS					
106.00	10600 HEART ACQUISITION				10	06. 00
	10900 PANCREAS ACQUISITION					09. 00
	11000 INTESTINAL ACQUISITION					10. 00
	11100 I SLET ACQUI SI TI ON					11. 00
	11300 I NTEREST EXPENSE					13. 00
200.00						00.00
200.00						01.00
201.00	· ·					02.00
202.00	p Total (See HISTIUCTIONS)	1			Į2C	02.00

Health Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der		Period: From 10/01/2013 To 09/30/2014		
		Ti tl	e XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges	Ratio of Cost	Inpati ent	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	<u> </u>					
50.00 05000 OPERATING ROOM	268, 275				10, 314	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	3, 799	127, 334			0	52. 00
53. 00 05300 ANESTHESI OLOGY	0	0	0. 00000		0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	195, 648	25, 098, 781	0.00779		2, 519	54.00
57.00 05700 CT SCAN	0	0	0.00000	0	0	57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0.00000		0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0.00000	0	0	59. 00
60. 00 06000 LABORATORY	105, 649	16, 006, 138	0.00660	1 453, 080	2, 991	60.00
60. 01 06001 BL00D LABORATORY	0	0	0.00000	0	0	60. 01
65. 00 06500 RESPIRATORY THERAPY	10, 789	743, 425	0. 01451	3 155, 745	2, 260	65. 00
66. 00 06600 PHYSI CAL THERAPY	6, 664	1, 914, 826	0. 00348	105, 535	367	66. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	0.00000	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	31, 579	1, 222, 686	0. 02582	58, 638	1, 515	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.00000	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	196	126, 215	0. 00155	3 25, 288	39	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	44, 205	3, 491, 003	0. 01266	3 245, 808	3, 113	73. 00
OUTPAȚI ENT SERVI CE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	0.00000	0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.00000		0	89. 00
90. 00 09000 CLI NI C	114, 131	192, 161	0. 59393	4 0	0	90.00
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	72, 796	627, 980	0. 11592	1 0	0	90. 01
90.02 09002 JAY FAMILY MEDICINE	10, 720	344, 711	0. 03109	9 0	0	90. 02
91. 00 09100 EMERGENCY	154, 739	4, 454, 157	0. 03474	1, 370	48	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	13, 142	61, 890	0. 21234	4 0	0	92. 00
93.00 04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.00000	0	0	93. 00
200.00 Total (lines 50-199)	1, 032, 332	66, 493, 220		1, 833, 066	23, 166	200. 00

Health Financial Systems	JAY COUNTY HOSP	I TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 151320	Peri od:	Worksheet D

THROUGH COSTS

Cost Center Description Non Physician Anesthetist Cost Non Physician Anesthetist Cost Nursing School Allied Health Medical Education Cost Nedical Education Cost 1.00 2.00 3.00 4.00 5.00 ANCILLARY SERVICE COST CENTERS
Cost Education Cost through col. 4) 1.00 2.00 3.00 4.00 5.00
1.00 2.00 3.00 4.00 5.00
1.00 2.00 3.00 4.00 5.00
IANCLLI ADV SEDVICE COST CENTEDS
50. 00 05000 OPERATI NG ROOM O O O O O 50
52. 00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 0 52
53. 00 05300 ANESTHESI OLOGY 0 0 0 53
54. 00 05400 RADI 0LOGY-DI AGNOSTI C 0 0 0 0 54
57. 00 05700 CT SCAN 0 0 0 57
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 0 0 58
59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 59
60. 00 06000 LABORATORY 0 0 0 0 0 0 0 60
60. 01 06001 BLOOD LABORATORY 0 0 0 60
65. 00 06500 RESPI RATORY THERAPY 0 0 0 65
66. 00 06600 PHYSI CAL THERAPY 0 0 0 66
68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 68
69. 00 06900 ELECTROCARDI OLOGY 0 0 0 69
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 71
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 72
73. 00 <u>07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 7</u> 3
OUTPATIENT SERVICE COST CENTERS
88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 88
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 89
90. 00 09000 CLI NI C 0 0 0 0 90
90.01 09001 FAMILY PRACTICE OF JAY COUNTY 0 0 0 0 90
90. 02 09002 JAY FAMILY MEDICINE 0 0 0 0 90
91. 00 09100 EMERGENCY 0 0 0 0 91
92.00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 92
93.00 O4040 OTHER OUTPATIENT SERVICE COST CENTER 0 0 0 0 0 93
200.00 Total (lines 50-199) 0 0 0 0 0 200

Health Financial Systems	JAY COUNTY HO	SPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 151320	Peri od:	Worksheet D

Health Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	S Provi der		Peri od:	Worksheet D	
THROUGH COSTS				From 10/01/2013 To 09/30/2014	Part IV Date/Time Pre	narod:
				10 09/30/2014	2/25/2015 3:1	pareu. 1 pm
		Ti tl	e XVIII	Hospi tal	Cost	
Cost Center Description	Total	Total Charges			Inpati ent	
		(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of	Part I, col.			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	10.004.040				
50. 00 05000 OPERATING ROOM	0	12, 081, 913			464, 477	
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0	127, 334			0	
53. 00 05300 ANESTHESI OLOGY	0	0	0.0000		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	25, 098, 781			323, 125	
57. 00 05700 CT SCAN	0	0	0.00000		0	
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0.00000		0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	1, 00, 100	0.00000		0	59. 00
60. 00 06000 LABORATORY	0	16, 006, 138			453, 080	
60. 01 06001 BL00D LABORATORY	0	742 425	0.00000		155 745	60. 01
65. 00 06500 RESPIRATORY THERAPY	0	743, 425			155, 745	
66. 00 06600 PHYSI CAL THERAPY	0	1, 914, 826			105, 535	66. 00 68. 00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0	0 1, 222, 686	0.0000		0 58, 638	
	0	1, 222, 080	0.00000		0 28, 638	71.00
	0	124 215			-	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0	126, 215 3, 491, 003			25, 288 245, 808	
OUTPATIENT SERVICE COST CENTERS		3, 491, 003	0.00000	0.00000	245, 808	73.00
88. 00 08800 RURAL HEALTH CLINIC			0.00000	0. 000000	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER			0.00000		0	1
90. 00 09000 CLINIC		192, 161			0	1
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY		627, 980			0	
90. 02 09002 JAY FAMILY MEDICINE		344, 711			-	1
91. 00 09100 EMERGENCY		4, 454, 157	1		1, 370	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		61, 890	1		1,370	1
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTER	1 0	0.,070	0.00000		, o	93. 00
200.00 Total (lines 50-199)	1	66, 493, 220	1	2.22000	ı	200. 00

In Lieu of Form CMS-2552-10 Health Financial Systems JAY COUNTY HOSPITAL APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provi der CCN: 151320 Peri od: Worksheet D From 10/01/2013 To 09/30/2014 Part IV THROUGH COSTS

Date/Time Prepared: 2/25/2015 3:11 pm Title XVIII Hospi tal Cost Cost Center Description I npati ent Outpati ent Outpati ent Program Program Program Pass-Through Pass-Through Charges Costs (col. Costs (col. x col . 10) 11.00 x col. 12) 13.00 12.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 53.00 05300 ANESTHESI OLOGY 0 0 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54.00 01 0 05700 CT SCAN 57.00 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 0 59.00 0 0 60.00 06000 LABORATORY 60.00 0 06001 BLOOD LABORATORY 0 60.01 60.01 06500 RESPIRATORY THERAPY 65.00 65.00 06600 PHYSI CAL THERAPY 0 0 66.00 66.00 0 06800 SPEECH PATHOLOGY 0 68 00 68 00 69.00 06900 ELECTROCARDI OLOGY 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 72 00 0 07300 DRUGS CHARGED TO PATIENTS 73.00 0 73.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 0 88.00 0 0 0 0 0 0 0 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89 00 0 0 0 89.00 09000 CLI NI C 90.00 0 90.00 09001 FAMILY PRACTICE OF JAY COUNTY 90. 01 90.01 09002 JAY FAMILY MEDICINE 0 90.02 0 0 0 90.02 91. 00 09100 EMERGENCY 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 0 93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTER 93.00

200.00

Total (lines 50-199)

200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provi der CCN: 151320 Peri od: Worksheet D From 10/01/2013 Part V 09/30/2014 Date/Time Prepared: 2/25/2015 3:11 pm Title XVIII Hospi tal Cost Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Services (see Ratio From Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1. 00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 283724 2, 217, 369 0 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.385467 0 0 0 52.00 53. 00 | 05300 | ANESTHESI OLOGY 0.000000 0 53 00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.112710 0 6, 168, 557 0 54.00 57. 00 05700 CT SCAN 0.000000 0 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0.000000 0 0 0 0 0 0 0 58.00 0 05900 CARDIAC CATHETERIZATION 59.00 0.000000 0 59.00 60.00 06000 LABORATORY 0.173501 4, 531, 871 0 60.00 06001 BLOOD LABORATORY 60.01 0.000000 0 60.01 06500 RESPIRATORY THERAPY 36, 941 0. 636485 65 00 65 00 0 66.00 06600 PHYSI CAL THERAPY 0.397598 430, 451 0 66.00 68.00 06800 SPEECH PATHOLOGY 0.000000 0 0 68.00 0 69.00 06900 ELECTROCARDI OLOGY 0.463197 69.00 423, 470 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0 0.000000 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.148358 0 54, 486 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0. 540277 943, 077 26, 309 0 73.00 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 0 89.00 09000 CLI NI C 4. 121273 20, 770 90.00 90.00 13, 946 0 09001 FAMILY PRACTICE OF JAY COUNTY 84, 921 90. 01 90.01 2.301153 0 0 09002 JAY FAMILY MEDICINE 90.02 90.02 2 238214 90.110 0 0 91.00 09100 EMERGENCY 0.596032 754, 022 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 1.573938 50, 738 0 93.00 04040 OTHER OUTPATIENT SERVICE COST CENTER 0 93.00 0.000000 C 0 200.00 Subtotal (see instructions) C 15, 806, 783 40, 255 0 200. 00 201.00 Less PBP Clinic Lab. Services-Program 201.00 Only Charges

15, 806, 783

40 255

0 202.00

202.00

Net Charges (line 200 +/- line 201)

				To 09/30/2014	Date/Time Prepared: 2/25/2015 3:11 pm
		Ti tl	e XVIII	Hospi tal	Cost
	Cos	sts			
Cost Center Description	Cost	Cost			
	Rei mbursed	Reimbursed			
	Servi ces	Services Not			
	Subject To	Subject To			
	Ded. & Coins.	Ded. & Coins.			
	(see inst.)	(see inst.)	-		
ANOLLI ADV. CEDVICE COCT CENTEDO	6. 00	7. 00			
ANCI LLARY SERVI CE COST CENTERS 50. 00 OPERATI NG ROOM	629, 121	(1		50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	029, 121				52. 00
53, 00 05200 DELI VERT ROOM & LABOR ROOM 53, 00 05300 ANESTHESI OLOGY		}			53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	695, 258	}			54.00
57. 00 05700 CT SCAN	095, 256	}			57.00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)			1		58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON					59.00
60. 00 06000 LABORATORY	786, 284	,			60.00
60. 01 06001 BL00D LABORATORY	700, 204				60.00
65. 00 06500 RESPIRATORY THERAPY	23, 512				65.00
66. 00 06600 PHYSI CAL THERAPY	171, 146	ì			66.00
68. 00 06800 SPEECH PATHOLOGY	0	ì			68.00
69. 00 06900 ELECTROCARDI OLOGY	196, 150	ì	o l		69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	i			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	8, 083	(72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	509, 523		1		73. 00
OUTPATIENT SERVICE COST CENTERS		,			
88. 00 08800 RURAL HEALTH CLINIC	0	(88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	(89. 00
90. 00 09000 CLI NI C	85, 599	57, 47	5		90.00
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	195, 416	(90. 01
90.02 09002 JAY FAMILY MEDICINE	201, 685	(90. 02
91. 00 09100 EMERGENCY	449, 421	(91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	79, 858	(92. 00
93.00 04040 OTHER OUTPATIENT SERVICE COST CENTER	0	(93. 00
200.00 Subtotal (see instructions)	4, 031, 056	71, 689	9		200. 00
201.00 Less PBP Clinic Lab. Services-Program	0				201. 00
Only Charges					
202.00 Net Charges (line 200 +/- line 201)	4, 031, 056	71, 689	9		202. 00

	Financial Systems	JAY COUNTY					eu of Form CMS-2	<u> 2552-10</u>
APPORT	IONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS		r CCN: 1513 nt CCN: 15M	F	Period: From 10/01/2013 Fo 09/30/2014		pared:
			Ti	tle XVIII		Subprovi der - I PF	PPS	
	Cost Center Description	Capi tal	Total Charge				Capital Costs	
		Related Cost				Program	(column 3 x	
		(from Wkst. B,			· col.	Charges	column 4)	
		Part II, col.	8)	2)				
		26)						
	[1.00	2. 00	3.00)	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	0/0.075	10.001.0			-1 070		
50. 00	05000 OPERATI NG ROOM	268, 275			022205		•	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	3, 799	127, 3		029835			
53. 00	05300 ANESTHESI OLOGY	0			000000		0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	195, 648	25, 098, 7		007795			
57. 00	05700 CT SCAN	0			000000		0	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0			000000		0	
59.00	05900 CARDI AC CATHETERI ZATI ON	105 (10	1, 00, 1		000000		0	
60.00	06000 LABORATORY	105, 649	16, 006, 1		006601	1		60.00
60. 01	06001 BLOOD LABORATORY	10.700	740.4		000000		1	
65.00	06500 RESPIRATORY THERAPY	10, 789			014513	1		
66.00	06600 PHYSI CAL THERAPY	6, 664	1, 914, 8		003480			
68. 00	06800 SPEECH PATHOLOGY	21 570	1 222 (000000		0	
69. 00 71. 00	06900 ELECTROCARDI OLOGY	31, 579	1, 222, 6		025828			69. 00 71. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	196	12/ 2)00000)01553		0	
	07300 DRUGS CHARGED TO PATIENTS	44, 205			012663			
73.00	OUTPATIENT SERVICE COST CENTERS	44, 203	3, 491, 0	0. 0	J12003	3/1,00/	4, 090	73.00
88. 00	08800 RURAL HEALTH CLINIC	1 0		0 0.0	000000	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER				000000		0	
90.00	09000 CLINIC	114, 131	192, 1		593934		0	1
90. 00	09001 FAMILY PRACTICE OF JAY COUNTY	72, 796			115921		0	
90. 02	09002 JAY FAMILY MEDICINE	10, 720			031099		0	1
91. 00	09100 EMERGENCY	154, 739			034740		_	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			000000		0	
	04040 OTHER OUTPATIENT SERVICE COST CENTER	0]		00000		0	1
	Total (lines 50-199)	1, 019, 190	66, 493, 2			1, 071, 025		200.00

Health Financial Systems	JAY COUNTY H	IOSP <u>I</u> TAL		In Li∈	eu of Form CMS-2	<u> 2552-10</u>
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY THROUGH COSTS	SERVICE OTHER PASS	Component	CCN: 151320 : CCN: 15M320		Date/Time Prep 2/25/2015 3:1	
		Ti tl	e XVIII	Subprovi der - I PF	PPS	
Cost Center Description	Non Physician Nu Anesthetist Cost	ursing School	Allied Healt	h All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS 50. 00 O5000 OPERATING ROOM		0		0 0		50.00
52. 00 05000 DELIVERY ROOM & LABOR ROOM		0		0 0	0	50.00
53. 00 05300 ANESTHESI OLOGY		0				53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	o o	0		o o	l ol	54. 00
57. 00 05700 CT SCAN	Ö	0		o o	o o	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	0		0 0	0	59. 00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
60. 01 06001 BL00D 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	66. 00
68. 00 06800 SPEECH PATHOLOGY	0	0		0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72. 00
73. 00 O7300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73. 00
OUTPATIENT SERVICE COST CENTERS			I			00.00
88. 00 08800 RURAL HEALTH CLINIC	0	0		0 0	1	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC	0	0		0 0	0	89. 00 90. 00
90. 00 09000 CLINIC 90. 01 09001 FAMILY PRACTICE OF JAY COUNTY		0		0		90.00
90. 02 09002 JAY FAMILY MEDICINE		0			0	90.01
91. 00 09100 EMERGENCY	o o	0				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTER		0			0	93. 00
200. 00 Total (lines 50-199)		0		0 0		200. 00
				•	'	•

Heal th Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS Provider CCN: 151320 Component CCN: 15M320 Title XVIII Cost Center Description Total Outpatient (from Wkst. C, to Charges Ratio of Cost Ratio of Cost Ratio of Cost Ratio of Cost Ratio of Cost Ratio of Cost Ratio of Cost Ratio of Cost Ratio of Cost Ratio of Cost Ratio of Cost Program	ed:
THROUGH COSTS Component CCN: 15M320 Component CCN: 15M320 To 09/30/2014 Date/Time Prepare 2/25/2015 3: 11 pr Title XVIII Cost Center Description Total Total Charges Ratio of Cost Outpatient Inpatient	ed: m
Component CCN: 15M320 To 09/30/2014 Date/Time Prepare 2/25/2015 3: 11 pr Title XVIII Subprovider - PPS IPF Cost Center Description Total Total Charges Ratio of Cost Outpatient Inpatient	ed: m
Title XVIII Subprovider - PPS IPF Cost Center Description Total Total Charges Ratio of Cost Outpatient Inpatient	m
Cost Center Description Total Total Charges Ratio of Cost Outpatient Inpatient	
Cost Center Description Total Total Charges Ratio of Cost Outpatient Inpatient	
Outpatient (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) 4) 7) (33.7)	
6.00 7.00 8.00 9.00 10.00	
ANCI LLARY SERVI CE COST CENTERS	
50. 00 05000 OPERATING ROOM 0 12, 081, 913 0. 000000 0. 000000 272 50	0. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 127, 334 0. 000000 0. 000000 0 52	2. 00
	3. 00
54. 00 05400 RADI 0LOGY - DI AGNOSTI C 0 25, 098, 781 0. 000000 0. 000000 180, 169 54	1. 00
57. 00 05700 CT SCAN 0 0, 000000 0, 000000 0 57	7. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0.000000 0.000000 0 58	3. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0. 000000 0. 000000 0 59	9. 00
60. 00 06000 LABORATORY 0 16, 006, 138 0. 000000 0. 000000 263, 779 60	0. 00
60. 01 06001 BLOOD LABORATORY 0 0. 000000 0. 000000 0 60	0. 01
65. 00 06500 RESPI RATORY THERAPY 0 743, 425 0. 000000 0. 000000 94, 069 65	5. 00
	o. 00
68. 00 06800 SPEECH PATHOLOGY 0 0, 000000 0, 000000 0 68	3. 00
	9. 00
	. 00
	2. 00
	3. 00
OUTPATIENT SERVICE COST CENTERS	
	3. 00
	9. 00
	0. 00
). 01
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	0. 02
	. 00
	2. 00
	3. 00
200. 00 Total (lines 50-199) 0 66, 493, 220 1, 071, 025 200	J. 00

Health Financial Systems	JAY COUNTY HOSP	I TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 151320	Peri od: From 10/01/2013	Worksheet D Part IV
		Component CCN: 15M320	To 09/30/2014	Date/Time Prepared: 2/25/2015 3:11 pm
		Title XVIII	Subprovi der -	PPS

Cost Center Description			Ti tl	le XVIII	Subprovi der -	PPS	
Program Program Program Program Program Charges Pass-Through Costs (col. 8 x col. 10) x col. 12)					I PF		
Pass-Through Costs (col. 8 x col. 10) x col. 12 x col. 1	Cost Center Description						
Costs (col 8							
X COI			Charges				
11.00 12.00 13.00					9		
ANCILLARY SERVICE COST CENTERS							
50. 00 05000 0PERATI NG ROOM 0 0 0 0 0 0 0 0 0		11. 00	12. 00	13. 00			
52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 0 0							
53. 00 05300 ANESTHESI OLOGY 0 0 0 0 53. 00 54. 00 05400 ARDI OLOGY-DI AGNOSTI C 0 0 0 0 0 57. 00 05700 CT SCAN 0 0 0 0 0 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 0 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 60. 00 06000 LABORATORY 0 0 0 0 60. 01 06001 BLOOD LABORATORY 0 0 0 0 65. 00 06500 RESPI RATORY THERAPY 0 0 0 0 66. 00 06500 RESPI RATORY THERAPY 0 0 0 0 68. 00 06600 SPEECH PATHOLOGY 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 88. 00 08900 FEDERALLY QUALI FIED HEALTH CENTER 0 0 0 90. 01 09000 CLI NI C 0 0 90. 02 09000 CLI NI C 0 0 90. 02 09000 CLI NI C 0 0 90. 02 09000 DRUGS CHARGED TO PATI ENTS 0 0 0 90. 02 09000 CLI NI C 0 0 90. 02 09000 CLI NI C 0 0 90. 02 09000 DRUGS CHARGED TO PATI ENTS 0 0 0 90. 02 09000 CLI NI C 0 0 90. 02 09000 CLI NI C 0 0 90. 02 09000 DRUGS CHARGED TO PATI ENTS 0 0 90. 02 09000 DRUGS CHARGED TO PATI ENTS 0 0 90. 02 09000 DRUGS CHARGED TO PATI ENTS 0 0 90. 02 09000 DRUGS CHARGED TO PATI ENTS 0 0 90. 02 09000 DRUGS CHARGED TO PATI ENTS 0 0 90. 02 09000 DRUGS CHARGED TO PATI ENTS 0 0 90. 02 09000 DRUGS CHARGED TO PATI ENTS 0 0 90. 01 09001 FAMI LY PRACTI CE OF JAY COUNTY 0 0 90. 02 09000 DRUGS CHARGED TO PATI ENTS 0 0 90. 02 09000 DRUGS CHARGED TO PATI ENTS 0 0 90. 02 09000 DRUGS CHARGED TO PATI ENTS 0 0 90. 02 09000 DRUGS CHARGED TO PATI ENTS 0 0 90. 02 09000 DRUGS CHARGED TO PATI ENTS 0 0 90. 02 09000 DRUGS CHARGED TO PATI ENTS		0	(9	0		
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 0 57. 00 57. 00 570. 00 570. 00 570. 00 570. 00 570. 00 570. 00 580. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 0 0 0 0		0	(0	0		
57. 00 05700 CT SCAN 0 0 0 0 0 557. 00 58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 0 0 0 0 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 60. 00 06000 LABORATORY 0 0 0 0 60. 01 06001 BLOOD LABORATORY 0 0 0 0 65. 00 06500 RESPI RATORY HERAPY 0 0 0 0 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 68. 00 06600 PHYSI CAL THERAPY 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 74. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 75. 00 08900 FEDERALLY QUALI FI ED HEALTH CENTER 0 0 0 89. 00 08900 FEDERALLY QUALI FI ED HEALTH CENTER 0 0 0 90. 01 09001 FAMI LY PRACTICE OF JAY COUNTY 0 0 0 90. 02 09002 JAY FAMI LY MEDI CI NE 0 0 0 91. 00 09200 DSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 93. 00 04040 OTHER OUTPATI ENT SERVICE COST CENTER	53. 00 05300 ANESTHESI OLOGY	0	(0	0		53.00
58. 00		0	(0	0		
59. 00	57. 00 05700 CT SCAN	0	(O	0		57. 00
60. 00	58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	(0	0		58. 00
60. 01 06001 BLOOD LABORATORY	59. 00 05900 CARDI AC CATHETERI ZATI ON	0	(o	0		59. 00
65. 00	60. 00 06000 LABORATORY	0	(0		60.00
66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 66. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0UTPATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLINI C 0 0 0 89. 00 09900 FEDERALLY QUALI FIED HEALTH CENTER 0 0 0 90. 01 09001 FAMILY PRACTI CE OF JAY COUNTY 0 0 0 90. 01 09002 JAY FAMILY MEDI CI NE 0 0 0 91. 00 09100 EMERGENCY 0 0 0 92. 00 09200 OBSSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 93. 00 04040 OTHER OUTPATI ENT SERVI CE COST CENTER 0 0 0 93. 00 04040 OTHER OUTPATI ENT SERVI CE COST CENTER 0 0 0 93. 00 04040 OTHER OUTPATI ENT SERVI CE COST CENTER 0 0 0 94. 00 09200 OBSSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 94. 00 09400 OTHER OUTPATI ENT SERVI CE COST CENTER 0 0 0 95. 00 04040 OTHER OUTPATI ENT SERVI CE COST CENTER 0 0 0 96. 00 04040 OTHER OUTPATI ENT SERVI CE COST CENTER 0 0 0 97. 00 04040 OTHER OUTPATI ENT SERVI CE COST CENTER 0 0 0 97. 00 04040 OTHER OUTPATI ENT SERVI CE COST CENTER 0 0 0 97. 00 04040 OTHER OUTPATI ENT SERVI CE COST CENTER 0 0 0 97. 00 04040 OTHER OUTPATI ENT SERVI CE COST CENTER 0 0 0 98. 00 04040 OTHER OUTPATI ENT SERVI CE COST CENTER 0 0 0 98. 00 04040 OTHER OUTPATI ENT SERVI CE COST CENTER 0 0 0 99. 00 04040 OTHER OUTPATI ENT SERVI CE COST CENTER 0 0 0 99. 00 04040 OTHER OUTPATI ENT SERVI CE COST CENTER 0 0 0 0 99. 00 04040 OTHER OUTPATI ENT SERVI CE COST CENTER 0 0 0 0 99. 00 04040 OTHER OUTPATI ENT SERVI CE COST CENTER 0 0 0 0 99. 00 04040 OTHER OUTPATI ENT SERVI CE COST CENTER 0 0 0 0	60. 01 06001 BLOOD LABORATORY	0	(0		60. 01
68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 73. 00 0000 DRUGS CHARGED TO PATI ENTS 0 0 0 88. 00 08800 RURAL HEALTH CLINIC 0 0 0 89. 00 08900 FEDERALLY QUALI FIED HEALTH CENTER 0 0 0 90. 00 09000 CLINIC 0 0 0 90. 01 09001 FAMI LY PRACTICE OF JAY COUNTY 0 0 0 90. 01 09002 JAY FAMI LY MEDI CINE 0 0 0 90. 02 09002 JAY FAMI LY MEDI CINE 0 0 0 91. 00 09100 EMERGENCY 0 0 0 92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 0 0 0 93. 00 04040 OTHER OUTPATI ENT SERVICE COST CENTER 0 0 0 93. 00 04040 OTHER OUTPATI ENT SERVICE COST CENTER 0 0 0 10 0 0 0 0 11 0 0 0 12 0 0 0 13 0 0 0 14 0 0 0 15 0 0 0 16 0 0 17 00 0 17 00 0 18 0 0 18 0 0 19 0 0 19 0 0 19 0 0 19 0 0 10 0 0 11 0 0 12 0 0 13 0 0 14 0 0 15 0 0 16 0 0 17 0 17 0 18 0 18 0 19 0 0 19 0 19 0 19 0 19 0 10 0 10 0 11 0 12 0 13 0 14 0 15 0 16 0 17 0 17 0 17 0 18 0 18 0 19 0 19 0 19 0 10 0 10 0 10 0 11 0 11 0 12 0 13 0 14 0 15 0 16 0 17 0 17 0 18 0 18 0 19 0 19 0 19 0 19 0 19 0 10 0	65. 00 06500 RESPIRATORY THERAPY	0	(0		65.00
69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	66. 00 06600 PHYSI CAL THERAPY	o	(0		66.00
71. 00	68. 00 06800 SPEECH PATHOLOGY	o	(ol	0		68.00
72. 00 07200 1 MPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0	69. 00 06900 ELECTROCARDI OLOGY	o	(ol	0		69.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	(ol	O		71.00
SECTION SUBSIDIAR SUBSTRUCT COST CENTERS SECTION SECTI	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	o	(ol	O		72.00
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 0 90. 00 90. 00 90. 00 90. 01 09001 FAMILY PRACTICE OF JAY COUNTY 0 0 0 0 90. 01 90. 01 90. 02 09002 JAY FAMILY MEDICINE 0 0 0 0 90. 00 90. 01 90. 02 09100 EMERGENCY 0 0 0 0 91. 00 92. 00 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 93. 00 00 0 0 93. 00 00 0 0 0 93. 00 00 0 0 0 0 93. 00 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	73.00 07300 DRUGS CHARGED TO PATIENTS	o	(0		73.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 0 0	OUTPATIENT SERVICE COST CENTERS	'		•			
90. 00 09000 CLINIC 0 0 0 0 0 0 0 0 0		0	(O	0		88. 00
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY 0 0 0 0 90. 01 90. 02 9	89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	o	(0		89. 00
90. 02 09002 JAY FAMILY MEDICINE	90. 00 09000 CLI NI C	o	(0		90.00
90. 02 09002 JAY FAMILY MEDICINE		ol	(0		90, 01
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTER 0 0 0 0 93. 00		o	(0		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTER 0 0 0 0 93. 00	91. 00 09100 EMERGENCY	o	(0		91.00
93.00 04040 OTHER OUTPATIENT SERVICE COST CENTER 0 0 0 93.00		l ol	(ol	o		
		ol	(O		
200. 00 Total (lines 50-199) 0 0 0 200. 00	200.00 Total (lines 50-199)	o	(ol	0		200.00

			Component	. 001. 132320 1	0 07/30/2014	2/25/2015 3: 1	
			Ti tl	e XVIII Si	wing Beds - SNF	Cost	
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1. 00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0. 283724	0	0	0	0	50.00
	05200 DELIVERY ROOM & LABOR ROOM	0. 385467	0	0	0	0	52.00
	05300 ANESTHESI OLOGY	0. 000000	l .	0	0	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C	0. 112710	l .	0	0	0	54. 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. 173501	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. 636485	0	0	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 397598	0	0	0	0	66. 00
68.00	06800 SPEECH PATHOLOGY	0. 000000	0	0	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 463197	0	0	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. 148358	0	0	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 540277	0	0	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0. 000000				0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	89. 00
90.00	09000 CLI NI C	4. 121273	0	0	0	0	90. 00
90. 01	09001 FAMILY PRACTICE OF JAY COUNTY	2. 301153	0	0	0	0	90. 01
90. 02	09002 JAY FAMILY MEDICINE	2. 238214	0	0	0	0	90. 02
91.00	09100 EMERGENCY	0. 596032	0	0	0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 573938	0	0	0	0	92. 00
	04040 OTHER OUTPATIENT SERVICE COST CENTER	0. 000000	0	0	0	0	93. 00
200.00	Subtotal (see instructions)		0	0	0	0	200. 00
201.00				0	0		201.00
	Only Charges						
202.00			0	0	0	0	202. 00

Health Fin	ncial Systems			JAY	COUNTY	HOSP	I TAL			In Lie	u of Form (CMS-2552-10
APPORTI ONN	ENT OF MEDICAL,	OTHER HEALTH	SERVICES AN	ND VACCINE	COST		Provi der	CCN:		od: 10/01/2013	Worksheet Part V	D
							Component	CCN:		09/30/2014		

Title XVIII Swing Beds - SNF Cost	
Costs	
Cost Center Description Cost Cost	
Reimbursed Reimbursed	
Servi ces Servi ces Not	
Subject To Subject To	
Ded. & Coi ns. Ded. & Coi ns.	
(see inst.) (see inst.)	
50. 00 05000 OPERATING ROOM 0	50. 00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 0 0	52. 00
53. 00 05300 ANESTHESI OLOGY 0 0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0	54. 00
57. 00 05700 CT SCAN 0 0	57. 00
58. OO 05800 MAGNETIC RESONANCE MAGING (MRI)	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0	59. 00
60. 00 06000 LABORATORY 0 0	60. 00
60. 01 06001 BLOOD LABORATORY 0 0	60. 01
65. 00 06500 RESPI RATORY THERAPY 0 0	65.00
66. 00 06600 PHYSI CAL THERAPY 0 0	66.00
68. 00 06800 SPEECH PATHOLOGY 0 0	68.00
69. 00 06900 ELECTROCARDI OLOGY 0 0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0	73.00
OUTPATIENT SERVICE COST CENTERS	
88. 00 08800 RURAL HEALTH CLINIC 0 0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0	89. 00
90. 00 09000 CLINIC 0 0	90.00
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY 0 0	90. 01
90. 02 09002 JAY FAMI LY MEDI CI NE 0 0	90. 02
91. 00 09100 EMERGENCY	91.00
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0 0 0 0 0 0	92. 00 93. 00
	93. 00 200. 00
	200. 00 201. 00
Only Charges	201.00
	202. 00

Health Financial Systems	JAY COUNTY HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Peri od: From 10/01/2013	Worksheet D-1
		To 09/30/2014	Date/Time Prepared: 2/25/2015 3:11 pm
	Title XVIII	Hospi tal	Cost

			10 077 007 2011	2/25/2015 3:1	1 pm	
		Title XVIII	Hospi tal	Cost		
	Cost Center Description					
	DART I ALL DROWNER COMPONENTS			1. 00		
	PART I - ALL PROVIDER COMPONENTS					
1. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days,	eveluding newborn)		2, 501	1.00	
2. 00	Inpatient days (including private room days, excluding swing-bed days,			1, 945	2.00	
3. 00	Private room days (excluding swing-bed and observation bed days		ivata room davs	1, 743	3.00	
3.00	do not complete this line.). If you have only pr	i vate i oom days,	١	3.00	
4.00	Semi-private room days (excluding swing-bed and observation bed	davs)		1, 883	4. 00	
5.00	Total swing-bed SNF type inpatient days (including private room		r 31 of the cost	0	5. 00	
	reporting period	3 , 3				
6.00	Total swing-bed SNF type inpatient days (including private room	days) after December	31 of the cost	515	6. 00	
	reporting period (if calendar year, enter 0 on this line)					
7. 00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	41	7. 00	
	reporting period			_ '		
8. 00	Total swing-bed NF type inpatient days (including private room	days) after December 3	1 of the cost	0	8. 00	
0.00	reporting period (if calendar year, enter 0 on this line)	the Dreamen (evaluding	owing bod and	405	9. 00	
9. 00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	swing-bed and	695	9.00	
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl	v (including private r	nom days)	0	10.00	
10.00	through December 31 of the cost reporting period (see instructi		oom days)	١	10.00	
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl		oom davs) after	445	11. 00	
	December 31 of the cost reporting period (if calendar year, ent					
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	e room days)	0	12. 00	
	through December 31 of the cost reporting period					
13.00	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 yea			_ '		
14.00	Medically necessary private room days applicable to the Program	(excluding swing-bed	days)	0	14.00	
15.00	Total nursery days (title V or XIX only)			0	15.00	
16. 00	Nursery days (title V or XIX only)			0	16. 00	
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to services	through Docombon 21 o	f the cost		17. 00	
17.00	reporting period	thi ough becember 31 o	i the cost		17.00	
18. 00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of	the cost		18. 00	
10.00	reporting period	arter becomber or or	the cost		10.00	
19. 00	Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	126. 36	19. 00	
	reporting period	3				
20.00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	126. 36	20. 00	
	reporting period					
21. 00	Total general inpatient routine service cost (see instructions)			3, 870, 191		
22. 00	Swing-bed cost applicable to SNF type services through December	31 of the cost report	ing period (line	0	22. 00	
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December 3	1 of the cost reportin	a ported (line 4	0	23. 00	
23.00	x line 18)	Tot the cost reporting	g perrou (Trile o	ا ا	23.00	
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	na period (line	5, 181	24. 00	
21.00	7 x line 19)	or or the cost reporting	ing period (inite	J	21.00	
25.00	Swing-bed cost applicable to NF type services after December 31	of the cost reporting	period (line 8	0	25. 00	
	x line 20)		,			
26.00	Total swing-bed cost (see instructions)			814, 318		
27. 00	General inpatient routine service cost net of swing-bed cost (ine 21 minus line 26)		3, 055, 873	27. 00	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT					
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	28. 00	
29. 00	Private room charges (excluding swing-bed charges)			0	29. 00	
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00	
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 000000	31.00	
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00	
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minu	e lino 22)(soo instruc	tions)	0. 00 0. 00	33. 00 34. 00	
35. 00	Average per diem private room cost differential (line 34 x line		tions)	0.00	35. 00	
36. 00	Private room cost differential adjustment (line 3 x line 35)		0.00	36.00		
37. 00		3, 055, 873	37.00			
57.00	C.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)					
	PART II - HOSPITAL AND SUBPROVIDERS ONLY					
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS					
38. 00	Adjusted general inpatient routine service cost per diem (see i			1, 571. 14	38. 00	
39. 00	Program general inpatient routine service cost (line 9 x line 3	•		1, 091, 942	39. 00	
40. 00	Medically necessary private room cost applicable to the Program			0	40. 00	
41. 00	Total Program general inpatient routine service cost (line 39 +	line 40)		1, 091, 942	41.00	

Period of CRE. 1913/20 Period of CRE. 1913/20 Period (2007/201) Period (2007/2	Heal th	Financial Systems	JAY COUNTY	HOSPI	TAL		In Lie	eu of Form CMS-	2552-10
Total Tota	COMPUT	ATION OF INPATIENT OPERATING COST			Provi der	CCN: 151320	From 10/01/2013	Date/Time Pre	pared:
1.00 QUISSERY (LITTLE V & XLX cnly)		Cost Center Description			Γotal	Average Pe Diem (col.	er Program Days	Cost Program Cost (col. 3 x col.	, p
Internal via Care Type Input ient Hospital Units						3.00		5. 00	
	42. 00		0		(0	. 00 ()[0	42.00
SIRN INTERSIVE CARE UNIT 46.00		INTENSIVE CARE UNIT	0		(0	. 00	0	
1.00 Progrem Impattent ancillary service cost (West. D.3. col. 3, Tine 200) 1.00	45.00	BURN INTENSIVE CARE UNIT							45. 00
Program Inpatient and Illary service cost (Mest. D-3, coll. 3, line 200) S52, 436 48.00 Program Inpatient costs (sum of lines 4, lithrough 4B) (see Instructions) 1,644,378 49.00 Program Inpatient costs (sum of lines 4, lithrough 4B) (see Instructions) 1,644,378 49.00 Program Inpatient costs (sum of lines 4, lithrough 4B) (see Instructions) 1,644,378 49.00 Program Inpatient costs (sum of lines 50 and 51) 50.00 Program Inpatient costs (sum of lines 50 and 51) 50.00 Total Program excludable cost (sum of lines 50 and 51) 51.00 Total Program inpatient coperating cost excluding capital related, non-physician anesthetist, and medical education costs (line 40 minus line 50) 52.00 Total Program inpatient coperating cost excluding capital related, non-physician anesthetist, and medical education costs (line 40 minus line 50) 52.00		OTHER SPECIAL CARE (SPECIFY)							47. 00
10 10 10 10 10 10 10 10	40.00	Drogram i proti ent ancil l'any comi ac acct (Wk	a+ D 2 aal 2) -	200)				40.00
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D., sum of Parts II and III 10.51.00 11.51.00 1		Total Program inpatient costs (sum of lines				ons)		1	
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. 0, sum of Parts II and Program excludable cost (sum of lines 50 and 51) Display to 151.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and Display to 153.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and Display to 153.00 Di	50. 00	Pass through costs applicable to Program inp	atient routine	servi	ces (fror	m Wkst. D, s	um of Parts I and	0	50. 00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52) FARRET AMOUNT AND LINIT COMPUTATION 54.00 Program discharge 54.00 Program discharge 55.00 Target amount per discharge 56.00 Target amount per discharge 57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 58.00 Deans payment (see Instructions) 59.00 Lesser of lines \$3.74 or 55 from prior year cost report, updated by the market basket 60.00 Clesser of lines \$3.74 or 55 from prior year cost report, updated by the market basket 60.01 Lesser of lines \$3.74 or 55 from prior year cost report, updated by the market basket 60.01 Clesser of lines \$3.74 or 55 from prior year cost report, updated by the market basket 60.01 Clesser of lines \$3.74 or 55 from prior year cost report, updated by the market basket 60.02 Relates of lines \$3.74 or 55 from prior year cost report, updated by the market basket 60.03 Clesser of lines \$3.74 or 55 from prior year cost report, updated by the market basket 60.04 Clesser of lines \$3.74 or 55 from prior year cost report, updated by the market basket 60.05 Clesser of lines \$3.74 or 55 from prior year cost report, updated by the market basket 60.06 Clesser of lines \$3.74 or 55 from prior year cost report, updated by the market basket 60.07 Clesser of lines \$3.74 or 55 from prior year cost report, updated by the market basket 60.08 Relate payment (see Instructions) 60.08 Relate payment (see Instructions) 60.09 Relate payment (see Instructions) 60.00 Relate payment (see Instructions) 60.00 Relate payment (see Instructions) 60.00 Relate payment (see Instructions) 60.00 Relate payment (see Instructions) 60.00 Relate payment (see Instructions) 60.00 Relate payment (see Instructions) 60.00 Relate payment (see Instructions) 60.00 Relate payment (see Instructions) 60.00 Relate payment (see Instructions) 60.00 Relate payment (see Instructions) 60.00 Relate payment (see Inst	51. 00	Pass through costs applicable to Program inp	atient ancillar	y ser	vices (fr	rom Wkst. D,	sum of Parts II	0	51. 00
54.00 Program discharges 0.6 54.00 55.00 Target amount per discharges 0.00 55.00 Target amount (line 54 x line 55) 0.00 55.00 Target amount (line 54 x line 55) 0.00 55.00 56.00		Total Program inpatient operating cost exclumedical education costs (line 49 minus line	ding capital re	el atec	l, non-phy	ysician anes [.]	thetist, and	_	
56.00 Target amount (Line 54 x line 55) 0 56.00 57.00 Difference between adjusted inpatient operating cost and target amount (Line 56 minus Line 53) 0 57.00 58.00 Bonus payment (see instructions) 0 58.00 58.00 Bonus payment (see instructions) 0 58.00 60.00 Losser of Lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 0.00 60.00 Losser of Lines 53/54 or 55 from the cost report, updated by the market basket 0.00 60.01 Lines 53/54 is less than the lower of Lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (Line 53) are less than expected costs (Lines 54 x 60), or 1% of the target amount (Line 56), otherwise enter zero (see instructions) 0 61.00 62.00 Reliceff payment (see instructions) 0 63.00 63.00 Allowable Linpatient cost plus lincentive payment (see instructions) 0 63.00 64.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See Instructions) (Line XVIII only). For CAH (see Instructions) 0 64.00 65.00 Total Medicare swing-bed SNF inpatient routine costs (Line 64 plus Line 65) (Litle XVIII only). For CAH (see Instructions) 0 67.00 67.00 Total Medicare swing-bed SNF inpatient routine costs (Line 64 plus Line 65) (Litle XVIII only). For CAH (see Instructions) 0 69.00 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period 0 67.00 69.00 Total Litle V or NIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period 0 69.00 69.00 Total Litle V or XIX swing-bed NF inpatient routine costs (Line 67 + Line 68) 0 69.00 69.00 Total Litle V or XIX swing-bed NF inpatient routine service cost (Line 67 + Line 68) 0 69.00 69.00 Total Litle V or XIX swing-bed NF inpatient routine service cost (Line 70 + Line 71) 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00	54. 00							0	54.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 0 57.00 59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 0.00 feet basket 10.00 lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 0.00 feet 10.00 line 53/54 is less than the lower of lines 55,59 or 60 enter the lesser of 5% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 0 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 0 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 0 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 0 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 0 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 0 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 0 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 0 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 0 63.00 Allowable Inpatient ocst plus incentive payment (see instructions) 0 64.00 Allowable Inpatient ocst plus incentive payment (see instructions) 0 64.00 Allowable Inpatient ocst plus incentive payment (see instructions) 0 64.00 Allowable Inpatient ocst plus incentive payment (see instructions) 0 64.00 Allowable Inpatient ocst plus incentive payment (see instructions) 0 64.00 Allowable Inpatient ocst plus incentive payment (see instructions) 0 64.00 Allowable Inpatient payment (see instructions) 0 64.00 Allowable Inpatient payment (see instructions) 0 64.00 Allowable Inpatient payment (see instructions) 0 64.00 Allowable Inpatient payment (see instructions) 0 64.00 Allowable Inpatient payment (see instructions) 0 64.00 Allowable Inpatient Payment (see instructions) 0 64.00 Allowable Inpatient Payment (see instructions) 0 64								1	
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60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 1.00 (1.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56.0). otherwise enter zero (see instructions) 2.00 (2.00 A) control of the see of the cost of the cost reporting period (see linestructions) 2.01 (2.00 Relief payment (see instructions) 2.02 (2.00 Relief payment (see instructions) 2.03 (2.00 A) control of the cost reporting period (see linestructions) 2.04 (2.00 Relief payment (see instructions) 2.05 (2.00 Relief payment (see instructions) 2.06 (2.00 Relief payment (see instructions) 2.07 (2.00 Relief payment (see instructions) 2.00 (a) (a) (a) (b) (b) (b) (b) (c) (c) (c) (c) (c) (c) (c) (c) (c) (c		Lesser of lines 53/54 or 55 from the cost re	porting period	endi r	ıg 1996, ι	updated and o	compounded by the		
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63.00 Allowable Inpatient cost plus incentive payment (see instructions) PROCRAM INPATEUR ROUTINE SWING BED COST 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 67.00 Total Itile V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Total Itile V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICE/MR ONLY 70.00 Skilled nursing facility/other nursing facility/ICE/MR routine service cost (line 37) 70.00 Total vitle V or XIX swing-bed NF inpatient routine costs (line 70 + line 2) 70.00 Program routine service cost (line 9 x line 71) 70.00 Algusted general inpatient routine service costs (line 72 + line 73) 70.00 Total Program general inpatient routine service costs (line 72 + line 73) 70.00 Total Program general inpatient routine service costs (line 72 + line 73) 70.00 Total Program general inpatient routine service costs (line 74 minus line 77) 70.00 Program capital -related costs (line 9 x line 76) 70.00 Program capital -related costs (line 9 x line 76) 70.00 Program capital -related costs (line 9 x line 76) 70.00 Program capital -related costs (line 9 x line 76) 70.00 Program capital -related costs (line 9 x line 76) 70.00 Program capital -related costs (line 9 x line 76) 70.00 Program capital -related costs (line 9 x line 76) 70.00 Program capital routine service cost (see instructions) 70.00 Reasonable inpatient routine service costs (see instructions) 70.00 Reasonable inpatient routine service costs (see instructions) 70.01 Program inpatient pour cost (see i	62. 00		nstructions)					0	62. 00
instructions) (title XVIII only) Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See Instructions) (title XVIII only) Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) CAH (see instructions) 70.700 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 80.700 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19) 80.700 Total title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 20) Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY. OTHER NURSING FACILITY, AND ICF/MR ONLY TOTAL VIA SWING FACILITY. OTHER NURSING FACILITY, AND ICF/MR ONLY TO Adjusted general inpatient routine service cost per diem (line 70 + line 2) 70.00 Total program routine service cost (line 9 x line 71) Total Program routine service cost (line 9 x line 71) Total Program general inpatient routine service costs (line 72 + line 73) Total Program capital related costs (line 75 + line 2) Total Program capital related costs (line 9 x line 76) Total Program routine service cost (line 74 minus line 77) Total Program routine service cost (line 74 minus line 77) Total Program routine service cost (line 74 minus line 77) Total Program routine service cost (line 74 minus line 77) Total Program inpatient routine service costs (see instructions) Total Program inpatient ancillary services (see instructions) Total Program inpatient ancillary services (see instructions) Total Program inpatient ancillary services (see instructions) Total Program inpatient ancillary services (see instructions) Total Program inpatient operating costs (see instructions) Total Program inpatient operating costs (see instructions) Total Program inpatient operating costs (see instruct	63. 00		ent (see instru	uction	s)			0	63. 00
instructions) (title XVIII only) Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 67. 00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 67. 00 Total title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68. 00 Total title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69. 00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69. 00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69. 00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69. 00 Total title V or XIX swing-bed NF inpatient routine service cost (line 37) 70. 00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37) 71. 00 Total program routine service cost (line 9 x line 71) 72. 00 Total Program general inpatient routine service costs (line 70 + line 2) 73. 00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 74. 00 Total Program capital -related costs (line 75 + line 2) 75. 00 Program capital -related costs (line 9 x line 76) 77. 00 Total Program routine service cost for comparison to the cost limitation (line 78 minus line 79) 78. 00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 80. 00 Total Program inpatient routine service costs (see instructions) 81. 00 Reasonable inpatient routine service costs (see instructions) 82. 00 Reasonable inpatient routine service costs (see instructions) 83. 00 Total Program inpatient ancillary services (see instructions) 84. 00 Program inpatient ancillary services (see instructions) 85. 00 Utilization review - physician compensation (see instructions) 86. 00 Total Program inpatient routine service cost (see instructions) 87	64. 00	9 '	ts through Dece	ember	31 of the	e cost repor	ting period (See	0	64. 00
CAH (see instructions) 7. 00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 8. 00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 9. 00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 9. 00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 9. 00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 9. 00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 9. 00 Skilled nursing facility/Other nursing facility/ICP/MR routine service cost (line 37) 7. 00 Skilled nursing facility/Other nursing facility/ICP/MR routine service cost (line 37) 7. 00 Program routine service cost (line 9 x line 71) 7. 00 Program routine service cost (line 9 x line 71) 7. 00 Total Program general inpatient routine service costs (line 72 + line 73) 7. 00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 7. 00 Per diem capital-related costs (line 75 + line 2) 7. 00 Program capital-related costs (line 75 + line 2) 7. 00 Program capital-related costs (line 75 + line 2) 7. 00 Program capital-related costs (line 75 + line 2) 7. 00 Total Program routine service cost for excess costs (from provider records) 7. 00 Total Program routine service cost for excess costs (from provider records) 7. 01 Total Program routine service cost for excess costs (from provider records) 8. 00 Inpatient routine service cost for excess costs (from provider records) 8. 00 Inpatient routine service cost for excess costs (from provider records) 8. 00 Inpatient routine service cost for excess costs (from provider records) 8. 00 Inpatient routine service cost for comparison to the cost limitation (line 78 minus line 79) 8. 00 Inpatient routine service cost for comparison to the cost limitation (line 78	65. 00		ts after Decemb	er 31	of the o	cost reporti	ng period (See	699, 157	65. 00
(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY 70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 72.00 Program routine service cost (line 9 x line 71) Medically necessary private room cost applicable to Program (line 14 x line 35) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital -related costs (line 75 ÷ line 2) 77.00 Aggregate charges to beneficiaries for excess costs (from provider records) 78.00 Inpatient routine service cost for excess costs (from provider records) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service costs for excess costs (from provider records) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost per diem limitation 83.00 Reasonable inpatient routine service (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)		CAH (see instructions)					•		
(line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY 70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 + line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 79.10 Inpatient routine service cost (see instructions) 79.00 Reasonable inpatient ancillary services (see instructions) 79.00 Program inpatient ancillary services (see instructions) 79.00 Interval in patient ancillary service see instructions) 79.00 Program inpatient operating costs (sum of lines 83 through 85) 70.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 70.00 Total observation bed days (see instructions) 70.00 Inpatient routine berval cost per diem (line 27 + line 2) 70.00 Total observation bed days (see instructions)		(line 12 x line 19)	•						
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY 70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37) 70.00 71.00 72.00 72.00 72.00 73.00 73.00 74.00 73.00 74.00 74.00 75.00		(line 13 x line 20)					porting period		
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service cost for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 89.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 80.00 Inpatient routine service cost get mistructions) 80.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 80.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	09.00							0] 09.00
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26, line 45) Per diem capital-related costs (line 75 ÷ line 2) 76.00 77.00 Program capital-related costs (line 9 x line 76) Response to beneficiaries for excess costs (from provider records) Response to line 1 Program routine service cost (line 74 minus line 77) Response to line 1 Program routine service costs for comparison to the cost limitation (line 78 minus line 79) Response to line 1 Program routine service costs for comparison to the cost limitation (line 78 minus line 79) Response to line 1 Program routine service cost per diem limitation Response le inpatient routine service cost (see instructions) Reasonable inpatient routine service costs (see instructions) Response le inpatient routine service costs (see instructions) Response le inpatient routine service (see instructions) Response le inpatient routine service (see instructions) Response le inpatient routine service (see instructions) Response le inpatient routine service (see instructions) Response le inpatient routine service (see instructions) Response le inpatient routine service (see instructions) Response le inpatient routine service (see instructions) Response le inpatient routine service (see instructions) Response le inpatient routine service (see instructions) Response le inpatient routine service costs (see instructions) Response le inpatient routine service cost (see instructions) Response le inpatient routine service cost (see instructions) Response le inpatient routine service cost (see instructions) Response le inpatient routine service cost (see instructions) Response le inpatient routine service cost (see instructions) Response le inpatient routine service cost (see instructions) Response le inpatient routine service cost (see instructions) Response le inpatient routine service cost (see instructions) Response le inpatient routine service cost (see instructions) Response le inpatient routine service cost (see instructions) Response le inpatient routine service cost (see instructions) Response le inpatient routine service cost (see									74.00
77. 00 78. 00 78. 00 79. 00 Roggregate charges to beneficiaries for excess costs (from provider records) 79. 00 Roggregate charges to beneficiaries for excess costs (from provider records) 79. 00 Roggregate charges to beneficiaries for excess costs (from provider records) 79. 00 Roggregate charges to beneficiaries for excess costs (from provider records) 79. 00 Roggregate charges to beneficiaries for excess costs (from provider records) 79. 00 Roggregate charges to beneficiaries for excess costs (from provider records) 79. 00 Roggregate charges to beneficiaries for excess costs (from provider records) 79. 00 Roggregate charges to beneficiaries for excess costs (from provider records) 79. 00 Roggregate charges to beneficiaries for excess costs (from provider records) 79. 00 Roggregate charges to beneficiaries for excess costs (from provider records) 79. 00 Roggregate charges to beneficiaries for excess costs (from provider records) 79. 00 Roggregate charges to beneficiaries for excess costs (from provider records) 79. 00 Roggregate charges to beneficiaries for excess costs (from provider records) 79. 00 Roggregate charges to beneficiaries for excess costs (from provider records) 79. 00 Roggregate charges to beneficiaries for excess costs (from provider records) 79. 00 Roggregate charges to beneficiaries for excess costs (from provider records) 79. 00 Roggregate charges to beneficiaries for excess costs (from provider records) 79. 00 Roggregate charges to beneficiaries for excess costs (from provider records) 79. 00 Roggregate charges to beneficiaries for excess costs (from provider records) 79. 00 Roggregate charges to beneficiaries for excess costs (from provider records) 79. 00 Roggregate charges to beneficiaries for excess costs (from provider records) 79. 00 Roggregate charges to beneficiaries for excess costs (from provider records) 79. 00 Roggregate charges to beneficiaries for excess costs (from provider records) 79. 00 Roggregate charges for excess cost (from provider records) 79. 00 Roggregate charges f	75. 00	·	routine service	cost	s (from V	Worksheet B,	Part II, column		75. 00
Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation Inpatient routine service cost limitation (line 9 x line 81) 82.00 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,571.14 88.00									77. 00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 86.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 Reasonable inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Inpatient routine service costs (see instructions) 89.00 Reasonable inpatient routine service cost limitation (line 78 minus line 79) 89.00 Reasonable inpatient routine service cost limitation (line 78 minus line 79) 89.00 Reasonable inpatient routine service cost limitation (line 78 minus line 79) 89.00 Reasonable inpatient routine service cost limitation (line 78 minus line 79) 89.00 Reasonable inpatient routine service cost limitation (line 78 minus line 79) 89.00 Reasonable inpatient routine service cost limitation (line 78 minus line 79) 89.00 Reasonable inpatient routine service cost limitation (line 78 minus line 79) 89.00 Reasonable inpatient routine service cost limitation (line 78 minus line 79) 89.00 Reasonable inpatient routine service cost limitation (line 78 minus line 79) 89.00 Reasonable inpatient routine service cost limitation (line 78 minus line 79) 89.00 Reasonable inpatient routine service cost limitation (line 78 minus line 79) 89.00 Reasonable inpatient routine service cost limitation (line 78 minus line 79) 89.00 Reasonable inpatient routine service cost limitation (line 79 minus limitation (line 79 minus limitation limitation (line 79 minus limitation limitation (line 79 minus limitation limitation limitation limitation limitation limitation li				orovi o	er record	ds)			
82.00 Inpatient routine service cost limitation (line 9 x line 81) Reasonable inpatient routine service costs (see instructions) 83.00 Program inpatient ancillary services (see instructions) 84.00 Utilization review - physician compensation (see instructions) 85.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 82.00 82.00 Seasonable inpatient routine service cost limitation (line 9 x line 81) 83.00 Seasonable inpatient routine service costs (see instructions) 84.00 Seasonable inpatient routine service costs (see instructions) 85.00 Seasonable inpatient routine service costs (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	80.00	Total Program routine service costs for compa	arison to the c				nus line 79)		80.00
Reasonable inpatient routine service costs (see instructions) 83.00 84.00 85.00 86.00 87.00 88.00 Reasonable inpatient routine service costs (see instructions) 88.00 88.00 88.00 88.00 88.00 Reasonable inpatient routine service costs (see instructions) 88.00 88.00 88.00 88.00 Reasonable inpatient routine service costs (see instructions) 88.00 88.00 88.00 88.00 88.00 Reasonable inpatient routine service costs (see instructions) 88.00 88.00 88.00 88.00 Reasonable inpatient routine service costs (see instructions) 88.00 88.00 88.00 88.00 88.00 88.00 Reasonable inpatient routine service costs (see instructions) 88.00 88.00 88.00 88.00 88.00 88.00 88.00 88.00 88.00 88.00 88.00		·		1)					1
85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) 87.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	83. 00	Reasonable inpatient routine service costs (see instruction	* .					83. 00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				ons)					
87.00 Total observation bed days (see instructions) 62 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 63 87.00 1,571.14 88.00		Total Program inpatient operating costs (sum	of lines 83 th		85)				86. 00
		Total observation bed days (see instructions))					1	1
		, , , , , , , , , , , , , , , , , , , ,	•		2)			l '	1

Health Financial Systems	JAY COUNTY HOSPITAL			In Lieu of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 10/01/2013		
				To 09/30/2014	Date/Time Pre 2/25/2015 3:1	
		Ti +L	e XVIII	Hospi tal	Cost	т рііі
	-					
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	412, 268	3, 055, 873	0. 13491	0 97, 411	13, 142	90. 00
91.00 Nursing School cost	0	3, 055, 873	0.00000	0 97, 411	0	91. 00
92.00 Allied health cost	0	3, 055, 873	0.00000	0 97, 411	0	92.00
93.00 All other Medical Education	0	3, 055, 873	0.00000	0 97, 411	0	93. 00

Health Financial Systems	JAY COUNTY HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 151320	Peri od: From 10/01/2013	Worksheet D-1
	Component CCN: 15M320		
	Title XVIII	Subprovi der -	PPS

		II the Aviii	I PF	FF3	
	Cost Center Description			1 00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, Inpatient days (including private room days, excluding swing-bed			2, 115	
2. 00 3. 00	Private room days (excluding swing-bed and observation bed days)		vate room days.	2, 115 0	3. 00
	do not complete this line.				
4.00	Semi-private room days (excluding swing-bed and observation bed		- 21 -6 -1	2, 115 0	4. 00
5. 00	O Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period				5. 00
6.00					6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost				7. 00
7.00	reporting period	days) till odgir becember	31 of the cost	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room	days) after December 3°	1 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-bed and				9. 00
7. 00	newborn days)	the frogram (exercating	Swifing bod dild	1, 787	7. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only		oom days)	0	10.00
11. 00	through December 31 of the cost reporting period (see instruction Swing-bed SNF type inpatient days applicable to title XVIII only		oom davs) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, enti-	er 0 on this line)	,		
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	only (including private	e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including private	e room days)	0	13. 00
44.00	after December 31 of the cost reporting period (if calendar yea	-	′		44.00
14. 00 15. 00	Medically necessary private room days applicable to the Program Total nursery days (title V or XIX only)	(excluding swing-bed of	days)	0	14. 00 15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
17.00	SWING BED ADJUSTMENT	+h	e +1		17.00
17. 00	Medicare rate for swing-bed SNF services applicable to services reporting period	through becember 31 of	the cost		17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of 1	the cost		18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0.00	19. 00
	reporting period	Ü			
20. 00	00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period				20. 00
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December	21 of the cost reporti	ing pariod (Line	2, 612, 427 0	21. 00 22. 00
22.00	5 x line 17)	31 of the cost reporti	riig perrou (Trile	U	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 3 x line 18)	l of the cost reporting	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reportin	ng period (line	0	24. 00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 31	of the cost reporting	neriod (line 8	0	25. 00
20.00	x line 20)	or the cost reporting	perred (Trie e	o o	
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (I	no 21 minus lino 24)		0 2, 612, 427	
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	ne 21 minus ime 20)	l	2,012,427	27.00
	General inpatient routine service charges (excluding swing-bed	and observation bed cha	arges)		28. 00
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷	ine 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0. 00	
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minu:	c lina 33)(saa instruct	tions)	0. 00 0. 00	
35. 00	Average per diem private room cost differential (line 34 x line	, ,	11 0113)	0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	,		0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and 27 minus line 36)	a private room cost dif	rrerential (line	2, 612, 427	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS			1 005 40	20.00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see in Program general inpatient routine service cost (line 9 x line 3)			1, 235. 19 2, 207, 285	
40. 00	Medically necessary private room cost applicable to the Program	(line 14 x line 35)		0	40. 00
41. 00	Total Program general inpatient routine service cost (line 39 +	line 40)		2, 207, 285	41.00

Heal th	Financial Systems	JAY COUNTY HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST			CCN: 151320	Peri od:	Worksheet D-1	
			Component	t CCN: 15M320	From 10/01/2013 To 09/30/2014	Date/Time Prep 2/25/2015 3:1	
			Ti tl	e XVIII	Subprovi der -	PPS	т рііі
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost Inp	oatient Days		÷	(col. 3 x col.	
		1.00	2.00	col . 2) 3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)	0	0				42. 00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.0	00	0	
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT			•		 -	44. 00 45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT						46.00
	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description						
48. 00	Program inpatient ancillary service cost (Wks	+ D 2 col 2	Lino 200)			1. 00 405, 215	48. 00
	Total Program inpatient costs (sum of lines 4			ons)		2, 612, 500	1
171.00	PASS THROUGH COST ADJUSTMENTS	c cag 10) (33				2/012/000	1 55
50.00	Pass through costs applicable to Program inpa	ntient routine se	rvices (from	Wkst. D, sum	of Parts I and	0	50.00
E1 00	Dags through seats applicable to Drogram inno	stiont oncillors	nomiloso (Fr	om Wko+ D c	um of Dosto II	12 204	F1 00
51. 00	Pass through costs applicable to Program inpa and IV)	iciencianciirary	services (Tr	UIII WKSL. D, S	oum UI PailS II	12, 296	51.00
52. 00	Total Program excludable cost (sum of lines 5	i0 and 51)				12, 296	52. 00
53.00	Total Program inpatient operating cost exclud		ted, non-phy	sician anesth	netist, and	2, 600, 204	53.00
	medical education costs (line 49 minus line 5 TARGET AMOUNT AND LIMIT COMPUTATION	52)					-
54. 00	Program discharges					0	54.00
55. 00	Target amount per discharge					0.00	
56.00	Target amount (line 54 x line 55)					0	
57. 00	Difference between adjusted inpatient operati	ng cost and targe	et amount (I	ine 56 minus	line 53)	0	
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost rep	norting period en	dina 1996 ı	indated and co	ampounded by the	0 0. 00	
07.00	market basket	or tring period en	arrig 1770, c	paarea ana ee	impounded by the	0.00	07.00
60.00	Lesser of lines 53/54 or 55 from prior year of					0.00	
61. 00	If line 53/54 is less than the lower of lines which operating costs (line 53) are less than					01	61. 00
	amount (line 56), otherwise enter zero (see i		(TITIES 34 X	00), 01 1% 01	the target	 -	
62.00	Relief payment (see instructions)	,				0	62.00
63.00	Allowable Inpatient cost plus incentive payme	ent (see instruct	i ons)			0	63.00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost	s through Docomb	or 21 of the	cost roporti	ng poriod (Soo	0	64. 00
04.00	instructions)(title XVIII only)	.3 thi odgir beceilib	er 31 or the	cost reporti	ng perrou (see	ا ا	04.00
65.00	Medicare swing-bed SNF inpatient routine cost	s after December	31 of the c	ost reportinç	period (See	0	65.00
<i>((</i> 00	instructions)(title XVIII only)	o costo (lino (4	nluo lino (E) (+: +1 o V)////	l anlu) Fan		// 00
66. 00	Total Medicare swing-bed SNF inpatient routing CAH (see instructions)	ne costs (Tine 64	prus rine d	5)(title XVII	i only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routine	costs through D	ecember 31 c	of the cost re	porting period	0	67. 00
/O CC	(line 12 x line 19)			.		 -	/
68. 00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	costs after Dec	ember 31 of	the cost repo	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient r	routine costs (li	ne 67 + line	: 68)		0	69. 00
	PART III - SKILLED NURSING FACILITY, OTHER NU	RSING FACILITY, A	AND ICF/MR C	NLY			1
70.00	Skilled nursing facility/other nursing facili						70.00
71. 00 72. 00	Adjusted general inpatient routine service co Program routine service cost (line 9 x line 7		e /U ÷ line	2)			71.00
73. 00	Medically necessary private room cost applica		line 14 x li	ne 35)			73.00
74.00	Total Program general inpatient routine servi	ce costs (line 7	2 + line 73)	ŕ			74. 00
75. 00	Capital -related cost allocated to inpatient r	outine service c	osts (from W	orksheet B, F	art II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ lin	ne 2)					76. 00
77. 00	Program capital -related costs (line 9 x line						77.00
78. 00	Inpatient routine service cost (line 74 minus	line 77)					78. 00
79.00	Aggregate charges to beneficiaries for excess				1: 70		79.00
80. 00 81. 00	Total Program routine service costs for compa Inpatient routine service cost per diem limit		ı ilmitatior	(line /8 mir	ius iine /9)		80. 00 81. 00
82. 00	Inpatient routine service cost limitation (li						82.00
83. 00	Reasonable inpatient routine service costs (s	see instructions)					83. 00
84.00	Program inpatient ancillary services (see ins						84.00
85. 00 86. 00	Utilization review - physician compensation (Total Program inpatient operating costs (sum						85. 00 86. 00
50.00	PART IV - COMPUTATION OF OBSERVATION BED PASS		ugii 00)				1 50.00
						0	87. 00
87. 00	Total observation bed days (see instructions)				l	0	07.00
88. 00	Total observation bed days (see instructions) Adjusted general inpatient routine cost per of Observation bed cost (line 87 x line 88) (see	liem (line 27 ÷ li	ine 2)			0. 00	88. 00 89. 00

Health Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
		Componen-	CCN: 15M320	From 10/01/2013 To 09/30/2014	Date/Time Prep 2/25/2015 3:1	
		Ti tl	e XVIII	Subprovider - IPF	PPS	
Cost Center Description	Cost	Routine Cost (from line 27)		Total Observation Bed Cost (from Iine 89)	(col. 3 x col. 4) (see instructions)	
COMPUTATION OF OBSERVATION BED PASS THROUGH (1.00	2. 00	3. 00	4. 00	5. 00	
90. 00 Capital -related cost	0	2, 612, 427	0.00000	0 0	0	90. 00
91.00 Nursing School cost	0	2, 612, 427	0.00000	0 0	0	91.00
92.00 Allied health cost	0	2, 612, 427	0.00000	0	0	92.00
93.00 All other Medical Education	0	2, 612, 427	0.00000	0 0	0	93. 00

Health Financial Systems	JAY COUNTY HOSPITAL	In Lie	eu of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 151320	From 10/01/2013	Worksheet D-1 Date/Time Pre 2/25/2015 3:1	pared:	
	Title XIX	Hospi tal	Cost	<u> </u>	
Cook Cooks Doors in the co					

-		Title XIX	Hospi tal	2/25/2015 3:1° Cost	1 pm
	Cost Center Description	I tie XIX	поѕрі таі	COST	
				1. 00	
-	PART I - ALL PROVIDER COMPONENTS				
4 00	I NPATI ENT DAYS			0.504	4.00
1.00	Inpatient days (including private room days and swing-bed days, Inpatient days (including private room days, excluding swing-be			2, 501 1, 945	1.00
2. 00 3. 00	Private room days (excluding private room days, excluding swing-be Private room days (excluding swing-bed and observation bed days		vata room dave	1, 945	2. 00 3. 00
3.00	do not complete this line.). IT you have only pr	vate room days,	U	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed	days)		1, 883	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room		r 31 of the cost	0	5. 00
	reporting period				
6.00	Total swing-bed SNF type inpatient days (including private room	days) after December	31 of the cost	515	6. 00
7 00	reporting period (if calendar year, enter 0 on this line)	daya) +brayab Dagambar	21 of the cost	41	7 00
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	days) through becember	31 Of the Cost	41	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room	davs) after December 3	1 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)				
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	55	9. 00
	newborn days)			_	
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only		oom days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instructions Swing-bed SNF type inpatient days applicable to title XVIII only		nom dave) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, ent		Joil days) arter	U	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12. 00
	through December 31 of the cost reporting period	3 .	3 ,		
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13. 00
44.00	after December 31 of the cost reporting period (if calendar yea			0	44.00
14. 00 15. 00	Medically necessary private room days applicable to the Program Total nursery days (title V or XIX only)	(excluding swing-bed	days)	0 147	
16. 00	Nursery days (title V or XIX only)			0	
10.00	SWING BED ADJUSTMENT			U	10.00
17. 00	Medicare rate for swing-bed SNF services applicable to services	through December 31 o	f the cost		17. 00
	reporting period	J			
18. 00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of	the cost		18. 00
40.00	reporting period				40.00
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	through December 31 of	the cost	0.00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	ne cost	0.00	20. 00
	reporting period				
21. 00	Total general inpatient routine service cost (see instructions)			3, 870, 191	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	31 of the cost report	ng period (line	0	22. 00
23. 00	5 x line 17)	1 of the cost reportin	a poriod (lino 4	0	23. 00
23.00	Swing-bed cost applicable to SNF type services after December 3 x line 18)	i or the cost reporting	g period (iine o	U	23.00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	na period (line	0	24. 00
	7 x line 19)		.g p (_	
25. 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)				
26. 00	Total swing-bed cost (see instructions)	ine 21 minus line 24)		810, 224	
27. 00	General inpatient routine service cost net of swing-bed cost (I PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	The 21 minus Tine 26)		3, 059, 967	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)		g/	0	
30.00	Semi -pri vate room charges (excluding swing-bed charges)			0	30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	a lina 22) (aca inatawa	ti ana)	0.00	
34. 00 35. 00	Average per diem private room charge differential (line 32 minu Average per diem private room cost differential (line 34 x line		LT ONS)	0. 00 0. 00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	31)		0.00	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost an	d private room cost di	fferential (line	3, 059, 967	37. 00
	27 minus line 36)			.,,,	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS				
38. 00	Adjusted general inpatient routine service cost per diem (see i			1, 573. 25	
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line 3	•		86, 529	
	Medically necessary private room cost applicable to the Program Total Program general inpatient routine service cost (line 39 +			0 86, 529	40. 00 41. 00
11.00	1.5ta sgram general impatront routine service cost (fille 37 +			00, 327	11.00

	Financial Systems	JAY COUNTY					In_Li	eu of Form CN	<u> 1S-2</u> 5	552-10
COMPUT	ATION OF INPATIENT OPERATING COST			Provi der	CCN: 15		Period: From 10/01/201			
							To 09/30/201	2/25/2015	3: 1 <u>1</u>	
	Cost Center Description	Total	Т	otal li t	le XIX Averaç	ge Per	Hospital Program Days	Cos Program Cos		
	·	Inpatient Cost	Inpati	ent Days	Diem (c		÷	(col. 3 x co	ol .	
12.00	NUDCEDY (4:41 - V 0 VIV1.)	1.00		2.00	3.	00	4.00	5. 00		12.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	353, 819		147		, 406. 9	3	0	0	42. 00
43. 00	INTENSIVE CARE UNIT	0		C		0.0	0	0		43.00
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT									44. 00 45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT									46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)									47. 00
	Cost Center Description							1.00		
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	3, lin	e 200)				48, 5	540	48. 00
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)((see i	nstructio	ns)			135, 0)69	49. 00
50. 00	Pass through costs applicable to Program inp	atient routine	servi	ces (from	Wkst.	D, sum	of Parts I an	d	0	50. 00
51. 00	Pass through costs applicable to Program inpand IV)	atient ancillar	y ser	vices (fr	om Wkst	. D, S	um of Parts II		0	51. 00
52. 00	Total Program excludable cost (sum of lines									52. 0
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		el ated	non-phy	si ci an	anesth	etist, and		0	53. 0
	TARGET AMOUNT AND LIMIT COMPUTATION	52)								
	Program di scharges									54.0
56. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)							0.		55. 0 56. 0
57. 00	Difference between adjusted inpatient operat	ing cost and ta	arget	amount (I	ine 56	mi nus	line 53)		0	57. 0
58.00	Bonus payment (see instructions)	nanting naniad	andi n	~ 100/ .	nda+ad	and aa	mnaundad by th			58. 0
59. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	porting period	enarn	J 1990, L	ipuateu	and co	iipouriaea by tri	e	00	59. 0
60.00	Lesser of lines 53/54 or 55 from prior year							0.		60.0
61. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less tha						,		0	61. 0
	amount (line 56), otherwise enter zero (see		(.00 0 . 7.	00), 0.		tilo tal got			
62.00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ont (soo instru	ıcti on	-)					- 1	62. 00 63. 00
03.00	PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see mstro	ic trom	5)				_		03.00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember	31 of the	cost r	eporti	ng period (See		0	64. 00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	oer 31	of the c	ost rep	orti ng	period (See		0	65. 00
	instructions)(title XVIII only)				•	Ü				
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line	64 pl	us line 6	5) (ti tl	e XVII	l only). For		0	66. 0
67. 00	Title V or XIX swing-bed NF inpatient routing	e costs through	Dece	mber 31 d	of the c	ost re	porting period		0	67. 0
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	o costs after D)ocomb	or 21 of	the cos	t ropo	rting ported		0	68. 0
00.00	(line 13 x line 20)	e costs after L	recellib	ei 31 01	the cos	т геро	iting period			00. 0
69. 00	Total title V or XIX swing-bed NF inpatient								0	69. 0
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil					e 37)				70. 0
71. 00	Adjusted general inpatient routine service c	ost per diem (I				,				71. 0
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic		n (lin	e 14 y li	ne 35)					72. 0 73. 0
74. 00	Total Program general inpatient routine serv									74. 0
75. 00	Capital-related cost allocated to inpatient					t B, P	art II, column			75. 0
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)								76. 0
77. 00	Program capital-related costs (line 9 x line	76)								77. 0
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		orovi d	er record	ls)					78. 00 79. 00
30. 00	Total Program routine service costs for comp					78 min	us line 79)			80.0
31. 00	Inpatient routine service cost per diem limi		13							81.0
32. 00 33. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (*							82. 0 83. 0
84. 00	Program inpatient ancillary services (see in	structions)								84. 0
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum	•	-	85)						85. 0 86. 0
50.00	PART IV - COMPUTATION OF OBSERVATION BED PASS		ougn	33)						00. U
07 00	Total observation bed days (see instructions									87. 0
87. 00	Adjusted general inpatient routine cost per	-I! (I! OT	1.1	2)				1, 573.	251	00 0

Health Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 10/01/2013 To 09/30/2014	Date/Time Prep 2/25/2015 3:1	
		Ti t	le XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(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	412, 268	3, 059, 967	0. 13473	0 97, 542	13, 142	90.00
91.00 Nursing School cost	0	3, 059, 967	0.00000	0 97, 542	0	91.00
92.00 Allied health cost	0	3, 059, 967	0.00000	97, 542	0	92.00
93.00 All other Medical Education	0	3, 059, 967	0. 00000	97, 542	0	93. 00

Health Financial Systems	JAY COUNTY HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151320	Peri od: From 10/01/2013	Worksheet D-1
	Component CCN: 15M320		Date/Time Prepared:
	Title XIX	Subprovi der -	2/25/2015 3:11 pm Cost

		TITLE XIX	I PF	COST	
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
1. 00 2. 00	Inpatient days (including private room days and swing-bed days, Inpatient days (including private room days, excluding swing-bed			2, 115 2, 115	1
3. 00	Private room days (excluding swing-bed and observation bed days)		vate room days	2,115	3.00
0.00	do not complete this line.	3	tato . com dayo,	, and the second	0.00
4.00	Semi-private room days (excluding swing-bed and observation bed			2, 115	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room reporting period	days) through December	31 of the cost	0	5. 00
6.00	Total swing-bed SNF type inpatient days (including private room	days) after December 3	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)				
7. 00	Total swing-bed NF type inpatient days (including private room or reporting period	days) through December	31 of the cost	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room o	davs) after December 3	1 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	ayo, area bacambar a			0.00
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	17	9. 00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII only	/ (including private ro	nom days)	0	10.00
10.00	through December 31 of the cost reporting period (see instruction		Join days)		10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only		oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, enter Swing-bed NF type inpatient days applicable to titles V or XIX of		room days)	0	12. 00
12.00	through December 31 of the cost reporting period	only (including private	e room days)	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX o			0	13. 00
14 00	after December 31 of the cost reporting period (if calendar year			0	14 00
14. 00 15. 00	Medically necessary private room days applicable to the Program Total nursery days (title V or XIX only)	(excluding Swing-bed (lays)	147	14. 00 15. 00
16. 00	Nursery days (title V or XIX only)			0	1
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to services reporting period	through December 31 of	f the cost		17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of	the cost		18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0. 00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services a	after December 31 of th	ne cost	0.00	20.00
	reporting period				
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December	21 of the cost managet:	ng ported (line	2, 612, 427	21. 00 22. 00
22.00	5 x line 17)	31 of the cost reporti	ng perrou (Trie	0	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 3	of the cost reporting	g period (line 6	0	23. 00
24.00	x line 18))1 -£ +b+			24.00
24. 00	Swing-bed cost applicable to NF type services through December (7×1) ine 19)	or the cost reporting	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 31	of the cost reporting	period (line 8	0	25. 00
27.00	x line 20)				24 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (li	ne 21 minus line 26)		0 2, 612, 427	
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	THE ZT IIITHGS TTHE ZO)		2,012,121	27.00
	General inpatient routine service charges (excluding swing-bed a	and observation bed cha	arges)		28. 00
29. 00	Pri vate room charges (excluding swing-bed charges)			0	ł
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ 1	ine 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)	1110 20)		0.00	•
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	•
34.00	Average per diem private room charge differential (line 32 minus		tions)	0.00	•
35. 00 36. 00	Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35)	31)		0.00	35. 00 36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and	d private room cost dit	fferential (line	2, 612, 427	37. 00
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST	MENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see in			1, 235. 19	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38			20, 998	
40.00	Medically necessary private room cost applicable to the Program	•		0	40.00
41. 00	Total Program general inpatient routine service cost (line 39 +	line 40)		20, 998	41.00

	Financial Systems ATION OF INPATIENT OPERATING COST	JAY COUNTY		CCN: 151320	Peri od:	u of Form CMS-2 Worksheet D-1	<u></u>
					From 10/01/2013 To 09/30/2014		
			Ti ti	le XIX	Subprovi der -	Cost	ı pııı
	Cost Center Description	Total npatient Cost	Total Inpatient Days	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x col.	
	_	1 00	2.00	col . 2)	4.00	4)	
12. 00	NURSERY (title V & XIX only)	1.00	2. 00	3.00	4.00	5. 00	42. 00
	Intensive Care Type Inpatient Hospital Units						
13.00	INTENSIVE CARE UNIT	0	0	0. 0	00	0	
14. 00 15. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT				ļ		44.00
16. 00	SURGICAL INTENSIVE CARE UNIT				ļ		46.00
17. 00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1.00	
18. 00	Program inpatient ancillary service cost (Wkst	t D-3 col 3	line 200)			1. 00 4, 483	48. 00
19. 00	Total Program inpatient costs (sum of lines 41			ns)		25, 481	
	PASS THROUGH COST ADJUSTMENTS						
50. 00	Pass through costs applicable to Program inpat	tient routine	services (from	Wkst. D, sum	of Parts I and	0	50.00
51. 00		tient ancillar	v services (fr	om Wkst D s	rum of Darts II	0	51.00
. 1. 00	and IV)	one unorrial	y Scivices (III	5 WK3t. D, 3	am or ruits if] 31.00
52. 00	Total Program excludable cost (sum of lines 50	,				0	
53. 00	Total Program inpatient operating cost excludi medical education costs (line 49 minus line 52		lated, non-phy	sician anesth	etist, and	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION	<u>2) </u>					1
54. 00	Program di scharges					0	54.00
55.00	Target amount per discharge					0.00	
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operatir	na cost and ta	ract amount (ino 56 minus	lino 52)	0	56. 00 57. 00
58. 00	Bonus payment (see instructions)	ig cost and ta	rget amount (r	THE 50 IIITHUS	111le 53)	0	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost repo	orting period	endi ng 1996, u	pdated and co	mpounded by the	_	
	market basket						
50. 00 51. 00	Lesser of lines 53/54 or 55 from prior year collf line 53/54 is less than the lower of lines				the amount by	0.00	60.00
31.00	which operating costs (line 53) are less than						01.00
	amount (line 56), otherwise enter zero (see ir	nstructions)	·				
52.00	Relief payment (see instructions)	+ (aaa i matsu	ationa)			0	62.00
53. 00	Allowable Inpatient cost plus incentive paymer PROGRAM INPATIENT ROUTINE SWING BED COST	it (see mstru	Ctrons)			0	63.00
54. 00	Medicare swing-bed SNF inpatient routine costs	s through Dece	mber 31 of the	cost reporti	ng period (See	0	64.00
· F . O.O.	instructions)(title XVIII only)	£t D	21 -6 +1				/ - 00
55. 00	Medicare swing-bed SNF inpatient routine costs instructions)(title XVIII only)	s arter becemb	er 31 of the co	ost reporting	period (See	0	65. 00
66.00	Total Medicare swing-bed SNF inpatient routine	e costs (line	64 plus line 6	5)(title XVII	I only). For	0	66. 00
57. 00	CAH (see instructions)		D 21	£ +1+		0	/7.00
37.00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	costs through	December 31 0	i the cost re	portring perrou	0	67.00
68. 00	Title V or XIX swing-bed NF inpatient routine	costs after D	ecember 31 of	the cost repo	rting period	0	68. 00
59. 00	(line 13 x line 20)	outine costs (lino 67 : 1:	60)		0	60.00
39. 00	Total title V or XIX swing-bed NF inpatient ro PART III - SKILLED NURSING FACILITY, OTHER NUR					0	69.00
70. 00	Skilled nursing facility/other nursing facilit						70.00
71.00	Adjusted general inpatient routine service cos	•	ine 70 ÷ line :	2)			71.00
72. 00 73. 00	Program routine service cost (line 9 x line 71 Medically necessary private room cost applicable)	*	(line 14 v lin	ne 35)			72.00
74. 00	Total Program general inpatient routine service			.ie 33)			74.00
75. 00	Capital -related cost allocated to inpatient ro			orksheet B, P	art II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ line	. 2)					76.00
0.00	Program capital-related costs (line 9 x line 7	,					77. 00
77. 00	Inpatient routine service cost (line 74 minus	line 77)					78. 00
77. 00 78. 00	Aggregate charges to beneficiaries for excess				1: 70)		79.00
77. 00 78. 00 79. 00		uson to the c	ost limitation	(line /8 min	us line 79)		80. 00 81. 00
77. 00 78. 00 79. 00 30. 00	Total Program routine service costs for compar						
77. 00 78. 00 79. 00		ati on)		1		82.00
77. 00 78. 00 79. 00 80. 00 81. 00	Total Program routine service costs for compar Inpatient routine service cost per diem limita Inpatient routine service cost limitation (lir Reasonable inpatient routine service costs (se	ation ne 9 x line 81 ee instruction	•				83.00
77. 00 78. 00 79. 00 30. 00 31. 00 32. 00 33. 00 34. 00	Total Program routine service costs for compar Inpatient routine service cost per diem limita Inpatient routine service cost limitation (lir Reasonable inpatient routine service costs (se Program inpatient ancillary services (see inst	ation ne 9 x line 81 ee instruction: tructions)	s)				83. 00 84. 00
77. 00 78. 00 79. 00 80. 00 81. 00 82. 00 83. 00 84. 00 85. 00	Total Program routine service costs for compar Inpatient routine service cost per diem limita Inpatient routine service cost limitation (lin Reasonable inpatient routine service costs (se Program inpatient ancillary services (see inst Utilization review - physician compensation (s	ation ne 9 x line 81 ee instruction: tructions) see instructio	ns)				83. 00 84. 00 85. 00
77. 00 78. 00 79. 00 30. 00 31. 00 32. 00 33. 00 34. 00	Total Program routine service costs for compar Inpatient routine service cost per diem limita Inpatient routine service cost limitation (lir Reasonable inpatient routine service costs (se Program inpatient ancillary services (see inst	ation ne 9 x line 81 se instruction tructions) see instruction of lines 83 th	ns)				83. 00 84. 00 85. 00
77. 00 78. 00 79. 00 80. 00 81. 00 82. 00 83. 00 84. 00 85. 00	Total Program routine service costs for compar Inpatient routine service cost per diem limita Inpatient routine service cost limitation (lin Reasonable inpatient routine service costs (se Program inpatient ancillary services (see inst Utilization review - physician compensation (s Total Program inpatient operating costs (sum of	ation ne 9 x line 81 ne instruction tructions see instructio of lines 83 th THROUGH COST	s) ns) rough 85)			0	82. 00 83. 00 84. 00 85. 00 86. 00 87. 00

Health Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
		Component	CCN: 15M320	From 10/01/2013 To 09/30/2014		
		Ti t	le XIX	Subprovi der - I PF	Cost	
Cost Center Description	Cost 1.00	Routine Cost (from line 27)	col umn 1 ÷ col umn 2	Total Observation Bed Cost (from	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions) 5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (2.00	3.00	4.00	3.00	
90.00 Capital -related cost	176, 464	2, 612, 427	0. 06754	8 0	0	90.00
91.00 Nursing School cost	0	2, 612, 427	0.00000	0 0	0	91. 00
92.00 Allied health cost	0	2, 612, 427			0	92. 00
93.00 All other Medical Education	0	2, 612, 427	0.00000	0 0	0	93. 00

Health Financial Systems	JAY COUNTY HOSP	I TAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der		Peri od: From 10/01/2013	Worksheet D-3	
				To 09/30/2014	Date/Time Prep 2/25/2015 3:1	
		Ti tl	e XVIII	Hospi tal	Cost	
Cost Center Description			Ratio of Cos	t Inpatient	I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	

	Title XVIII	Hospi tal	Cost	
Cost Center Description	Ratio of Cos	t Inpatient	I npati ent	
	To Charges	Program	Program Costs	
		Charges	(col. 1 x col.	
			2)	
	1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS		1, 042, 286		30. 00
31.00 03100 INTENSIVE CARE UNIT		0		31.00
40. 00 04000 SUBPROVI DER - 1 PF		0		40.00
41. 00 04100 SUBPROVI DER - RF		0		41.00
42. 00 04200 SUBPROVI DER		0		42.00
43. 00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATI NG ROOM	0. 28372	4 464, 477	131, 783	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 38546	7 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0.00000	0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 11271	0 323, 125	36, 419	54.00
57. 00 05700 CT SCAN	0.00000	0	0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.00000	0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0.00000	0	0	59. 00
60. 00 06000 LABORATORY	0. 17350	1 453, 080	78, 610	60.00
60. 01 06001 BL00D LABORATORY	0.00000	0	0	60. 01
65. 00 06500 RESPI RATORY THERAPY	0. 63648	5 155, 745	99, 129	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 39759	8 105, 535	41, 961	66. 00
68. 00 06800 SPEECH PATHOLOGY	0.00000	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 46319	7 58, 638	27, 161	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.00000	0 0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 14835	8 25, 288	3, 752	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 54027	7 245, 808	132, 804	73. 00
OUTPATIENT SERVICE COST CENTERS	·			
88. 00 08800 RURAL HEALTH CLINIC	0.00000	0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.00000	0	0	89. 00
90. 00 09000 CLI NI C	4. 12127	3 0	0	90.00
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	2. 30115	3 0	0	90. 01
90.02 09002 JAY FAMILY MEDICINE	2. 23821	4 0	0	90. 02
91. 00 09100 EMERGENCY	0. 59603	2 1, 370	817	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 57393	8 0	0	92. 00
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTER	0.00000		0	93. 00
200.00 Total (sum of lines 50-94 and 96-98)		1, 833, 066	552, 436	200. 00
201.00 Less PBP Clinic Laboratory Services-Program only chard	jes (line 61)	0		201. 00
202.00 Net Charges (line 200 minus line 201)		1, 833, 066		202. 00
	•	•	•	

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Componen	t CCN: 15M320	Period: From 10/01/2013 To 09/30/2014	Worksheet D-3 Date/Time Pre 2/25/2015 3:1	pared:
	Ti tl	e XVIII	Subprovi der - I PF	PPS	
Cost Center Description		Ratio of Cos To Charges	Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2. 00	3. 00	
80. 00 03000 ADULTS & PEDIATRICS			T 0		30.0
B1. 00 03100 NTENSI VE CARE UNI T			0		31. 0
10. 00 04000 SUBPROVI DER - I PF			1, 193, 400		40.0
I1. 00 04100 SUBPROVI DER - RF			0		41.0
12. 00 04200 SUBPROVI DER			0		42.0
43. 00 04300 NURSERY					43.0
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATING ROOM		0. 28372		77	1
52. OO O5200 DELIVERY ROOM & LABOR ROOM		0. 38546		0	
53. 00 05300 ANESTHESI OLOGY		0.00000		0	
54. 00 05400 RADI OLOGY - DI AGNOSTI C		0. 11271		20, 307	
57. 00 05700 CT SCAN		0.00000		0	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 59.00 05900 CARDIAC CATHETERIZATION		0. 00000 0. 00000		0	
50. 00 06000 LABORATORY		0. 00000		45, 766	
50. 01 06000 EABORATORY		0. 17330		45, 766	
55. 00 06500 RESPI RATORY THERAPY		0. 63648		59, 874	
66. 00 06600 PHYSI CAL THERAPY		0. 40099		29, 826	
58. 00 06800 SPEECH PATHOLOGY		0. 00000		0	•
59. 00 06900 ELECTROCARDI OLOGY		0. 46319		10, 964	1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.00000		0	•
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 14835	8 0	0	72. (
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 54027	7 371, 007	200, 447	73. (
OUTPATIENT SERVICE COST CENTERS			٦	_	
88. 00 08800 RURAL HEALTH CLINIC		0.00000		0	
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000		0	
90. 00 09000 CLINI C		4. 12127		0	
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY		2. 30115		0	
PO. 02 09002 JAY FAMILY MEDICINE P1. 00 09100 EMERGENCY		2. 23821 0. 59603		0 37, 954	
71.00 09100 EMERGENCY 22.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 57393		37, 954	1
23. 00 04040 OTHER OUTPATIENT SERVICE COST CENTER		0.00000		0	1
200.00 Total (sum of lines 50-94 and 96-98)		0.00000	1, 071, 025	405, 215	
201.00 Less PBP Clinic Laboratory Services-Program only charg	es (line 61)		1,0/1,025	405, 215	200.
101.00 Less For Citilic Laboratory Services-Frogram only Charge		1	1		1201.

Health Financial Systems	Systems JAY COUNTY HOSPITAL I	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 151320 Period:	Worksheet D-3

Heal th Fi	nancial Systems	JAY COUNTY HOSPITAL		In Lie	eu of Form CMS-2	2552-10
I NPATI EN	T ANCILLARY SERVICE COST APPORTIONMENT	Provi der		Peri od:	Worksheet D-3	
		Component	CCN: 15Z320	From 10/01/2013 To 09/30/2014	Date/Time Pre	nared·
		Compenent	CON. 132320	10 07/30/2014	2/25/2015 3:1	
		Ti tl		Swing Beds - SNF		
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			1. 00	2.00	2) 3. 00	
LN	IPATIENT ROUTINE SERVICE COST CENTERS		1.00	2. 00	3.00	
	8000 ADULTS & PEDIATRICS			0		30.00
	3100 INTENSIVE CARE UNIT			0		31.00
	1000 SUBPROVI DER - I PF			0		40. 00
	1100 SUBPROVI DER - I RF			0		41.00
	1200 SUBPROVI DER			0		42. 00
	1300 NURSERY					43. 00
	ICI LLARY SERVI CE COST CENTERS					
	5000 OPERATING ROOM		0. 28372	120	34	50.00
52.00 05	5200 DELIVERY ROOM & LABOR ROOM		0. 38546	07	0	52. 00
53.00 05	3300 ANESTHESI OLOGY		0. 00000	0 0	0	53. 00
54.00 05	5400 RADI OLOGY-DI AGNOSTI C		0. 11271		1, 753	54.00
57. 00 05	5700 CT SCAN		0.00000	0 0	0	57. 00
	800 MAGNETIC RESONANCE IMAGING (MRI)		0.00000		0	58. 00
	5900 CARDI AC CATHETERI ZATI ON		0.00000		0	59. 00
	5000 LABORATORY		0. 17350		5, 263	60. 00
	5001 BLOOD LABORATORY		0. 00000			60. 01
	5500 RESPI RATORY THERAPY		0. 63648			65. 00
	6600 PHYSI CAL THERAPY		0. 39759			66. 00
	SPEECH PATHOLOGY		0. 00000		0	68. 00
	9900 ELECTROCARDI OLOGY		0. 46319		3, 169	69. 00
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 00000		0	71. 00
	7200 I MPL. DEV. CHARGED TO PATIENTS		0. 14835		0	72. 00
	7300 DRUGS CHARGED TO PATIENTS		0. 54027	7 84, 286	45, 538	73. 00
	ITPATIENT SERVICE COST CENTERS BROORURAL HEALTH CLINIC		0. 00000	10	0	00 00
	8900 FEDERALLY QUALIFIED HEALTH CENTER		0. 00000		0	88. 00 89. 00
	2000 CLINIC		4. 12127		0	90.00
	2001 FAMILY PRACTICE OF JAY COUNTY		4. 12127 2. 30115		0	90.00
	2002 JAY FAMILY MEDICINE		2. 23821		0	90.01
	2100 EMERGENCY		0. 59603		0	91.00
	2200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 57393		0	92.00
	1040 OTHER OUTPATIENT SERVICE COST CENTER		0. 00000		0	93. 00
200.00	Total (sum of lines 50-94 and 96-98)		0.00000	416, 796	-	
201.00	Less PBP Clinic Laboratory Services-Progr	ram only charges (line 61)		0	1.75, 100	201. 00
202. 00	Net Charges (line 200 minus line 201)	y g (416, 796		202. 00
	, Jan (1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	·	ı	,	1	

Heal th	Financial Systems	JAY COUNTY HOSPITAL		In Lie	eu of Form CMS-2	2552-10
	ENT ANCILLARY SERVICE COST APPORTIONMENT		der CCN: 151320	Peri od:	Worksheet D-3	
				From 10/01/2013 To 09/30/2014		
			Title XIX	Hospi tal	Cost	
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges		Program Costs	
				Charges	(col. 1 x col.	
			1.00	0.00	2)	
	INDATI ENT DOUTINE CEDVICE COCT CENTERS		1.00	2. 00	3. 00	
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS			84, 349		30. 00
30.00	03100 INTENSIVE CARE UNIT			84, 349		30.00
40. 00	04000 SUBPROVI DER – I PF					40.00
41. 00	04100 SUBPROVI DER - I RF					41. 00
42.00	04200 SUBPROVI DER					42.00
43. 00	04300 NURSERY					43. 00
10.00	ANCI LLARY SERVI CE COST CENTERS					10.00
50.00	05000 OPERATING ROOM		0. 2837	24 84, 838	24, 071	50. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 3854		0	52. 00
53. 00	05300 ANESTHESI OLOGY		0.0000	00	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 1127	10 19, 008	2, 142	54.00
57.00	05700 CT SCAN		0.0000	00	0	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0.0000	00	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON		0.0000	00	0	59.00
60.00	06000 LABORATORY		0. 1735	34, 719	6, 024	60.00
60. 01	06001 BLOOD LABORATORY		0.0000	00	0	60. 01
65.00	06500 RESPI RATORY THERAPY		0. 6364			65.00
66. 00	06600 PHYSI CAL THERAPY		0. 3975	98 516	205	66. 00

0.000000

0. 463197

0.000000

0.148358

0.540277

0.000000

0.000000

4. 121273

2. 301153

2. 238214

0.596032

1.573938

0.000000

0

0

0

0

0

5, 341

167, 303

167, 303

17, 135

0 68.00

0

0

0

0 88.00

0

0 90.01

0 90.02

0 93.00

48, 540 200. 00

3, 183

9, 258

69.00

71.00

72.00

73.00

89.00

90.00

91.00

0 92.00

201.00

202. 00

68. 00 06800 SPEECH PATHOLOGY

09000 CLI NI C

91. 00 09100 EMERGENCY

71.00

72.00

73.00

88.00

89.00

90.00

90.01

90.02

93.00

200.00

201.00

202.00

69. 00 06900 ELECTROCARDI OLOGY

07100 MEDICAL SUPPLIES CHARGED TO PATIENTS

07200 IMPL. DEV. CHARGED TO PATIENTS

08900 FEDERALLY QUALIFIED HEALTH CENTER

09001 FAMILY PRACTICE OF JAY COUNTY

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

04040 OTHER OUTPATIENT SERVICE COST CENTER

Total (sum of lines 50-94 and 96-98)

Net Charges (line 200 minus line 201)

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

07300 DRUGS CHARGED TO PATIENTS

OUTPATIENT SERVICE COST CENTERS

08800 RURAL HEALTH CLINIC

09002 JAY FAMILY MEDICINE

Heal th Financial Systems	JAY COUNTY HOSPITAL	00N 4E4000		eu of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 151320	Peri od: From 10/01/2013	Worksheet D-3	
	Componen	t CCN: 15M320	To 09/30/2014	Date/Time Pre 2/25/2015 3:1	
	Ti t	le XIX	Subprovi der – I PF	Cost	
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	0.00	2)	
LAIDATI ENT. DOUTLAIE CEDIA OF COCT. CENTEDO		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		I		I	20.00
30. 00 03000 ADULTS & PEDI ATRI CS			0		30.00
31. 00 03100 NTENSI VE CARE UNI T			_		31.00
40. 00 04000 SUBPROVI DER - 1 PF 41. 00 04100 SUBPROVI DER - 1 RF			13, 934		40.00
			0		41.00
42. 00 04200 SUBPROVI DER 43. 00 04300 NURSERY			0		42.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS					43.00
50. 00 O5000 OPERATING ROOM		0. 28372	24 0	0	50.00
52.00 05000 DELIVERY ROOM & LABOR ROOM		0. 28372			52.00
53. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY		1		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 00000 0. 1127		95	
57. 00 05700 CT SCAN		0. 1127		0	
58. OO O5700 CT SCAN 58. OO O5800 MAGNETIC RESONANCE IMAGING (MRI)		0.00000			58.00
59. 00 05900 MAGNETTC RESONANCE TWAGTING (WRT)		0.00000		0	59.00
60. 00 06000 LABORATORY		0. 17350		1	60.00
60. 01 06000 EABORATORY		0. 00000		0	60.00
65. 00 06500 RESPI RATORY THERAPY		0. 63648			•
66. 00 06600 PHYSI CAL THERAPY		0. 39759		000	66.00
68. 00 06800 SPEECH PATHOLOGY		0. 00000		0	68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 46319		0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 00000		Ö	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 14835		o o	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 54027			
OUTPATIENT SERVICE COST CENTERS		0.0.02	0,012	2,770	70.00
88. 00 08800 RURAL HEALTH CLINIC		0.00000	00 0	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0. 00000		•	89.00
90. 00 09000 CLI NI C		4. 12127			90.00
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY		2. 30115		Ō	90. 01
90. 02 09002 JAY FAMILY MEDICINE		2. 2382		Ō	90. 02
91. 00 09100 EMERGENCY		0. 59603		Ō	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 57393		Ō	92.00
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTER		0.00000		0	1
200 00 Total (sum of lines 50-04 and 06-08)			11 606	1 102	200 00

Total (sum of lines 50-94 and 96-98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)
Net Charges (line 200 minus line 201)

4, 483 200. 00 201. 00 202. 00

200. 00 201. 00 202. 00

Health Financial Systems	JAY COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CCN: 151320	Peri od: Worksheet D-3 From 10/01/2013
	Component CCN: 15Z320	To 09/30/2014 Date/Time Prepared:

TINPATT	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provider	CCN: 151320	From 10/01/2013	worksneet D-3	
		Component	CCN: 15Z320		Date/Time Pre	nared:
		Component	0011. 102020	077 007 2011	2/25/2015 3:1	
		Ti t	le XIX	Swing Beds - SNF		
	Cost Center Description	•	Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
			9		(col. 1 x col.	
				3.1	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 I NTENSI VE CARE UNI T			o		31.00
40.00	04000 SUBPROVI DER - I PF			o		40. 00
41. 00	04100 SUBPROVI DER - I RF			0		41.00
42. 00	04200 SUBPROVI DER			o		42.00
	04300 NURSERY			o		43.00
	ANCI LLARY SERVI CE COST CENTERS			-1		
50.00	05000 OPERATING ROOM		0. 2837	24 0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		0. 3854	67 ol	0	52. 00
53.00	05300 ANESTHESI OLOGY		0.0000	ool ol	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 1127	10 ol	0	54.00
57. 00	05700 CT SCAN		0.0000		0	57. 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. 1735		0	60.00
	06001 BLOOD LABORATORY		0.0000		0	60. 01
65. 00	06500 RESPI RATORY THERAPY		0. 6364		0	65. 00
66. 00	06600 PHYSI CAL THERAPY		0. 3975		0	66. 00
	06800 SPEECH PATHOLOGY		0.0000		0	68. 00
	06900 ELECTROCARDI OLOGY		0. 4631		0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.0000		0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 1483		0	71.00
	07300 DRUGS CHARGED TO PATIENTS		0. 5402		0	73. 00
73.00	OUTPATIENT SERVICE COST CENTERS		0.3402	77	0	73.00
88 00	08800 RURAL HEALTH CLINIC		0.0000	00 0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000		0	89. 00
	09000 CLINIC		4. 1212		0	90.00
	09001 FAMILY PRACTICE OF JAY COUNTY		2. 3011		0	90. 01
	09002 JAY FAMILY MEDICINE		2. 2382		0	90.01
	09100 EMERGENCY		0. 5960		0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 5739		0	92.00
	04040 OTHER OUTPATIENT SERVICE COST CENTER		0.0000		0	93.00
200.00			0.0000	0	•	200. 00
200.00		(Lino 61)		0		200.00
201.00		(TITIE OT)		0		201.00
202.00	Net Charges (line 200 minus line 201)		I	ı V		₁ 202.00

Health Financial Systems	JAY COUNTY HOSPITA	AL		In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Pr	rovider CCN:	151320	From 10/01/2013	Worksheet E Part B Date/Time Prepared: 2/25/2015 3:11 pm

			To 09/30/2014	Date/Time Pre 2/25/2015 3:1	
		Title XVIII	Hospi tal	Cost	
	DADT D. MEDICAL AND OTHER HEALTH CERVICES			1. 00	
1. 00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)			4, 102, 745	1.00
2. 00	Medical and other services (see Fristractions) Medical and other services reimbursed under OPPS (see instructi	ons)		4, 102, 743	2.00
3. 00	PPS payments	0113)		Ö	3. 00
4.00	Outlier payment (see instructions)			0	4. 00
5.00	Enter the hospital specific payment to cost ratio (see instruct	i ons)		0.000	5. 00
6.00	Line 2 times line 5			0	6. 00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00	7. 00
8. 00	Transitional corridor payment (see instructions)			0	8. 00
9. 00	Ancillary service other pass through costs from Worksheet D, Pa	rt IV, column 13, line	200	0	9. 00
10.00	Organ acqui si ti ons			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			4, 102, 745	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 Worksheet D-4, Part III, line 6	9. col. 4)		Ö	13. 00
14. 00	Total reasonable charges (sum of lines 12 and 13)	.,,		Ō	14. 00
	Customary charges				
15.00	Aggregate amount actually collected from patients liable for pa	yment for services on	a charge basis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for	payment for services o	n a chargebasis	0	16. 00
	had such payment been made in accordance with 42 CFR 413.13(e)				
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	17. 00
18.00	Total customary charges (see instructions)	. 6 1 . 40	44) (0	18.00
19. 00	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds li	ne 11) (see	0	19. 00
20. 00	<pre>instructions) Excess of reasonable cost over customary charges (complete only</pre>	if line 11 exceeds li	no 10) (coo	0	20. 00
20.00	instructions)	IT TIME IT exceeds IT	116 10) (366	l	20.00
21. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	instructions)		4, 143, 772	21. 00
22. 00	Interns and residents (see instructions)	,		0	22. 00
23.00	Cost of physicians' services in a teaching hospital (see instru	ctions)		0	23. 00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			0	24. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00	Deductibles and coinsurance (for CAH, see instructions)			53, 649	25. 00
26. 00	Deductibles and Coinsurance relating to amount on line 24 (for			2, 317, 318	26. 00
27. 00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus t see instructions)	ne sum of lines 22 and	23} (TOF CAH,	1, 772, 805	27. 00
28. 00	Direct graduate medical education payments (from Worksheet E-4,	line 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Worksheet E-4, line 3	•		0	29. 00
30. 00	Subtotal (sum of lines 27 through 29)	-,		1, 772, 805	
31.00	Primary payer payments			423	
32.00	Subtotal (line 30 minus line 31)			1, 772, 382	32. 00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	S)			
33. 00	Composite rate ESRD (from Worksheet I-5, line 11)			0	33. 00
34.00	Allowable bad debts (see instructions)			407, 593	
35. 00	Adjusted reimbursable bad debts (see instructions)	-+:>		309, 771	35. 00
36.00	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		339, 499	
37. 00 38. 00	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			2, 082, 153 0	38.00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
39. 98	Partial or full credits received from manufacturers for replace	d devices (see instruc	tions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	u uev. ees (ees et. ue		Ö	39. 99
40. 00	Subtotal (see instructions)			2, 082, 153	40.00
40. 01	Sequestration adjustment (see instructions)			41, 643	40. 01
41.00	Interim payments			1, 679, 699	41.00
42.00	Tentative settlement (for contractors use only)			0	42.00
43.00	Balance due provider/program (see instructions)			360, 811	43. 00
44. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2,	chapter 1,	0	44. 00
	§115. 2				
00.00	TO BE COMPLETED BY CONTRACTOR			_	00.00
90.00	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	90. 00 91. 00
91. 00 92. 00	The rate used to calculate the Time Value of Money			0.00	91.00
93.00	Time Value of Money (see instructions)			0.00	93.00
	Total (sum of lines 91 and 93)			0	94. 00
00	1 (,	

Health Financial Systems

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

					2/25/2015 3: 1	1 pm
			e XVIII	Hospi tal	Cost	
		Inpatien	it Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		1, 439, 479)	1, 679, 699	1. 00
2.00	Interim payments payable on individual bills, either		()	0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER				0	3. 01
3. 02	A SOCIAL PROPERTY OF THE PROPE				l ol	3. 02
3. 03					l ol	3. 03
3. 04					l ol	3. 04
3. 05					l ol	3. 05
	Provider to Program			"		
3.50	ADJUSTMENTS TO PROGRAM		()	0	3. 50
3.51			(0	3. 51
3.52)	0	3. 52
3.53			()	0	3. 53
3.54			(0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		()	0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 439, 479	?	1, 679, 699	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate) TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5. 00
3.00	desk review. Also show date of each payment. If none,					3.00
	write "NONE" or enter a zero. (1)					
	Program to Provider		I.			
5.01	TENTATI VE TO PROVI DER)	0	5. 01
5.02					0	5. 02
5.03			()	0	5. 03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM		(0	5. 50
5. 51			(0	5. 51
5. 52			(0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98))	0	5. 99
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		28, 438	3	360, 811	6. 01
6.02	SETTLEMENT TO PROGRAM)	0	6. 02
7.00	Total Medicare program liability (see instructions)		1, 467, 917		2, 040, 510	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
0.00	News of Contractors)	1. 00	2. 00	0.00
8.00	Name of Contractor					8. 00

Health Financial Systems

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

		Ti tl	e XVIII	Subprovi der - I PF	PPS	
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		1, 653, 300		0	1. 00
2.00	Interim payments payable on individual bills, either		C		0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
3. 00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment					3. 00
3.00	amount based on subsequent revision of the interim rate					3.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER		C		0	3. 01
3.02			C)	0	3. 02
3.03			C)	0	3. 03
3.04			C		0	3. 04
3.05			C		0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		C		0	3. 50
3. 51			0		0	3. 51
3. 52 3. 53			0		0	3. 52 3. 53
3. 53 3. 54			0		0	3. 53
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3. 99
3. 77	3. 50-3. 98)		0		O O	3. 77
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 653, 300	1	0	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as		.,,			
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
E 01	Program to Provider TENTATIVE TO PROVIDER			1	0	F 01
5. 01 5. 02	TENTATIVE TO PROVIDER		C			5. 01 5. 02
5. 02			0			5. 02
5.05	Provider to Program			1	0	3.03
5. 50	TENTATI VE TO PROGRAM		C)	0	5. 50
5. 51			C)	O	5. 51
5.52			C)	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		C)	0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6. 00
,	the cost report. (1)		_		_	,
6. 01	SETTLEMENT TO PROVIDER		0		0	6. 01
6. 02	SETTLEMENT TO PROGRAM Total Medicare program Liability (see instructions)		1 652 200		0	6. 02
7. 00	Total Medicare program liability (see instructions)		1, 653, 300	Contractor	NPR Date	7. 00
				Number	(Mo/Day/Yr)	
		()	1. 00	2. 00	
8. 00	Name of Contractor					8. 00
	-			•		·

					2/25/2015 3:1	1 pm
		Ti t	e XVIII	Swing Beds - SNF	Cost	
		Inpatie	nt Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		813, 83	39	0	1. 00
2.00	Interim payments payable on individual bills, either			0	0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER		T	0	0	3. 01
3. 02	ADJUSTWIENTS TO TROVIDER		1	0	Ö	3. 02
3. 03			1	0	o	3. 03
3. 04				o	0	3. 04
3. 05				o	0	3. 05
	Provider to Program				-	
3.50	ADJUSTMENTS TO PROGRAM			0	0	3. 50
3.51				0	0	3. 51
3.52				0	0	3. 52
3.53				0	0	3. 53
3.54				0	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		813, 83	39	0	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate) TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5. 00
5.00	desk review. Also show date of each payment. If none,					3.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5. 02				0	0	5. 02
5.03				0	0	5. 03
	Provider to Program		•			
5.50	TENTATI VE TO PROGRAM			0	0	5. 50
5. 51				0	0	5. 51
5. 52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5. 99
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		41, 95	58	0	6. 01
6.02	SETTLEMENT TO PROGRAM			0	0	6. 02
7.00	Total Medicare program liability (see instructions)		855, 79	97	0	7. 00
				Contractor	NPR Date	
			^	Number	(Mo/Day/Yr)	
0.00	None of Contractor		0	1. 00	2. 00	0.00
8. 00	Name of Contractor					8. 00

Heal th	Financial Systems JAY COUNTY HOS	PI TAL	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provi der CCN: 151320	Peri od:	Worksheet E-1	
			From 10/01/2013 To 09/30/2014		nared:
			077 307 2014	2/25/2015 3:1	
		Title XVIII	Hospi tal	Cost	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1. 00	Total hospital discharges as defined in AARA §4102 from Wkst S-	-3, Part I column 15 li	ne 14	637	1. 00
2.00	00 Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8–12 695				
3.00	00 Medicare HMO days from Wkst S-3, Part I, column 6. line 2				
4.00	4.00 Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12				
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			71, 519, 393	5. 00
6.00	Total hospital charity care charges from Wkst S-10, column 3 li	ne 20		631, 150	6. 00
7.00	CAH only - The reasonable cost incurred for the purchase of cer	tified HIT technology	Worksheet S-2,	184, 886	7. 00
	Part I line 168			1	
8.00	Calculation of the HIT incentive payment (see instructions)			120, 287	8. 00
9.00	Sequestration adjustment amount (see instructions)			0	9. 00
10.00	Calculation of the HIT incentive payment after sequestration (s	see instructions)		120, 287	10. 00
	I NPATI ENT HOSPI TAL SERVI CES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			0	30. 00
31.00	Other Adjustment (specify)			0	31.00
32 00	Ralance due provider (line 8 (or line 10) minus line 30 and lin	ne 31) (see instruction	(2)	120 287	32 00

32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)

120, 287 32. 00

Health Financial Systems		JAY COUNTY HOSP	I TAL		In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS		Provi der CCN	151320		Worksheet E-2
					From 10/01/2013	
			Component CC	N. 157220	To 00/20/2014	Data/Tima Droparod

			From 10/01/2013		
		Component CCN: 15Z320	To 09/30/2014	Date/Time Pre 2/25/2015 3:1	
		Title XVIII	Swing Beds - SNF	Cost	т рііі
			Part A	Part B	
			1. 00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES		<u> </u>		
1.00	Inpatient routine services - swing bed-SNF (see instructions)		706, 149	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part	A, and sum of Wkst. D,	177, 930	0	3.00
	Part V, columns 6 and 7, line 202 for Part B) (For CAH, see inst	ructions)			
4.00	Per diem cost for interns and residents not in approved teaching	program (see		0.00	4. 00
	instructions)				
5.00	Program days		445	0	5. 00
6.00	Interns and residents not in approved teaching program (see inst	ructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional metho	d only	0		7. 00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		884, 079	0	8. 00
9.00	Primary payer payments (see instructions)		6, 121	0	9. 00
10.00	Subtotal (line 8 minus line 9)		877, 958	0	10.00
11. 00	Deductibles billed to program patients (exclude amounts applicab	le to physician	0	0	11. 00
	professional services)				
	Subtotal (line 10 minus line 11)		877, 958	0	1
13. 00	Coinsurance billed to program patients (from provider records) (exclude coinsurance	4, 696	0	13. 00
14.00	for physician professional services)			0	14 00
	80% of Part B costs (line 12 x 80%)		070 040	0	
	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		873, 262	0	15.00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
	RURAL DEMONSTRATION PROJECT		0	0	16. 50
	Allowable bad debts (see instructions)		0	0	
	Adjusted reimbursable bad debts (see instructions)		0	0	
	Allowable bad debts for dual eligible beneficiaries (see instruc	tions)	070.00	0	
	Total (see instructions)		873, 262	0	
	Sequestration adjustment (see instructions)		17, 465	0	
	Interim payments		813, 839	0	20.00
	Tentative settlement (for contractor use only)	_	0	0	
	Balance due provider/program line 19 minus lines 19.01, 20 and 2		41, 958	0	
23. 00	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub. 15-2,	0	0	23. 00
	section 115.2				l

Health Financial Systems		JAY COUNTY HOSP	I TAL		In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS		Provi der CCN:	151320	Peri od:	Worksheet E-2
					From 10/01/2013	D-+- /T: D

		Component CCN: 15Z320	From 10/01/2013 To 09/30/2014	2/25/2015 3:1	
		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 instructions)		0		1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)		0		2. 00
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A		0		3. 00
	Part V, columns 6 and 7, line 202 for Part B) (For CAH, see inst				
4.00	Per diem cost for interns and residents not in approved teaching	program (see	0.00		4. 00
	instructions)				
5.00	Program days		0		5. 00
6.00	Interns and residents not in approved teaching program (see inst		0		6. 00
7. 00	Utilization review - physician compensation - SNF optional method	d only	0		7. 00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		0		8. 00
9. 00	Primary payer payments (see instructions)		0		9. 00
	Subtotal (line 8 minus line 9)		0		10.00
11. 00	Deductibles billed to program patients (exclude amounts applicable	le to physician	0		11. 00
	professional services)				
	Subtotal (line 10 minus line 11)		0		12. 00
13. 00	Coinsurance billed to program patients (from provider records) (exclude coinsurance	0		13. 00
	for physician professional services)				
	80% of Part B costs (line 12 x 80%)		0		14. 00
	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		0		15. 00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		16. 00
	RURAL DEMONSTRATION PROJECT		0		16. 50
	Allowable bad debts (see instructions)		0		17. 00
	Adjusted reimbursable bad debts (see instructions)		0		17. 01
	Allowable bad debts for dual eligible beneficiaries (see instruc	tions)	0		18. 00
	Total (see instructions)		0		19. 00
	Sequestration adjustment (see instructions)		0		19. 01
20. 00			0		20. 00
	Tentative settlement (for contractor use only)		0		21. 00
	Balance due provider/program line 19 minus lines 19.01, 20 and 2		0		22. 00
23. 00	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub. 15-2,	0		23. 00
	section 115.2				

Health Financial Systems	JAY COUNTY HOSPITAL		In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi	der CCN: 151320	From 10/01/2013	Worksheet E-3 Part V Date/Time Prepared: 2/25/2015 3:11 pm
	1	Title XVIII	Hospi tal	Cost

			10 09/30/2014	2/25/2015 3:1	
		Title XVIII	Hospi tal	Cost	<u> </u>
				1. 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART V - CALCULATION OF REIMBURSEMENT FOR MEDICARE PART V - CALCULATION OF REIMBURSEMENT FOR MEDICARE PART V - CALCULATION OF REIMBURSEMENT FOR MEDICARE PART V - CALCULATION OF REIMBURSEMENT FOR MEDICARE PART V - CALCULATION OF REIMBURSEMENT FOR MEDICARE PART V - CALCULATION OF REIMBURSEMENT FOR MEDICARE PART V - CALCULATION OF REIMBURSEMENT FOR MEDICARE PART V - CALCULATION OF REIMBURSEMENT FOR MEDICARE PART V - CALCULATION OF REIMBURSEMENT FOR MEDICARE PART V - CALCULATION OF REIMBURSEMENT FOR MEDICARE PART V - CALCULATION OF REIMBURSEMENT FOR V - CALCULATION OF REIMBURSEMENT FOR V - CALCULATION OF REIMBURSEMENT FOR V - CALCULATION OF REIMBURSEMENT FOR V - CALCULATION OF REIMBURSEMENT FOR V - CALCULATION OF REIMBURSEMENT FOR V - CAL	ART A SERVICES - COST	REIMBURSEMENT		
1.00	Inpatient services			1, 644, 378	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)		0	2. 00
3.00	Organ acqui si ti on			0	3. 00
4.00	Subtotal (sum of lines 1 thru 3)			1, 644, 378	4. 00
5.00	Pri mary payer payments			0	5. 00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			1, 660, 822	6. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable charges				
7.00	Routi ne servi ce charges			0	7. 00
8.00	Ancillary service charges			0	8. 00
9.00	Organ acquisition charges, net of revenue			0	9. 00
10.00	Total reasonable charges			0	10.00
	Customary charges				
11. 00	Aggregate amount actually collected from patients liable for page			0	11. 00
12.00	Amounts that would have been realized from patients liable for	payment for services o	n a charge basis	0	12.00
	had such payment been made in accordance with 42 CFR 413.13(e)				
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000	13.00
14.00	Total customary charges (see instructions)			0	14. 00
15.00	Excess of customary charges over reasonable cost (complete only	if line 14 exceeds li	ne 6) (see	0	15. 00
	instructions)				
16. 00	Excess of reasonable cost over customary charges (complete only	if line 6 exceeds lin	e 14) (see	0	16. 00
	instructions)			_	
17. 00	Cost of physicians' services in a teaching hospital (see instru	ctions)		0	17. 00
10.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT	11 10		0	40.00
18.00	Direct graduate medical education payments (from Worksheet E-4,	line 49)		-	18. 00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			1, 660, 822	
20.00	Deductibles (exclude professional component)			205, 184	•
21. 00	Excess reasonable cost (from line 16)			0	21. 00
22. 00	Subtotal (line 19 minus line 20 and 21)			1, 455, 638	
23. 00	Coinsurance			0	23. 00
24. 00	Subtotal (line 22 minus line 23)			1, 455, 638	
25. 00	Allowable bad debts (exclude bad debts for professional services	s) (see instructions)		55, 575	
26. 00	Adjusted reimbursable bad debts (see instructions)			42, 237	
27. 00	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		37, 145	
28. 00	Subtotal (sum of lines 24 and 25, or line 26)			1, 497, 875	
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
29. 99	Recovery of Accel erated Depreciation			0	
30.00	Subtotal (line 28, plus or minus lines 29)			1, 497, 875	
30. 01	Sequestration adjustment (see instructions)			29, 958	
31.00	Interim payments			1, 439, 479	
32. 00	Tentative settlement (for contractor use only)			0	
33. 00	Balance due provider/program line 30 minus lines 30.01, 31, and			28, 438	•
34. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2,	chapter 1,	0	34. 00
	§115. 2		l		l

			I PF		
				1. 00	
	PART II - MEDICARE PART A SERVICES - IPF PPS			1.00	
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education	ion payments)		1, 686, 100	1. 00
2.00	Net IPF PPS Outlier Payments			101, 069	2. 00
3.00	Net IPF PPS ECT Payments			0	3. 00
4. 00	Unweighted intern and resident FTE count in the most recent cost report	filed on or b	efore November	0.00	4. 00
	15, 2004. (see instructions)				
4. 01	Cap increases for the unweighted intern and resident FTE count for resident program or hospital closure, that would not be counted without a temporal §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00	4. 01
5.00	New Teaching program adjustment. (see instructions)			0.00	5. 00
6. 00	Current year's unweighted FTE count of I&R excluding FTEs in the new productions of I&R excluding FTEs in the n	aram arowth p	eriod of a "new	0.00	6. 00
	teaching program". (see inst.)	g g p			
7. 00	Current year's unweighted I&R FTE count for residents within the new proteaching program". (see inst.)	gram growth p	eriod of a "new	0. 00	7. 00
8.00	Intern and resident count for IPF PPS medical education adjustment (see	instructions)		0.00	8. 00
9.00	Average Daily Census (see instructions)	,		5. 794521	9. 00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of	f .5150 -1}.		0.000000	10.00
11. 00	Teaching Adjustment (line 1 multiplied by line 10).	•		o	11. 00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			1, 787, 169	12. 00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0	13. 00
14.00	Organ acquisition (DO NOT USE THIS LINE)				14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			o	15. 00
16. 00				1, 787, 169	16. 00
17. 00	Primary payer payments			0	17. 00
18. 00	Subtotal (line 16 less line 17).			1, 787, 169	
19. 00	Deducti bl es			100, 128	
20. 00	Subtotal (line 18 minus line 19)			1, 687, 041	
	Coinsurance			0	21. 00
22. 00	Subtotal (line 20 minus line 21)			1, 687, 041	
	Allowable bad debts (exclude bad debts for professional services) (see in	nstructions)		0	23. 00
24. 00	, , , , , , , , , , , , , , , , , , , ,	,		0	24. 00
25. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)			o	25. 00
26. 00				1, 687, 041	
27. 00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0	27. 00
	Other pass through costs (see instructions)			0	
29. 00	Outlier payments reconciliation			ol	29. 00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			o l	30.00
	, , , , ,			o	30. 99
31. 00	Total amount payable to the provider (see instructions)			1, 687, 041	
31. 01	Sequestration adjustment (see instructions)			33, 741	31. 01
32. 00	Interim payments			1, 653, 300	
33. 00	Tentative settlement (for contractor use only)			0	33. 00
34. 00	Balance due provider/program line 31 minus lines 31.01, 32 and 33			ő	34. 00
35. 00	Protested amounts (nonallowable cost report items) in accordance with CM	IS Pub 15-2	chapter 1	o l	35. 00
00.00	§115. 2	0 1 401 10 27	onapto,	Ĭ	00.00
	TO BE COMPLETED BY CONTRACTOR				
50. 00	Original outlier amount from Worksheet E-3, Part II, line 2			101, 069	50. 00
	Outlier reconciliation adjustment amount (see instructions)			0	51. 00
	The rate used to calculate the Time Value of Money			0.00	
	Time Value of Money (see instructions)				53. 00
	1			۰۱	

Health Financial Systems	JAY COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 151320	Peri od: Worksheet E-3
		From 10/01/2013 Part VII
		T- 00/20/2014 D-+-/T: D

09/30/2014 Date/Time Prepared: To 2/25/2015 3:11 pm Title XIX Hospi tal Cost Outpati ent Inpati ent 1.00 2.00 PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES COMPUTATION OF NET COST OF COVERED SERVICES 1.00 Inpatient hospital/SNF/NF services 135, 069 1.00 Medical and other services Ω 2.00 2.00 3.00 Organ acquisition (certified transplant centers only) 3.00 Subtotal (sum of lines 1, 2 and 3) 4.00 135, 069 4.00 5.00 Inpatient primary payer payments 5.00 Outpatient primary payer payments 6.00 Ω 6.00 7.00 Subtotal (line 4 less sum of lines 5 and 6) 135, 069 Ω 7.00 COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges 8.00 Routine service charges 84, 349 8.00 9.00 Ancillary service charges 167, 303 0 9.00 10.00 Organ acquisition charges, net of revenue 10.00 0 11 00 Incentive from target amount computation 11 00 0 12.00 Total reasonable charges (sum of lines 8 through 11) 251, 652 0 12.00 CUSTOMARY CHARGES 13.00 Amount actually collected from patients liable for payment for services on a charge 0 13.00 basi s Amounts that would have been realized from patients liable for payment for services on 14.00 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 0.000000 15.00 16.00 Total customary charges (see instructions) 251, 652 16.00 17.00 17.00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 116, 583 0 line 4) (see instructions) 18.00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 0 18.00 0 (see instructions) 19.00 Interns and Residents (see instructions) 0 0 19.00 20.00 Cost of physicians' services in a teaching hospital (see instructions) 0 20.00 0 21.00 Cost of covered services (enter the lesser of line 4 or line 16) 135, 069 0 21.00 PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers 22.00 0 0 22.00 Other than outlier payments 23.00 0 23.00 Outlier payments Λ 24.00 Program capital payments 0 24.00 0 25.00 Capital exception payments (see instructions) 25.00 26.00 26 00 Routine and Ancillary service other pass through costs 0 0 27.00 Subtotal (sum of lines 22 through 26) 0 27.00 28. 00 Customary charges (title V or XIX PPS covered services only) O 0 28.00 29.00 Titles V or XIX (sum of lines 21 and 27) 135, 069 0 29.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 30.00 Excess of reasonable cost (from line 18) 0 30.00 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 135, 069 0 31.00 32.00 Deducti bl es 32.00 0 0 33 00 33 00 Coi nsurance 0 0 34.00 Allowable bad debts (see instructions) 0 Ω 34.00 35.00 Utilization review 35.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 36, 00 135, 069 36, 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 37.00 0 37.00 38. 00 Subtotal (line 36 ± line 37) 135, 069 38.00 0 Direct graduate medical education payments (from Wkst. E-4) 39.00 39.00 40.00 40.00 Total amount payable to the provider (sum of lines 38 and 39) 0 135, 069 41.00 Interim payments 138, 708 0 41.00 Balance due provider/program (line 40 minus line 41) 42.00 -3, 639 0 42.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 43.00 0 43.00

chapter 1, §115.2

Health Financial Systems	JAY COUNTY HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 151320	Peri od: From 10/01/2013	Worksheet E-3 Part VII
	Component CCN: 15M320	To 09/30/2014	
	Title XIX	Subprovi der -	Cost

		Title XIX	Subprovi der - I PF	Cost	
			Inpati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICE	ES FOR TITLES V OR XIX	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		25, 481		1. 00
2.00	Medical and other services			0	2. 00
3.00	Organ acquisition (certified transplant centers only)		0		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		25, 481	0	4. 00
5.00	Inpatient primary payer payments		0	_	5. 00
6.00	Outpatient primary payer payments		05 404	0	6. 00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		25, 481	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
8. 00	Reasonable Charges Routine service charges		13, 934		8. 00
9. 00	Ancillary service charges		11, 606	0	9.00
10. 00	Organ acquisition charges, net of revenue		11,000	U	10.00
11. 00	Incentive from target amount computation		0		11. 00
12. 00	Total reasonable charges (sum of lines 8 through 11)		25, 540	0	12. 00
	CUSTOMARY CHARGES		20,010		12.00
13.00	Amount actually collected from patients liable for payment for se	rvices on a charge	0	0	13. 00
	basis	Ç .			
14.00	Amounts that would have been realized from patients liable for pa		0	0	14. 00
	a charge basis had such payment been made in accordance with 42 C	FR §413.13(e)			
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0. 000000	15. 00
16.00	Total customary charges (see instructions)		25, 540	0	16. 00
17. 00	Excess of customary charges over reasonable cost (complete only i	f line 16 exceeds	59	0	17. 00
18. 00	line 4) (see instructions) Excess of reasonable cost over customary charges (complete only i	fline 4 avecade line		0	18. 00
16.00	16) (see instructions)	Title 4 exceeds fille	U	U	16.00
19. 00	Interns and Residents (see instructions)		0	0	19. 00
20. 00	Cost of physicians' services in a teaching hospital (see instruct	ions)	0	0	20. 00
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)	. 5.1.5)	25, 481	0	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be com	pleted for PPS provide	rs.		
22. 00	Other than outlier payments		0	0	22. 00
23.00	Outlier payments		0	0	23. 00
24.00	Program capital payments		0		24. 00
25.00	Capital exception payments (see instructions)		0		25. 00
26. 00	Routine and Ancillary service other pass through costs		0	0	26. 00
27. 00	Subtotal (sum of lines 22 through 26)		0	0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		25, 481	0	29. 00
20.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		0	0	20.00
30. 00 31. 00	Excess of reasonable cost (from line 18) Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		25, 481	0	30. 00 31. 00
31.00	Deductibles		25, 481	0	31.00
33. 00	Coinsurance		0	0	33. 00
34. 00	Allowable bad debts (see instructions)		0	0	34. 00
35. 00	Utilization review		0	· ·	35. 00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	25, 481	0	36. 00
37. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	,	0	0	37. 00
38. 00	Subtotal (line 36 ± line 37)		25, 481	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)		25, 481	0	40. 00
41. 00	Interim payments		16, 374	0	41. 00
42.00	Balance due provider/program (line 40 minus line 41)		9, 107	0	42. 00
43. 00	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub 15-2,	0	0	43. 00
	chapter 1, §115.2		1		

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

Provi der CCN: 151320 | Peri od: | From 10/01/2013 | To 09/30/2014

| Period: | Worksheet G | From 10/01/2013 | To 09/30/2014 | Date/Time Prepared: 2/25/2015 3:11 pm |

				077 007 2011	2/25/2015 3: 1	1 pm
		General Fund	Speci fi c	Endowment Fund		
			Purpose Fund			
		1. 00	2. 00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	6, 456, 790)	0	0	1. 00
2.00	Temporary investments	0)	0	0	2. 00
3.00	Notes receivable	0		0	0	3. 00
4.00	Accounts receivable	11, 178, 708	3	0	0	4.00
5.00	Other recei vable	0		o	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	0) (0	0	6.00
7.00	Inventory	653, 330		0	0	7. 00
8. 00	Prepaid expenses	0		0	0	
9. 00	Other current assets	0		0	0	
10. 00	Due from other funds	0		0	0	
11. 00	Total current assets (sum of lines 1-10)	18, 288, 828	3	0		
11.00	FIXED ASSETS	10, 200, 020	1	<u>, </u>		11.00
12. 00	Land	220, 245	j (0	0	12. 00
13. 00	Land improvements	220, 243	1		0	
14. 00	Accumulated depreciation		1			
15. 00	Buildings	12, 441, 766	1		0	
16. 00	Accumulated depreciation	12, 441, 700	1		0	
		0		-	0	1
17. 00	Leasehold improvements	0			-	
18.00	Accumulated depreciation	0		0	0	
19. 00	Fi xed equipment	0		0	0	
20. 00	Accumulated depreciation	0		0	0	
21. 00	Automobiles and trucks	0	1	0	0	
22. 00	Accumul ated depreciation	0	1	0	0	
23. 00	Major movable equipment	0)	0	0	1
24. 00	Accumul ated depreciation	0)	0	0	
25. 00	Mi nor equi pment depreci abl e	0) (0	0	
26. 00	Accumul ated depreciation	0) (0	0	26. 00
27. 00	HIT designated Assets	0)	0	0	27. 00
28. 00	Accumul ated depreciation	0)	0	0	28. 00
29.00	Mi nor equi pment-nondepreci abl e	0) (0	0	29. 00
30.00	Total fixed assets (sum of lines 12-29)	12, 662, 011		0	0	30.00
	OTHER ASSETS					
31.00	Investments	0) (0	0	31. 00
32.00	Deposits on Leases	0		0	0	32. 00
33.00	Due from owners/officers	0		o	0	33. 00
34.00	Other assets	15, 235, 591		0	0	34.00
35. 00	Total other assets (sum of lines 31-34)	15, 235, 591		0	0	35. 00
36.00	Total assets (sum of lines 11, 30, and 35)	46, 186, 430	1	0	0	36.00
	CURRENT LIABILITIES		•			
37. 00	Accounts payable	758, 337	' (0	0	37. 00
38. 00	Salaries, wages, and fees payable	1, 434, 761	1	0	0	
39. 00	Payrol I taxes payable	1, 101, 701	1	0	0	
40. 00	Notes and Loans payable (short term)	0			0	
41. 00	Deferred income	١		o o	0	
42. 00	Accel erated payments	0	\(\)			42. 00
43. 00	Due to other funds				0	1
44. 00	Other current liabilities	117, 408	()		0	
			1	1		
45. 00	Total current liabilities (sum of lines 37 thru 44) LONG TERM LIABILITIES	2, 310, 506	y (0	0	45. 00
47 00				1 0	0	4/ 00
46. 00	Mortgage payable	0	1	·		
47. 00	Notes payable	0	1	0	-	1
48. 00	Unsecured Loans	0	1	0	0	
49. 00	Other long term liabilities	0	1	0	0	1
50. 00	Total long term liabilities (sum of lines 46 thru 49	0)			
51. 00	Total liabilites (sum of lines 45 and 50)	2, 310, 506) (0	0	51. 00
	CAPITAL ACCOUNTS					
52. 00	General fund balance	43, 875, 924				52. 00
53. 00	Specific purpose fund					53. 00
54. 00	Donor created - endowment fund balance - restricted			0		54. 00
55. 00	Donor created - endowment fund balance - unrestricted		1	0		55. 00
56.00	Governing body created - endowment fund balance		1	0		56. 00
57.00	Plant fund balance - invested in plant				0	
58.00	Plant fund balance - reserve for plant improvement,				0	58. 00
	repl acement, and expansion					
59. 00	Total fund balances (sum of lines 52 thru 58)	43, 875, 924	. (0	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	46, 186, 430)	0	0	60.00
	[59]					

					To 09/30/201	14 Date/Time Pre 2/25/2015 3:1	pared:
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2. 00	3. 00	4. 00	5. 00	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 14.00 15.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) ROUNDING	0 0 0 0 0 0 0	42, 002, 985 1, 872, 965 43, 875, 950 0 43, 875, 950	0, 50	0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
16. 00 17. 00 18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0	26 43, 875, 924 Pl ant	Fund	0 0	0 0	16. 00
		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	0.00	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) ROUNDING 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		10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

		-	Го 09/30/2014				
	Cost Center Description	Inpatient	Outpati ent	2/25/2015 3: 1 Total	I pm		
	cost center bescription	1.00	2. 00	3. 00			
	PART I - PATIENT REVENUES	1.00	2.00	0.00			
	General Inpatient Routine Services						
1.00	Hospi tal	3, 735, 13	7	3, 735, 137	1.00		
2.00	SUBPROVI DER - I PF	1, 480, 260		1, 480, 260	2. 00		
3.00	SUBPROVI DER - I RF			0	3.00		
4.00	SUBPROVI DER			0	4. 00		
5.00	Swing bed - SNF			0	5.00		
6.00	Swing bed - NF			0	6.00		
7.00	SKILLED NURSING FACILITY				7. 00		
8.00	NURSING FACILITY				8. 00		
9.00	OTHER LONG TERM CARE				9. 00		
10.00	Total general inpatient care services (sum of lines 1-9)	5, 215, 39	7	5, 215, 397	1		
	Intensive Care Type Inpatient Hospital Services						
11.00	INTENSIVE CARE UNIT	(0	11. 00		
12.00	CORONARY CARE UNIT				12. 00		
13.00	BURN INTENSIVE CARE UNIT				13. 00		
14.00	SURGICAL INTENSIVE CARE UNIT				14. 00		
15.00	OTHER SPECIAL CARE (SPECIFY)				15. 00		
16.00	Total intensive care type inpatient hospital services (sum of lines			0	16. 00		
	11-15)						
17.00	Total inpatient routine care services (sum of lines 10 and 16)	5, 215, 39	7	5, 215, 397	17. 00		
18.00	Ancillary services	7, 653, 022	56, 336, 677	63, 989, 699	18. 00		
19.00	Outpati ent servi ces	185, 686	10, 750, 214	10, 935, 900	19. 00		
20.00	RURAL HEALTH CLINIC		o	0	20. 00		
21.00	FEDERALLY QUALIFIED HEALTH CENTER		ol ol	0	21. 00		
22.00	HOME HEALTH AGENCY				22. 00		
23.00	AMBULANCE SERVI CES				23. 00		
24.00	CMHC				24. 00		
24. 10	CORF		0	0	24. 10		
25.00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00		
26.00	HOSPI CE				26. 00		
27. 00	PHYSI CI AN OFFI CES		5, 273, 394	5, 273, 394	27. 00		
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	13, 054, 10	72, 360, 285	85, 414, 390	28. 00		
	G-3, line 1)						
	PART II - OPERATING EXPENSES						
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		36, 546, 003		29. 00		
30.00	ADD (SPECIFY)				30. 00		
31. 00					31. 00		
32. 00		1			32. 00		
33. 00		1			33. 00		
34. 00		1			34.00		
35. 00					35. 00		
36. 00	Total additions (sum of lines 30-35)		0		36. 00		
37. 00	DEDUCT (SPECIFY)				37. 00		
38. 00		1			38. 00		
39.00		1			39.00		
40.00					40.00		
41. 00	Tatal daduations (com a6 lines 27 44)	1			41.00		
42. 00	Total deductions (sum of lines 37-41)		0 547 222		42.00		
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer		36, 546, 003		43. 00		
	to Wkst. G-3, line 4)	I	1		I		

Heal th	th Financial Systems JAY COUNTY HOSPITAL In Li		eu of Form CMS-2552-10			
STATEMENT OF REVENUES AND EXPENSES Provider CCN: 151320 Period:			Worksheet G-3			
			From 10/01/2013			
			To 09/30/2014	Date/Time Pre 2/25/2015 3:1		
				2/23/2013 3.1	Pill	
				1. 00		
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line	28)		85, 414, 390	1. 00	
2.00	Less contractual allowances and discounts on patients' accounts			49, 098, 588	2. 00	
3.00	Net patient revenues (line 1 minus line 2)			36, 315, 802	3. 00	
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)		36, 546, 003	4. 00	
5.00	Net income from service to patients (line 3 minus line 4)			-230, 201	5. 00	
	OTHER I NCOME					
6.00	Contributions, donations, bequests, etc			0	6. 00	
7.00	Income from investments			0	7. 00	
8.00	Revenues from telephone and other miscellaneous communication services			0	8. 00	
9.00	Revenue from television and radio service			0	9. 00	
10.00	Purchase di scounts			0	10.00	
	Rebates and refunds of expenses			0	11. 00	
	Parking lot receipts			0	12.00	
	Revenue from Laundry and Linen service			0	13.00	
	Revenue from meals sold to employees and guests			0	14. 00	
	Revenue from rental of living quarters			0	15. 00	
	Revenue from sale of medical and surgical supplies to other than patients			0	16. 00	
	Revenue from sale of drugs to other than patients			0	17. 00	
	Revenue from sale of medical records and abstracts			0	18. 00	
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00	
	Revenue from gifts, flowers, coffee shops, and canteen			0	20. 00	
	Rental of vending machines			0	21. 00	
	Rental of hospital space			0	22. 00	
	Governmental appropriations			0	23. 00	
24. 00	OTHER INCOME			2, 103, 166	24. 00	

2, 103, 166 1, 872, 965

0 27.00

1, 872, 965 29. 00

25. 00 26. 00

28. 00

25.00 Total other income (sum of lines 6-24)
26.00 Total (line 5 plus line 25)

28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)

27. 00