ayments	made since	the bec	gi nni ng	of the	cost	reportin	ig period	bei ng	deemed (	overpay	yments	(42	USC	1395g).		0938-0050 05-31-2019
OSPI TAI	AND HOSPLT	AL HEALT	TH CARE	COMPLEX	COST	REPORT	CERTLELCA	NOITA	Provi de	r CCN:	15-1320	) [	Peri	od.	Workshee	ot S

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provi der CCN: 15-1320		Worksheet S Parts I-III Date/Time Prepared: 2/27/2017 10:39 am
---	------------------------	--	---

					2/27/2017 1	0:39 am
PART I - COST	REPORT STATUS					
Provi der	1. [ X ] Electronically filed cost	report		Date: 2/27/20	17 Time:	10: 39 a
use only	2. [ ] Manually submitted cost r	report				
	3. [ 0 ] If this is an amended rep 4. [ F ] Medicare Utilization. Ent			esubmitted this co	st report	
Contractor use only	(2) Settled without Audit 8. [	ontractor No.	11.0 this Provider CCN 12.	NPR Date: Contractor's Vendo [ O ]If line 5, co	lumn 1 is 4:	

## PART II - CERTIFICATION

(3) Settled with Audit

(4) Reopened (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 ( 15-1320 ) for the cost reporting period beginning 10/01/2015 and ending 09/30/2016 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		

number of times reopened = 0-9.

Date

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
·	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	-60, 885	-345, 780	0	0	1. 00
2.00	Subprovider - IPF	0	6	0		-2, 832	2. 00
3.00	Subprovider - IRF	0	0	0		0	3. 00
4.00	SUBPROVI DER I						4.00
5.00	Swing bed - SNF	0	-54, 232	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	-115, 111	-345, 780	0	-2, 832	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.

	and brangere		1		ł ł		1	ł	ł	
19. 00	Other						<u> </u>			19. 00
						From		To	:	
						1.00	)	2.0	00	
20.00	Cost Reporting Period (mm/dd/yyyy)					10/01/2	015	09/30/	′2016	20.00
21.00	Type of Control (see instructions)					9				21. 00
	Inpatient PPS Information					·				]
22.00	Does this facility qualify and is it	currently receiving pay	ments for	di spropo	rti onate	N				22. 00
	share hospital adjustment, in accord									
	for yes or "N" for no. Is this facil									
	amendment hospital?) In column 2, en			. , ,	. , .					
22. 01	Did this hospital receive interim un	compensated care payment	s for thi	s cost re	eporting	N		N		22. 01
	period? Enter in column 1, "Y" for y									
	reporting period occurring prior to									
	for no for the portion of the cost r									
	(see instructions)	. 3.	3							
22. 02	Is this a newly merged hospital that	requires final uncomper	sated car	e payment	s to be	N		N		22. 02
	determined at cost report settlement	? (see instructions) Ent	er in col	umn 1, "Y	" for yes					
	or "N" for no, for the portion of th	e cost reporting period	prior to	October 1	. Enter					
	in column 2, "Y" for yes or "N" for									
	or after October 1.			. 3	•					
22. 03	Did this hospital receive a geograph	ic reclassification from	n urban to	rural as	a result	N		N		22. 03
	of the OMB standards for delineating	statistical areas adopt	ed by CMS	in FY201	5? Enter					
	in column 1, "Y" for yes or "N" for	no for the portion of th	ne cost re	porting p	eri od					
	prior to October 1. Enter in column	2, "Y" for yes or "N" for	or no for	the porti	on of the					
	cost reporting period occurring on o									
	hospital contain at least 100 but no	t more than 499 beds (as	counted	in accord	dance with					
	42 CFR 412.105)? Enter in column 3,	"Y" for yes or "N" for r	10.							
23.00	Which method is used to determine Me	dicaid days on lines 24	and/or 25	below? I	n column		3	N		23. 00
	1, enter 1 if date of admission, 2 i	f census days, or 3 if c	late of di	scharge.	Is the					
	method of identifying the days in th	is cost reporting period	differen	t from th	ne method					
	used in the prior cost reporting per	iod? In column 2, enter	"Y" for	yes or "N	l" for no.					
		In-Sta	ite In-St	tate Ou	it-of (	Out-of I	ledi ca	id 0	ther	

unpai d paid days el i gi bl e unpai d days 1.00 2.00 3. 00 4. 00 5. 00 6.00 24.00 | If this provider is an IPPS hospital, enter the 24. 00 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. O 0 25 00 25.00 If this provider is an IRF, enter the in-state 0 O Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.

Medi cai d

paid days

Medi cai d

eligible

State

Medi cai d

State

Medi cai d

HMO days

Medi cai d

days

IUSFI IAL F	AND HOSPITAL HEALTH CARE COMPL	EX IDENTIFICATION DA	TA	Provi der CC		eriod: com 10/01/2015	Worksheet S-2 Part I	
					To			pared: 37 am
			Y/N	IME	Direct GME	I ME	Direct GME	
4 0/			1. 00	2. 00	3. 00	4.00	5.00	(1.0
used	er the amount of ACA §5503 aw d for cap relief and/or FTEs e or general surgery. (see in	that are nonprimary		0.00	0.00			61.0
'		,	Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
				1.00	2. 00	3. 00	4.00	
spec for colu prog unwe	the FTEs in line 61.05, specicialty, if any, and the numbe each new program. (see instrumn 1, the program name, ente gram code, enter in column 3, eighted count and enter in counweighted count.	r of FTE residents uctions) Enter in r in column 2, the the IME FTE				0. 00	0.00	61. 1
progressi ins ente 3,	the FTEs in line 61.05, speci gram specialty, if any, and t idents for each expanded prog tructions) Enter in column 1, er in column 2, the program co the IME FTE unweighted count direct GME FTE unweighted cou	ne number of FTE ram. (see the program name, ode, enter in column and enter in column				0. 00	0. 00	61. 2
.,							1.00	
	Provisions Affecting the Hea							
you	er the number of FTE resident r hospital received HRSA PCRE	funding (see instruc	tions)					62.0
duri	er the number of FTE residenting in this cost reporting pe	riod of HRSA THC prog	ıram. (s	<u>ee instruction</u>		your hospital	0.00	62.0
3.00 Has	ching Hospitals that Claim Re your facility trained reside for yes or "N" for no in col	nts in nonprovider se	ettings	during this co		eri od? Enter	N	63. 0
	,	, , , , , , , , , , , , , , , , , , ,			Unwei ghted FTEs Nonprovi der	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	,
					Si te			
Sec.	tion 5504 of the ACA Base Yea	r FTE Residents in No	onprovi d	der SettingsT	1.00 This base year	2.00 is your cost r	a.00 eporting	
4.00 Entering in resingue.	iod that begins on or after Jer in column 1, if line 63 is the base year period, the num ident FTEs attributable to rotings. Enter in column 2 the ident FTEs that trained in yo (column 1 divided by (column	yes, or your facilit per of unweighted non tations occurring in number of unweighted ur hospital. Enter in	y train i-primar all non I non-pr i column	ed residents by care provider imary care 3 the ratio	0.00	0.00	0. 000000	64.0
		Program Name	Pro	ogram Code	Unwei ghted FTEs Nonprovi der	Unwei ghted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	,
		1.00		2.00	Si te 3. 00	4.00	5.00	-
is section is section to the color of the co	er in column 1, if line 63 yes, or your facility ined residents in the base r period, the program name ociated with primary care s for each primary care gram in which you trained idents. Enter in column 2, program code, enter in umn 3, the number of eighted primary care FTE idents attributable to ations occurring in all -provider settings. Enter in umn 4, the number of eighted primary care ident FTEs that trained in				0.00	0.00	0. 000000	65.0

lealth Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLE)		Provi der CC1	N: 15-1320			Worksheet S-Part I Date/Time Pro 2/27/2017 10	epared:
					1. 00	2. 00	-
133.00 If this is a Medicare certified ot in column 1 and termination date,			cation dat		1.00	2.00	133. 00
134.00 If this is an organ procurement or and termination date, if applicable		he OPO number i	n column 1				134. 00
All Providers  140.00 Are there any related organization chapter 10? Enter "Y" for yes or "I are claimed, enter in column 2 the	N" for no in column 1. If	yes, and home	office cos		Y		140. 00
1.00	2. (	•			3. 00		
If this facility is part of a chai				e name and	d address	of the	
<pre>home office and enter the home off 41.00 Name:</pre>	Contractor name and c	contractor numbe		ctor's Nu	ımhar:		141. 00
42. 00 Street:	PO Box:		Contra	CLUI S NU	illiber.		142. 0
43. 00 Ci ty:	State:		Zip Co	de:			143. 0
<u> </u>							
						1. 00	
44.00 Are provider based physicians' cos	ts included in Worksheet	A?				Y	144. 0
					1. 00	2. 00	-
45.00 If costs for renal services are cla	aimed on Wkst. A. line 74	. are the costs	for		N N	2.00	145. 0
inpatient services only? Enter "Y" no, does the dialysis facility inc period? Enter "Y" for yes or "N"	for yes or "N" for no in Lude Medicare utilization for no in column 2.	column 1. If confirmation for this cost	olumn 1 is reporting				
46.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/d	column 1. (See CMS Pub.			lf	N		146. 0
						1. 00	
47.00 Was there a change in the statistic	cal basis? Enter "Y" for	yes or "N" for I	no.			N	147. 0
48.00 Was there a change in the order of						N	148. 0
49.00 Was there a change to the simplific	ed cost finding method? E					N	149. 0
		Part A 1.00	Part E 2.00		itle V 3.00	1 tle XIX 4.00	
Does this facility contain a provi	der that qualifies for an			cation of			
or charges? Enter "Y" for yes or "							
55. 00 Hospi tal	·	N	N		N	N	<b>1</b> 55. 0
56.00 Subprovi der - IPF		N	N		N	N	156. 0
57. 00 Subprovi der - I RF		N	N		N	N	157. 0
58. 00 SUBPROVI DER 59. 00 SNF		N	N		N	N	158. 0 159. 0
60. OO HOME HEALTH AGENCY		N N	N		N	N	160. 0
61. 00 CMHC			N		N	N	161. 0
61. 10 CORF			N		N	N	161. 1
M. I. 4.1						1. 00	
Multicampus 65.00 Is this hospital part of a Multical Enter "Y" for yes or "N" for no.	mpus hospital that has on	ne or more campus	ses in dif	ferent CE	BSAs?	N	165. 0
	Name	County		Zip Code	CBSA	FTE/Campus	
(( 00  5   ) 4/5	0	1. 00	2. 00	3. 00	4. 00	5. 00	04::
66.00 ffline 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.0	0 166. 0
Uselah Jafannasi T. J. J. Cut		D	Dala :			1.00	
Health Information Technology (HIT 67.00 sthis provider a meaningful user 68.00 of this provider is a CAH (line 10.00 of the content of the c	under §1886(n)? Enter "	Y" for yes or "I	N" for no.		tho.	N	167. 0
reasonable cost incurred for the H 68.01 If this provider is a CAH and is no	IT assets (see instructio	ons)					0168. 0 168. 0
exception under §413.70(a)(6)(ii)?							0169. 0

Health Financial Systems JAY COUNTY HOSPITAL					In Lieu of Form CMS-2552-10			
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	Peri	od: 1 10/01/2015	Worksheet S-2 Part I	2				
	To					oparod:		
		10	09/30/2010	Date/Time Pro 2/27/2017 10:	37 am			
				Begi nni ng	Endi ng			
				1. 00	2. 00			
170.00 Enter in columns 1 and 2 the EHR beginner period respectively (mm/dd/yyyy)		10/01/2015	09/30/2016	170. 00				
				1. 00	2.00			
171.00 If line 167 is "Y", does this provide	der have any days for indiv	viduals enrolled in		N		0171.00		
section 1876 Medicare cost plans rep								
"Y" for yes and "N" for no in column	n 1. If column 1 is yes, er	nter the number of section	on					
1876 Medicare days in column 2. (see	e instructions)							

1 17	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C			Date/Time Pro 2/27/2017 10:	epared:
				Y/N 1. 00	2. 00	
1	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	for all NO re	esponses. Ente			
	Provider Organization and Operation					+
o [	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in co			N		1.0
			Y/N	Date	V/I	
		0.16	1.00	2. 00	3. 00	
	Has the provider terminated participation in the Medicare Pryes, enter in column 2 the date of termination and in column voluntary or "I" for involuntary.		N			2.0
	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other relationships? (see instructions)	fices, drug r or its the board	N			3. 00
	Teratronships: (See Thistructions)		Y/N	Type	Date	
			1. 00	2. 00	3. 00	
	Financial Data and Reports  Column 1: Were the financial statements prepared by a Certi	fied Dublie	l N	С	1	4
	Accountant? Column 2: If yes, enter "A" for Audited, "C" fo or "R" for Reviewed. Submit complete copy or enter date avai column 3. (see instructions) If no, see instructions.	r Compiled,	IN IN			4.00
	Are the cost report total expenses and total revenues differ		N			5. 0
	those on the filed financial statements? If yes, submit reco	nciliation.		Y/N	Legal Oper.	
				1. 00	2. 00	
	Approved Educational Activities					
	Column 1: Are costs claimed for nursing school? Column 2:	If yes, is th	ne provider is	N		6.00
	the legal operator of the program?  Are costs claimed for Allied Health Programs? If "Y" see ins	tructions		N	+	7. 0
)	Were nursing school and/or allied health programs approved a cost reporting period? If yes, see instructions.	nd/or renewed	Ü	N		8. 00
	Are costs claimed for Interns and Residents in an approved g		cal education	N		9.00
00	program in the current cost report? If yes, see instructions Was an approved Intern and Resident GME program initiated or cost reporting period? If yes, see instructions.		the current	N		10.00
00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N	V/AI	11. 00
					1. 00	
	Bad Debts				1.00	
00	Is the provider seeking reimbursement for bad debts? If yes, If line 12 is yes, did the provider's bad debt collection po			st reporting	Y N	12. 00 13. 00
00 [	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-paymen	ts waived? If	yes, see ins	tructi ons.	N	14. 0
- +	Bed Complement Did total beds available change from the prior cost reportin	<del>-</del>		ructions.	N N	15. 0
		Y/N	Tt A Date	Y/N	nt B Date	
		1. 00	2.00	3. 00	4. 00	
	PS&R Data					
	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)	Υ	01/18/2017	Y	01/18/2017	16.00
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	N		N		17.00
00	in columns 2 and 4. (see instructions)  If line 16 or 17 is yes, were adjustments made to PS&R  Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		18.00
00	cost report? If yes, see instructions.  If line 16 or 17 is yes, were adjustments made to PS&R  Report data for corrections of other PS&R Report	N		N		19. 0

Heal th	Financial Systems JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS	-2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der CC	CN: 15-1320	Peri od: From 10/01/2015 To 09/30/2016	Worksheet S- Part II Date/Time Pr 2/27/2017 10	epared:
		Descri	ption	Y/N	Y/N	7. 07 4111
		C		1. 00	3. 00	
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20. 00
	Integer t data for other beson be the other day astheres.	Y/N	Date	Y/N	Date	
21 00	Was the seat warmed and or or in the seat deal or	1.00 N	2. 00	3. 00 N	4. 00	21.00
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	IV		IN		21. 00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS HO	OSPI TALS)	'		
	Capital Related Cost					
22. 00	Have assets been relifed for Medicare purposes? If yes, see				N	22. 00
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to apprais	als made dur	ing the cost	N	23. 00
24. 00	Were new leases and/or amendments to existing leases entere If yes, see instructions	ed into during	this cost re	porting period?	N	24. 00
25. 00	Have there been new capitalized leases entered into during	the cost repor	ting period?	If yes, see	N	25. 00
26. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acquired during th	ne cost reporti	ng period? I	f yes, see	N	26. 00
27. 00	instructions. Has the provider's capitalization policy changed during the	e cost reportin	g period? If	yes, submit	N	27. 00
	Interest Expense					
28. 00	Were new loans, mortgage agreements or letters of credit er period? If yes, see instructions.	ntered into dur	ing the cost	reporting	N	28. 00
29. 00						
30. 00						
31. 00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.					
32. 00	Purchased Services Have changes or new agreements occurred in patient care ser		d through co	ntractual	N	32. 00
33. 00	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.		g to competi	tive bidding? If	N	33. 00
	Provi der-Based Physi ci ans					
34. 00	Are services furnished at the provider facility under an ar	rangement with	provi der-ba	sed physi ci ans?	Υ	34. 00
35. 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended exi		ts with the	provi der-based	Υ	35. 00
	physicians during the cost reporting period? If yes, see in	istructions.		Y/N	Date	
				1.00	2. 00	
	Home Office Costs			1.00	2.00	
36. 00	Were home office costs claimed on the cost report?			N		36.00
	If line 36 is yes, has a home office cost statement been pr If yes, see instructions.	repared by the	home office?			37. 00
38. 00	If line 36 is yes , was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end			N		38. 00
39. 00	If line 36 is yes, did the provider render services to other			, N		39. 00
40. 00	see instructions. If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see	N		40. 00
		1. (	20	2.0	00	
	Cost Report Preparer Contact Information	1. (	30	2.1	00	
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	TI NA		SEVERS		41. 00
42. 00		BLUE & CO., LLO	0			42. 00
43. 00	preparer. Enter the telephone number and email address of the cost	317-713-7946		TSEVERS@BLUEANI	DCO. COM	43. 00
	report preparer in columns 1 and 2, respectively.					

Health Financial Systems	JAY COUNT	TY HOSPI TAL		In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE I	REIMBURSEMENT QUESTIONNAIRE	Provi der CC		Peri od:	Worksheet S-2	
				From 10/01/2015 To 09/30/2016	Part II   Date/Time Pre	narod:
				10 09/30/2010	2/27/2017 10:	37 am
		3. (	00			
Cost Report Preparer Contact	Information					
41.00 Enter the first name, last r		MANAGER				41.00
held by the cost report prep	arer in columns 1, 2, and 3,					
respectively.						
42.00 Enter the employer/company r	ame of the cost report					42. 00
preparer.						
43.00 Enter the telephone number a						43. 00
report preparer in columns 1	and 2, respectively.					

In Lieu of Form CMS-2552-10

| Period: | Worksheet S-3 |
| From 10/01/2015 | Part |
| To 09/30/2016 | Date/Time Prepared: | 2/27/2017 | 10:37 am

							2/27/2017 10:	37 am
							I/P Days / O/P	
							Visits / Trips	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours	Title V	
		Line Number			Avai I abl e			
		1. 00		2.00	3. 00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		25	9, 150	60, 288. 00	0	1. 00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2.00
3.00	HMO I PF Subprovi der							3. 00
4.00	HMO I RF Subprovi der							4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF						0	6. 00
7. 00	Total Adults and Peds. (exclude observation			25	9, 150	60, 288. 00	0	7. 00
0.00	beds) (see instructions)	04.00				0.00		0.00
8. 00	INTENSIVE CARE UNIT	31. 00		0		0.00	0	8. 00
9. 00	CORONARY CARE UNIT							9. 00
10.00	BURN INTENSIVE CARE UNIT							10.00
11. 00	SURGICAL INTENSIVE CARE UNIT							11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						_	12.00
13. 00	NURSERY	43. 00					0	13. 00
14. 00	Total (see instructions)			25	9, 150	60, 288. 00		14. 00
15. 00	CAH visits						0	15. 00
16.00	SUBPROVI DER - I PF	40. 00		10	3, 660		0	16.00
17. 00	SUBPROVI DER - I RF	41. 00		0	9		0	17. 00
18.00	SUBPROVI DER	42. 00		O	(	)	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	00.00						24.00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25. 00	CMHC - CMHC	00.10						25. 00
25. 10	CMHC - CORF	99. 10					0	25. 10
26. 00	RURAL HEALTH CLINIC	88. 00					0	26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00		0.5			0	26. 25
27. 00	Total (sum of lines 14-26)			35				27. 00
28. 00	Observation Bed Days						0	28. 00
29. 00	Ambul ance Tri ps							29. 00
30.00	Employee discount days (see instruction)							30.00
31. 00	Employee discount days - IRF							31.00
32.00	Labor & delivery days (see instructions)			0	'			32.00
32. 01	Total ancillary labor & delivery room							32. 01
22.00	outpatient days (see instructions)							22.00
33.00	LTCH non-covered days		l		I	1	l l	33. 00

Health Financial Systems JAY
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-1320

| Peri od: | Worksheet S-3 | From 10/01/2015 | Part I | To 09/30/2016 | Date/Time Prepared:

				''	0 07/30/2010	2/27/2017 10:	
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	97 diii
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6.00	7. 00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	1, 264	0	2, 512			1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	76	86				2.00
3.00	HMO IPF Subprovider	46	35				3. 00
4.00	HMO I RF Subprovi der	0	0				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	560	0				5. 00
6.00	Hospital Adults & Peds. Swing Bed NF	4 004	0				6.00
7. 00	Total Adults and Peds. (exclude observation	1, 824	0	3, 210			7. 00
8. 00	beds) (see instructions)	0	0	0			8. 00
9. 00	INTENSIVE CARE UNIT	U	U	U			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		0	126			13. 00
14. 00	Total (see instructions)	1, 824	0		0.00	292. 36	•
15. 00	CAH visits	1, 624	0		0.00	272.30	15. 00
16. 00	SUBPROVIDER - IPF	848	24		0.00	14. 92	•
17. 00	SUBPROVIDER - I RF	040	0		0.00	l e	1
18. 00	SUBPROVI DER		0	0	0.00	l e	1
19. 00	SKILLED NURSING FACILITY		O	l o	0.00	0.00	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)	0	0	0			24. 10
25. 00	CMHC - CMHC						25. 00
25. 10	CMHC - CORF	o	0	0	0.00	0.00	25. 10
26. 00	RURAL HEALTH CLINIC	0	0	0	0.00		ł
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	l e	ı
27. 00	Total (sum of lines 14-26)				0.00	307. 28	27. 00
28. 00	Observation Bed Days		0	145			28. 00
29. 00	Ambul ance Tri ps	o					29. 00
30.00	Employee discount days (see instruction)			0			30. 00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	o	0	0			32.00
32. 01	Total ancillary labor & delivery room			0			32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days	0					33. 00

				Ť	09/30/2016	Date/Time Pre 2/27/2017 10:	
		Full Time Equivalents	-	Di sch	arges		
	Component	Nonpai d 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)		(	302		779	1.00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)			28	0		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY						8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
14. 00 15. 00	Total (see instructions) CAH visits	0. 00	(	362	43	779	14. 00 15. 00
16. 00	SUBPROVIDER - IPF	0. 00	(	78	4	174	16.00
17. 00	SUBPROVI DER - I RF	0.00	(	1	0	0	17. 00
18. 00	SUBPROVI DER	0. 00	(		O	0	18. 00
19. 00 20. 00 21. 00 22. 00 23. 00 24. 00	SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P. ) HOSPICE						19. 00 20. 00 21. 00 22. 00 23. 00 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					26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00 29. 00	Observation Bed Days Ambulance Trips						28. 00 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

LUCDII	Financial Systems  AL UNCOMPENSATED AND INDIGENT CARE DATA  JAY COUNTY	HOSPITAL Provider CCN: 15-1	1220 D	eri od:	u of Form CMS-2 Worksheet S-10					
позетт	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN. 15-1		rom 10/01/2015	WOLKSHEET 3-10	U				
			T	0 09/30/2016	Date/Time Prep 2/27/2017 10:3					
					1. 00					
	Uncompensated and indigent care cost computation				1.00					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 Medicaid (see instructions for each line)	divided by line 202	col umn	8)	0. 318752	1.00				
2.00	Net revenue from Medicaid				755, 629	2. 00				
3.00	Did you receive DSH or supplemental payments from Medicaid?					3. 00				
4.00	If line 3 is "yes", does line 2 include all DSH or supplement	ntal payments from Me	edi cai d?			4. 00				
5.00	If line 4 is "no", then enter DSH or supplemental payments 1	from Medicaid			0					
6.00	Medi cai d charges				6, 514, 438					
7. 00	Medicaid cost (line 1 times line 6)		2, 076, 490	1						
8. 00	Difference between net revenue and costs for Medicaid progra < zero then enter zero)		of lines	s 2 and 5; if	1, 320, 861	8. 00				
	Children's Health Insurance Program (CHIP) (see instructions	s for each line)								
9.00	Net revenue from stand-alone CHIP				0					
10.00	Stand-allone CHIP charges		0							
11.00			0							
12. 00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)  Other state or local government indigent care program (see instructions for each line)									
13. 00	Net revenue from state or local indigent care program (Not i				0	13.00				
14. 00										
15. 00	State or local indigent care program cost (line 1 times line	2 14)			0	15. 00				
	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0 1									
	13; if < zero then enter zero) Uncompensated care (see instructions for each line)									
17. 00	Private grants, donations, or endowment income restricted to	funding charity car	re		0	17. 00				
18. 00	Government grants, appropriations or transfers for support of				0	18. 00				
19. 00	Total unreimbursed cost for Medicaid , CHIP and state and Ic			(sum of lines	1, 320, 861					
	8, 12 and 16)									
			sured	Insured	Total (col. 1					
			i ents	pati ents 2.00	+ col . 2) 3.00					
20.00	Charity care charges for the entire facility (see instruction		. 00 424, 392	2.00	3. 00 424, 392	20.00				
20.00	Cost of patients approved for charity care (line 1 times line)		424, 392 135, 276		424, 392 135, 276					
22. 00	Partial payment by patients approved for charity care	le 20)	133, 276	0	135, 276	•				
	Cost of charity care (line 21 minus line 22)		135, 276	-	135, 276					
23.00	cost of charity care (fille 21 illifings fille 22)		133, 270	0	135, 270	23.00				
					1. 00					
24. 00	Does the amount in line 20 column 2 include charges for pati imposed on patients covered by Medicaid or other indigent ca		ength of	stay limit		24. 00				
25. 00	If line 24 is "yes," charges for patient days beyond an inc		s Length	of stay limit	0	25. 00				
26. 00	Total bad debt expense for the entire hospital complex (see		- i ong til	c. Stay IIIII t	0	26.00				
27. 00					351, 662					
28. 00			27)							
29 00										
29. 00 30. 00		expense (line i time	Cost of uncompensated care (line 23 column 3 plus line 29)							

	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	JAY COUNTY H	Provider C	°N: 15_1320 □	eriod:	w of Form CMS- Worksheet A	2552-10
KLULA	STITEATION AND ADJUSTMENTS OF TRIAL BALANCE O	I EAFENSES	Frovider C	F	rom 10/01/2015 o 09/30/2016		narod:
						2/27/2017 10:	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance	
				001. 2)	0113 (300 71 0)	(col. 3 +-	
		1.00	2. 00	3.00	4. 00	col . 4) 5.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		1, 562, 111				1
2. 01 2. 02	OO201   NEW CAP REL COSTS-MVBLE EQUIP MOB   OO202   NEW CAP REL COSTS-MVBLE EQUIP-POB		8, 676 106, 456			8, 676 106, 456	1
2. 03	00203 NEW CAP REL COSTS-MVBLE EQUI P- WJ		31, 142			31, 142	1
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	6, 953, 613			6, 953, 613	
5. 00 7. 00	OO5OO   ADMINISTRATIVE & GENERAL   OO7OO   OPERATION OF PLANT	2, 344, 722 311, 093	4, 562, 614 907, 509			6, 907, 336 1, 201, 983	1
7. 01	00701 OPERATION OF PLANT-MOB	0	34, 570				7. 01
7.02	00702 OPERATION OF PLANT-POB	0	146, 133	146, 133		154, 694	
7. 03 8. 00	OO7O3   OPERATION OF PLANT-WJ   OO8OO   LAUNDRY & LINEN SERVICE	27, 038	41, 414	68, 452	2, 545 0	2, 545 68, 452	1
9. 00	00900 HOUSEKEEPI NG	421, 774	80, 355	502, 129	0	502, 129	9.00
10. 00 11. 00	01000  DI ETARY  01100  CAFETERI A	361, 053	319, 403	680, 456	-309, 722 309, 722	370, 734 309, 722	1
13. 00	01300 NURSI NG ADMI NI STRATI ON	1, 034, 141	11, 018	1, 045, 159		1, 045, 159	1
14. 00	01400 CENTRAL SERVI CES & SUPPLY	61, 737	120, 088			181, 825	1
16. 00	01600   MEDICAL RECORDS & LIBRARY     NPATIENT ROUTINE SERVICE COST CENTERS	368, 481	56, 963	425, 444	0	425, 444	16. 00
30. 00	03000 ADULTS & PEDIATRICS	1, 456, 517	212, 344	1, 668, 861	-122, 835	1, 546, 026	30.00
31. 00	03100   NTENSI VE CARE UNI T	0	0	0	0	0	31.00
40. 00 41. 00	04000  SUBPROVI DER - I PF   04100  SUBPROVI DER - I RF	698, 062	251, 269	949, 331	0	949, 331 0	40.00
42. 00	04200 SUBPROVI DER		0	o c	0	0	42. 00
43. 00	04300 NURSERY	0	0	C	105, 107	105, 107	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS    05000   OPERATING ROOM	864, 045	743, 967	1, 608, 012	0	1, 608, 012	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0,000,012			1
53.00	05300 ANESTHESI OLOGY	0	833, 474			833, 474	1
54. 00 57. 00	05400   RADI OLOGY-DI AGNOSTI C   05700   CT   SCAN	805, 442	546, 850 0	1, 352, 292	0	1, 352, 292 0	1
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	i c	0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	1 252 012	1 020 004	0	1 020 004	
60. 00 60. 01	06000   LABORATORY   06001   BLOOD   LABORATORY	667, 091	1, 252, 913 0	1, 920, 004 C	0	1, 920, 004 0	60.00
65.00	06500 RESPIRATORY THERAPY	0	356, 309			356, 309	65.00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	807, 762	807, 762		671, 400 110, 695	1
68. 00	06800 SPEECH PATHOLOGY		0	o c	25, 667	25, 667	1
69. 00	06900 ELECTROCARDI OLOGY	217, 726	377, 194	594, 920	0	594, 920	1
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	0	0	
	07300 DRUGS CHARGED TO PATIENTS	411, 655	1, 167, 714	1, 579, 369	0	_	
00.00	OUTPATIENT SERVICE COST CENTERS					0	00.00
88. 00 89. 00	08800   RURAL HEALTH CLINIC   08900   FEDERALLY QUALIFIED HEALTH CENTER	0	0	C	0	0	
90. 00	09000 CLI NI C	339, 080	221, 511			560, 591	1
90. 01	09001 FAMILY PRACTICE OF JAY COUNTY	1, 644, 595 1, 689, 420	260, 362 296, 960			1, 904, 957 1, 986, 380	
91. 00	09100 EMERGENCY	2, 337, 768	315, 005			2, 652, 773	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		44 050	44.050		44.050	92.00
93. 00	04040 OTHER OUTPATIENT SERVICE COST CENTER OTHER REIMBURSABLE COST CENTERS	0	11, 050	11, 050	0	11, 050	93.00
99. 10	09910 CORF	0	0	C	0	0	99. 10
104 00	SPECIAL PURPOSE COST CENTERS 10600 HEART ACQUISITION					0	106. 00
	10900 PANCREAS ACQUISITION	0	0	C			109.00
110.00	11000 INTESTINAL ACQUISITION	0	0	C	0	0	110. 00
	11100  SLET ACQUISITION  11300  NTEREST EXPENSE	0	0	O	0		111. 00 113. 00
118.00		16, 061, 440	22, 596, 749	38, 658, 189			
	NONREI MBURSABLE COST CENTERS			I			1
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		190. 00 192. 00
	19300 NONPALD WORKERS		0		0		193. 00
	07950 MOB	0	0	C.	0		194. 00
	07951   POB   07952   WEST JAY CLINIC	0 483, 051	0 39, 218	522, 269	0	0 522, 269	194. 01 194. 02
194. 03	07953 OTHER NONREIMBURSABLE COST CENTERS	0	0	022, 207	o o	0	194. 03
	07954 OTHER NONREIMBURSABLE COST CENTERS	0	0	C	0		194. 04
	07955 OTHER NONREIMBURSABLE COST CENTERS 07956 TRI COUNTY	0 171, 962	0 1, 182, 766	1, 354, 728	0	0 1, 354, 728	194. 05 194. 06
	1	, , , , , , ,	., .52, .60	1 1,00.,720	1 3	., 55 ., .20	1

Health Financial Systems	JAY COUNTY	HOSPI TAL		In Lieu of Form CMS-2552-10			
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	F EXPENSES	Provi der Co		Peri od:	Worksheet A		
				From 10/01/2015 To 09/30/2016		nared:	
					2/27/2017 10:		
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Recl assi fi ed		
			+ col . 2)	ons (See A-6)	Trial Balance		
					(col. 3 +-		
					col . 4)		
	1.00	2. 00	3. 00	4. 00	5. 00		
194. 07 07957 HOSPI TALI ST	478, 379	12, 151	490, 530	0	490, 530	194. 07	
194.08 07958 FAMILY FIRST HEALTH	150, 215	42, 235	192, 450	0	192, 450	194. 08	
200 00 TOTAL (SUM OF LINES 118-199)	17 345 047	23 873 119	41 218 166	0	41 218 166	200 00	

Peri od: From 10/01/2015 To 09/30/2016 Date/Ti me Prepared: 2/27/2017 10:37 am

				2/27/2017 10:	37 am
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8) 6.00	For Allocation 7.00		
G	GENERAL SERVICE COST CENTERS	0.00	7.00		
	00200 NEW CAP REL COSTS-MVBLE EQUIP	-325, 842	1, 236, 269		2.00
2.01	00201 NEW CAP REL COSTS-MVBLE EQUIP MOB	0	8, 676		2. 01
	00202 NEW CAP REL COSTS-MVBLE EQUIP-POB	0	106, 456		2. 02
	00203 NEW CAP REL COSTS-MVBLE EQUIP- WJ	0			2. 03
	00400 EMPLOYEE BENEFITS DEPARTMENT	-311, 332			4.00
	DOSOO ADMINISTRATIVE & GENERAL	-1, 102, 128			5. 00
	DO700 OPERATION OF PLANT DO701 OPERATION OF PLANT-MOB	0			7.00
	00702 OPERATION OF PLANT-MOB	0			7. 01 7. 02
	00703 OPERATION OF PLANT-WJ				7. 02
1	00800 LAUNDRY & LINEN SERVICE		_, _, _,		8.00
	00900 HOUSEKEEPI NG	-36, 360			9. 00
	01000 DI ETARY	00,000	370, 734		10.00
	01100 CAFETERI A	-190, 751	118, 971		11. 00
	01300 NURSI NG ADMI NI STRATI ON	-9, 984			13. 00
	01400 CENTRAL SERVICES & SUPPLY	0	181, 825		14.00
1	01600 MEDICAL RECORDS & LIBRARY	-20, 001	405, 443		16. 00
	NPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	0	1, 546, 026		30. 00
31.00	03100 INTENSIVE CARE UNIT	0	0		31. 00
	04000 SUBPROVI DER - I PF	0	949, 331		40. 00
	04100 SUBPROVI DER – I RF	0			41. 00
	04200 SUBPROVI DER	0			42. 00
	04300 NURSERY	0	105, 107		43. 00
	ANCILLARY SERVICE COST CENTERS		4 (00 040		
	D5000 OPERATING ROOM	0			50.00
	D5200 DELIVERY ROOM & LABOR ROOM	022 474	'		52.00
	D5300 ANESTHESI OLOGY	-833, 474			53. 00 54. 00
	D5400  RADI OLOGY-DI AGNOSTI C D5700  CT   SCAN	0	1, 352, 292		57.00
	D5800 MAGNETIC RESONANCE IMAGING (MRI)		0		58.00
1	D5900 CARDI AC CATHETERI ZATI ON				59.00
1	06000 LABORATORY	-55,000	1, 865, 004		60.00
1	06001 BLOOD LABORATORY	33,000			60. 01
	06500 RESPIRATORY THERAPY				65. 00
1	06600 PHYSI CAL THERAPY	-35, 288			66. 00
	06700 OCCUPATI ONAL THERAPY	0			67. 00
	06800 SPEECH PATHOLOGY	0			68. 00
	06900 ELECTROCARDI OLOGY	-31, 538			69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72. 00
	D7300 DRUGS CHARGED TO PATIENTS	-87, 933	1, 491, 436		73. 00
	OUTPAȚIENT SERVICE COST CENTERS				
	08800 RURAL HEALTH CLINIC	0	0		88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0			89. 00
	09000 CLINIC	-350, 774			90.00
	09001 FAMILY PRACTICE OF JAY COUNTY	-1, 528, 870			90. 01
	09002 JAY FAMILY MEDICINE	-1, 488, 302			90. 02
	09100 EMERGENCY	-1, 887, 109	765, 664		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		11 050		92.00
	04040 OTHER OUTPATIENT SERVICE COST CENTER OTHER REIMBURSABLE COST CENTERS	0	11, 050		93.00
	09910 CORF		0		99. 10
<u> </u>	SPECIAL PURPOSE COST CENTERS		<u> </u>		//. 10
	10600 HEART ACQUISITION	1 0	0		106. 00
	10900 PANCREAS ACQUISITION		ő		109.00
	11000 INTESTINAL ACQUISITION				110.00
1	11100   SLET ACQUISITION				111. 00
	11300   NTEREST EXPENSE	0	0		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-8, 294, 686	30, 363, 503		118. 00
N	NONREI MBURSABLE COST CENTERS				
190.001	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
192. 00 1	19200 PHYSICIANS' PRIVATE OFFICES	0	0		192. 00
	19300 NONPALD WORKERS	0	0		193. 00
	07950 MOB	0	0		194. 00
	07951 P0B	0	0		194. 01
	07952 WEST JAY CLINIC	-483, 942	38, 327		194. 02
	07953 OTHER NONREIMBURSABLE COST CENTERS	0	0		194. 03
	07954 OTHER NONREIMBURSABLE COST CENTERS	0			194. 04
	07955 OTHER NONREIMBURSABLE COST CENTERS	0			194. 05
	07956 TRI COUNTY	0	,		194. 06
	D7957 HOSPITALIST D7958 FAMILY FIRST HEALTH	0			194. 07 194. 08
174.000	7/750 TAWIELLINST REALIR	1 0	192, 450	I	174. Uδ

Health Financial Systems	JAY COUNTY	HOSPI TAL	In Lie	u of Form CMS-	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CCN:	Period: From 10/01/2015	Worksheet A	
				Date/Time Pre 2/27/2017 10:	
Cost Center Description	Adjustments	Net Expenses		272772017 10.	7 4111
	(See A-8)	For Allocation			
	6. 00	7. 00			
200.00 TOTAL (SUM OF LINES 118-199)	-8, 778, 628	32, 439, 538			200. 00

Health Financial Systems

RECLASSIFICATIONS

Provider CCN: 15-1320
Period: From 10/01/2015 To 09/30/2016
Pate/Time Prepared: 2/27/2017 10: 37 am

						2/27/2017 10	:37 am_
		Increases					
	Cost Center	Li ne #	Sal ary	0ther			
	2. 00	3. 00	4.00	5. 00			
	A - NURSERY RECLASS						
1.00	NURSERY	43.00	90, 721	14, 386			1. 00
	0		90, 721	14, 386			
	B - LABOR & DELIVERY RECLASS						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	15, 377	2, 351			1. 00
	0		15, 377	2, 351			
	C - CAFETERIA RECLASS						
1.00	CAFETERI A	11. 00	164, 340	145, 382			1. 00
	0		164, 340	145, 382			
	D - MOB, POB, WEST JAY MAINT	RECLASS					
1.00	OPERATION OF PLANT-MOB	7. 01	5, 513	0			1. 00
2.00	OPERATION OF PLANT-POB	7. 02	8, 561	0			2. 00
3.00	OPERATION OF PLANT-WJ	7. 03	2, 545	0			3. 00
	0		16, 619				
	F - OCCUPATIONAL AND SPEECH T	HERAPY RECL					
1.00	OCCUPATI ONAL THERAPY	67.00	0	110, 695			1. 00
2.00	SPEECH PATHOLOGY	68. 00	o	25, 667			2. 00
	0 — — — — —			136, 362			
500.00	Grand Total: Increases		287, 057	298, 481			500.00
	•	'					•

Heal th Financial Systems

RECLASSIFICATIONS

Provider CCN: 15-1320
Period: From 10/01/2015
To 09/30/2016
Prepared:

					'	2/27/2017 10	: 37 am
		Decreases					
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
	A - NURSERY RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	90, 721	14, 386	0		1. 00
	0		90, 721	14, 386			
	B - LABOR & DELIVERY RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	15, 377	2, 351	0		1. 00
	0 — — — — —		15, 377	2, 351			
	C - CAFETERIA RECLASS						
1.00	DI ETARY	10. 00	164, 340	145, 382	0		1. 00
	0		164, 340	145, 382			
	D - MOB, POB, WEST JAY MAINT	RECLASS					
1.00	OPERATION OF PLANT	7. 00	16, 619	0	0		1. 00
2.00		0.00	0	0	0		2. 00
3.00		0.00	0	0	0		3. 00
	0		16, 619				
	F - OCCUPATIONAL AND SPEECH T	HERAPY RECL					
1.00	PHYSI CAL THERAPY	66. 00	0	136, 362	0		1. 00
2.00		0.00	0	0	0		2. 00
	0 — — — — —			136, 362			
500.00	Grand Total: Decreases		287, 057	298, 481			500.00

2/27/2017 10    Beginning   Purchases   Donation   Total   Disposals and Retirements	1.00
Beginning Purchases Donation Total Disposals and Balances Donation Total Retirements	1.00
Balances Retirements	1.00
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	
1. 00 Land 0 0 0	
2.00   Land Improvements   952,332   0   0   0	2.00
3.00 Buildings and Fixtures 25,114,962 0 0 1,788,70	1
4.00 Building Improvements 0 0 0 0	4.00
5.00   Fi xed Equipment   2,426,508   1,233,359   0   1,233,359	5. 00
6.00   Movable Equipment   13,931,159   0   0   709,42	6. 00
77 00 Till 1 doct grid tod 7600 to	7.00
8.00   Subtotal (sum of lines 1-7)   42,772,694   1,233,359   0   1,233,359   2,498,13	8.00
9.00   Reconciling   Items   0   0   0   0	9.00
10.00 Total (line 8 minus line 9) 42,772,694 1,233,359 0 1,233,359 2,498,13	2 10.00
Ending Balance Fully	
Depreciated	
Assets	
6.00 7.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	
1.00 Land 347, 733 0	1. 00
2.00 Land Improvements 952,332 0	2. 00
3.00 Buildings and Fixtures 23,326,257 0	3. 00
4.00 Building Improvements 0 0	4. 00
5.00   Fi xed Equi pment   3,659,867   0	5. 00
6.00 Movable Equipment 13, 221, 732 0	6. 00
7.00 HIT designated Assets 0 0	7. 00
8.00   Subtotal (sum of lines 1-7)   41,507,921   0	8. 00
9.00 Reconciling Items 0 0	9. 00
10. 00   Total (line 8 minus line 9) 41, 507, 921 0	10. 00

Health Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CO	CN: 15-1320	Peri od: From 10/01/2015 To 09/30/2016	Worksheet A-7 Part II Date/Time Pre 2/27/2017 10:	pared:
		SL	JMMARY OF CAP	I 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 WOR	KSHEET A, COLUM	IN 2, LINES 1 a	nd 2			
2.00 NEW CAP REL COSTS-MVBLE EQUIP	1, 562, 111	0		0 0	0	2. 00
2.01 NEW CAP REL COSTS-MVBLE EQUIP MOB	8, 676	0		0 0	0	2. 01
2.02 NEW CAP REL COSTS-MVBLE EQUIP-POB	106, 456	0		0 0	0	2. 02
2.03 NEW CAP REL COSTS-MVBLE EQUIP- WJ	31, 142	0		0 0	0	2. 03
3.00 Total (sum of lines 1-2)	1, 708, 385	0		0 0	0	3.00
	SUMMARY O	F CAPITAL				
Cost Center Description	0ther	Total (1) (sum				
	Capi tal -Rel ate	of cols. 9				
	d Costs (see	through 14)				
	instructions)					
PART II - RECONCILIATION OF AMOUNTS FROM WORL	14.00	15. 00				

	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUMN	2, LINES 1 ar	nd 2	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	1, 562, 111		2. 00
2.01	NEW CAP REL COSTS-MVBLE EQUIP MOB	0	8, 676		2. 01
2.02	NEW CAP REL COSTS-MVBLE EQUIP-POB	0	106, 456		2. 02
2.03	NEW CAP REL COSTS-MVBLE EQUIP- WJ	0	31, 142		2. 03
3.00	Total (sum of lines 1-2)	0	1, 708, 385		3. 00
					•

Health Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 10/01/2015 Fo 09/30/2016	Worksheet A-7 Part III Date/Time Prep 2/27/2017 10:3	pared:
	COME	PUTATION OF RAT	TIOS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col 2)	Ratio (see instructions)	Insurance	
	1.00	2.00	3.00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CE						
2.00 NEW CAP REL COSTS-MVBLE EQUIP	23, 326, 257	0	23, 326, 25		0	2.00
2.01 NEW CAP REL COSTS-MVBLE EQUIP MOB	0	0		0. 000000	0	2. 01
2. 02 NEW CAP REL COSTS-MVBLE EQUIP-POB	0	0	1	0. 000000	0	2. 02
2. 03 NEW CAP REL COSTS-MVBLE EQUIP- WJ	0	0		0. 000000	0	2. 03
3.00 Total (sum of lines 1-2)	23, 326, 257	0	23, 326, 25		0	3. 00
	ALLUCA	FION OF OTHER (	JAPITAL	SUMMARY O	F CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
cost center bescription		Capi tal -Relate		Depi eci ati on	Lease	
		d Costs	through 7)			
	6. 00	7. 00	8.00	9. 00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS		•			
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	0	)	1, 236, 269	0	2.00
2.01 NEW CAP REL COSTS-MVBLE EQUIP MOB	0	0	)	8, 676	0	2. 01
2.02 NEW CAP REL COSTS-MVBLE EQUIP-POB	0	0		106, 456	0	2. 02
2.03 NEW CAP REL COSTS-MVBLE EQUIP- WJ	0	0		31, 142	0	2. 03
3.00 Total (sum of lines 1-2)	0	0	)	1, 382, 543	0	3. 00
		Sl	JMMARY OF CAPI	TAL		
Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
				d Costs (see	through 14)	
				instructions)		
	11. 00	12. 00	13. 00	14. 00	15. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CE		^			1 22/ 2/2	2 00
2.00 NEW CAP REL COSTS MYBLE EQUIP	0	0	1	0	1, 236, 269	2.00
2. 01 NEW CAP REL COSTS-MVBLE EQUIP MOB	0	0		0	8, 676	2. 01
2. 02 NEW CAP REL COSTS-MVBLE EQUI P-POB	0	0		0	106, 456	2. 02
2.03 NEW CAP REL COSTS-MVBLE EQUIP- WJ	0	0			31, 142	2. 03
3.00  Total (sum of lines 1-2)	l O	0	'I	0	1, 382, 543	3. 00

ADJUSTMENTS TO EXPENSES Provider CCN: 15-1320 Peri od: Worksheet A-8 From 10/01/2015 09/30/2016 Date/Time Prepared: 2/27/2017 10:37 am 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) 2 02 Investment income - NEW CAP ONEW CAP REL COSTS-MVBLE 2.02 2.02 REL COSTS-MVBLE EQUIP-POB EQUI P-POB (chapter 2) 2.03 Investment income - NEW CAP ONEW CAP REL COSTS-MVBLE 2.03 2.03 REL COSTS-MVBLE EQUIP- WJ EQUIP- WJ (chapter 2) 3.00 Investment income - other 0.00 Λ 3.00 (chapter 2) Trade, quantity, and time 4.00 0.00 4.00 discounts (chapter 8) 5.00 Refunds and rebates of 0.00 5.00 expenses (chapter 8) 6.00 Rental of provider space by 0.00 6.00 suppliers (chapter 8) 7.00 Tel ephone services (pay 0.00 7.00 stations excluded) (chapter 21) 8.00 Tel evi si on and radio servi ce 0.00 8.00 (chapter 21) 9 00 Parking lot (chapter 21) 0.00 9.00 Provider-based physician 10.00 A-8-2 -5, 310, 055 10.00 adjustment Sale of scrap, waste, etc. (chapter 23) 11.00 11.00 0.00 0 12.00 Related organization A-8-1 -35, 288 12.00 transactions (chapter 10) 13.00 Laundry and linen service 0.00 13.00 Cafeteria-employees and guests В -191, 980 CAFETERI A 14.00 11.00 0 14.00 Rental of quarters to employee 15.00 0.00 15.00 and others Sale of medical and surgical 0.00 16.00 16.00 supplies to other than pati ents Sale of drugs to other than 0 00 17.00 17.00 O pati ents -18, 809 MEDI CAL RECORDS & LI BRARY 18.00 Sale of medical records and В 16.00 18.00 abstracts 19.00 Nursing school (tuition, fees, 0 0.00 19.00 books, etc.) 20.00 Vending machines 0.00 20.00 0 21 00 Income from imposition of 0 0.00 21.00 interest, finance or penalty charges (chapter 21) 22.00 Interest expense on Medicare 0.00 22.00 overpayments and borrowings to repay Medicare overpayments Adjustment for respiratory ORESPIRATORY THERAPY 23.00 A-8-3 65.00 23.00 therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical A-8-3 OPHYSICAL THERAPY 66.00 24.00 therapy costs in excess of limitation (chapter 14) 0 \*\*\* Cost Center Deleted \*\*\* 25.00 Utilization review -114.00 25.00 physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL 0 \*\*\* Cost Center Deleted \*\*\* 1.00 26.00 COSTS-BLDG & FLXT ONEW CAP REL COSTS-MVBLE 27.00 Depreciation - NEW CAP REL 2.00 27.00 COSTS-MVBLE EQUIP FOUL P 27.01 Depreciation - NEW CAP REL ONEW CAP REL COSTS-MVBLE 2.01 27.01 COSTS-MVBLE EQUIP MOB EQUIP MOB Depreciation - NEW CAP REL ONEW CAP REL COSTS-MVBLE 27.02 2.02 27.02 COSTS-MVBLE EQUI P-POB EQUI P-POB

Peri od: Provi der CCN: 15-1320 Worksheet A-8 From 10/01/2015
To 09/30/2016 Date/Time Prepared:

Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted	
Cost Costs Description Design(Costs (2)) Amount Cost Costs Design (Costs Costs Design (Costs Costs Design (Costs Costs Design (Costs Design (C	
Cost Center Description         Basis/Code (2)         Amount         Cost Center         Line #         Wkst. A-7 R           1.00         2.00         3.00         4.00         5.00	0 27.03
1.00         2.00         3.00         4.00         5.00           27.03         Depreciation - NEW CAP REL         ONEW CAP REL COSTS-MVBLE         2.03	
COSTS-MVBLE EQUIP- WJ EQUIP- WJ	1
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 00CCUPATIONAL THERAPY 67.00	30. 00
therapy costs in excess of	
limitation (chapter 14)	
30.99 Hospice (non-distinct) (see OADULTS & PEDIATRICS 30.00	30. 99
instructions)	
31.00 Adjustment for speech A-8-3 OSPEECH PATHOLOGY 68.00	31. 00
pathology costs in excess of	
Iimitation (chapter 14) 32.00   CAH HIT Adjustment for   0   0.00	0 32.00
Depreciation and Interest	0 32.00
33. 00 0 0. 00	0 33.00
33.01 SUPPLY REBATES AND DISCOUNTS B -51, 121 ADMI NI STRATI VE & GENERAL 5.00	0 33.01
33. 02 OTHER REVENUE B -13, 448 ADMI NI STRATI VE & GENERAL 5. 00	0 33.02
33. 03 OTHER REVENUE-DI ABETI C B -9, 984 NURSI NG ADMI NI STRATI ON 13. 00	0 33.03
COUNSELI NG	
33. 04 CRNA OFFSET A -833, 474 ANESTHESI OLOGY 53. 00	0 33.04
33. 05 PHYSICIAN RECRUITMENT A -31, 885 ADMINISTRATIVE & GENERAL 5. 00	0 33.05
33.06 ADVERTISING EXPENSE A -145,082 ADMINISTRATIVE & GENERAL 5.00	0 33.06
33. 07   SENI OR PROGRAM A -14, 557   ADMI NI STRATI VE & GENERAL 5. 00	0 33. 07
33. 08 SWI TCHBOARD SALARY A -8, 348 ADMI NI STRATI VE & GENERAL 5. 00	0 33. 08
33. 09 SWITCHBOARD EH&W A -2,721 EMPLOYEE BENEFITS DEPARTMENT 4. 00	0 33.09
33. 10 PATI ENT TELEPHONE EXPENSE A -15, 598 ADMI NI STRATI VE & GENERAL 5. 00	0 33. 10
33. 11 PATI ENT TELEPHONE DEPRECIATION A -3, 996 NEW CAP REL COSTS-MVBLE 2. 00	9 33. 11
	0 33, 12
33. 12   HEALTH EDUCATION   B   -166, 748 ADMI NI STRATI VE & GENERAL   5. 00   33. 13   VENDI NG MACHI NE REVENUE   B   1, 256 CAFETERI A   11. 00	0 33. 12
33. 14 PHARMACY EMPLOYEE SALES B -87, 933 DRUGS CHARGED TO PATIENTS 73. 00	0 33. 13
33. 16 HOUSEKEEPING WAGES A -36, 360HOUSEKEEPING 9. 00	0 33. 14
33. 17   I HA DUES A -702 ADMI NI STRATI VE & GENERAL 5. 00	0 33. 17
33. 18 LAND RENT B -3, 881 ADMI NI STRATI VE & GENERAL 5. 00	0 33.18
33. 19 CLINIC RENTAL B -31, 538 ELECTROCARDI OLOGY 69. 00	0 33.19
33. 20 CONFERENCE ROOM RENTAL B -280 ADMI NI STRATI VE & GENERAL 5. 00	0 33. 20
33. 21 VENDOR/CONTRACT REV B -14, 970 ADMI NI STRATI VE & GENERAL 5. 00	0 33. 21
33.22 EHR DEPRECIATION A -321,846 NEW CAP REL COSTS-MVBLE 2.00	9 33. 22
EQUI P	
33. 23 HOSPITAL ASSESSMENT FEE A -635, 508 ADMINISTRATIVE & GENERAL 5. 00	0 33. 23
33. 24 OTHER REVENUE B -27 CAFETERI A 11. 00	0 33. 24
33. 25 OTHER REVENUE B -1, 192 MEDI CAL RECORDS & LI BRARY 16. 00	0 33. 25
33. 26 MERIDIAN HEALTH WAGE B -483, 942 WEST JAY CLINIC 194. 02	0 33. 26
REIMBURSEMENT	0 22 27
33. 27   PENSION EXPENSE   A   -308, 611   EMPLOYEE BENEFITS DEPARTMENT   4. 00   0. 00   0. 00	0 33. 27 0 33. 28
33. 28 OTHER ADJUSTMENTS (SPECIFY) 0.00	0 33. 20
33. 29 OTHER ADJUSTMENTS (SPECIFY) 0 0.00	0 33. 29
(3)	] = 3. 27
50.00 TOTAL (sum of lines 1 thru 49) -8,778,628	50. 00
(Transfer to Worksheet A,	
column 6, line 200.)	

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

<sup>(2)</sup> Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

<sup>(3)</sup> Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

					2/27/2017 10:	37 am
	Li ne No.	Cost Center	Expense I tems	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00	66. 00	PHYSI CAL THERAPY	RENT/LEASE EXPENSE	24, 712	60, 000	1.00
2.00	0.00			0	0	2. 00
3.00	0.00			0	0	3. 00
4.00	0.00			0	0	4. 00
5.00	TOTALS (sum of lines 1-4).			24, 712	60, 000	5. 00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					1
	line 12.					

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

			Related Organization(s) and	or Home Office	
Symbol (1)	Name	Percentage of	Name	Percentage of	
, , ,		Ownershi p		Ownershi p	
1. 00	2. 00	3. 00	4. 00	5. 00	
B. INTERRELATIONSHIP TO RELAT	ED 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:
- 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.

Hool +b	Financial Cuat	-m-c		IAV	COUNTY HO	CDLTAI				ما ا ما	u of Form C	MC 2552 10
	Financial Syste									in Lie		
STATEME	INT OF COSTS OF	SERVICES FROM	RELATED OR	GANIZATIONS A	AND HOME	Provi der	CCN: 1	15-1320	Peri c	od:	Worksheet	A-8-1
OFFICE	COSTS								From	10/01/2015		
002	000.0								To	09/30/2016	Date/Time	Prepared:
											2/27/2017	
	Net	Wkst. A-7 Ref.					_					
	Adjustments											
	(col. 4 minus											
	col. 5)*											
	6. 00	7. 00										
	A. COSTS INCUR	RED AND ADJUSTN	MENTS REQUI	RED AS A RESU	JLT OF TRA	NSACTI ONS	WI TH	RELATED C	RGANI :	ZATIONS OR	CLAI MED	
	HOME OFFICE CO	STS:										
1.00	-35, 288	0										1. 00
2.00	0	0										2.00
3.00	0	0										3. 00
4. 00	i o	٥										4. 00
	25 200	0										
5. 00	-35, 288											5. 00
* The	amounts on line	es 1-4 (and sub	scripts as	appropri ate)	are trans	sferred in	detai	il to Wor	ksheet	: A, column	6, lines as	i

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

Related Organization(s)		
and/or Home Office		
Type of Business		
Type of Business		
6. 00		1
B. INTERRELATIONSHIP TO RELAT	ED 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	8. 00 9. 00
10. 00	10.00
6. 00 7. 00 8. 00 9. 00 10. 00 100. 00	10. 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.

Peri od: From 10/01/2015 To 09/30/2016 Date/Ti me Prepared:

						077 007 2010	2/27/2017 10:	37 am
	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	91. 00	EMERGENCY	2, 144, 442	1, 887, 109	257, 333	0	0	1. 00
2.00	60. 00	LABORATORY	55, 000	55, 000	0	0	0	2. 00
3.00	90. 00	CLINIC	350, 774	350, 774	0	0	O	3.00
4.00	90. 01	FAMILY PRACTICE OF JAY	1, 528, 870	1, 528, 870	0	0	O	4.00
		COUNTY						
5.00	90. 02	JAY FAMILY MEDICINE	1, 488, 302	1, 488, 302	0	0	0	5.00
6.00	0. 00		0	0	0	0	0	6.00
7.00	0. 00		0	0	0	0	0	7. 00
8.00	0. 00		0	0	0	0	0	8. 00
9.00	0. 00		0	0	0	0	0	9. 00
10.00	0. 00		0	0	0	0	0	10.00
200.00			5, 567, 388	5, 310, 055	257, 333		0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE	Memberships &	Component	of Malpractice	
				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		EMERGENCY	0	~	0		0	1. 00
2.00		LABORATORY	0	0	0		0	2. 00
3.00		CLINIC	0	0	0	0	0	3.00
4.00	90. 01	FAMILY PRACTICE OF JAY	0	0	0	0	0	4. 00
		COUNTY						
5.00		JAY FAMILY MEDICINE	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	0	7. 00
8.00	0. 00		0	0	0	0	0	8. 00
9.00	0.00		0	0	0	0	0	9.00
10.00	0. 00		0	0	0	0	0	10.00
200.00	MI+ A I : "	C+ C+ (Ph	0	0 A-1:+1 DCE	RCE	0	0	200. 00
	Wkst. A Line #	,	Provi der	Adjusted RCE		Adjustment		
		l denti fi er	Component Share of col.	Limit	Di sal I owance			
			14					
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00		
1.00		EMERGENCY	0.00	0	0	1, 887, 109		1. 00
2. 00		LABORATORY	0	0	0	55,000		2. 00
3. 00		CLI NI C	0	0	0	350, 774		3. 00
4. 00		FAMILY PRACTICE OF JAY	0	0	0			4. 00
1. 00		COUNTY	Ĭ	Ĭ	J	1,020,070		1. 00
5. 00		JAY FAMILY MEDICINE	0	0	0	1, 488, 302		5. 00
6. 00	0. 00		0	0	0	0		6. 00
7. 00	0. 00		l o	l o	o o	o o		7. 00
8. 00	0. 00		l o	l o	0	o o		8. 00
9. 00	0. 00		l o	0	0	o o		9. 00
10. 00	0. 00		l o	Ö	0	o o		10. 00
200.00			l o	0	0	5, 310, 055		200. 00
	'	1			1		'	

6.00	assistant and on which supervisor and/or the		,	,		0	6.00
	instructions)						
7.00	Standard travel expense rate					0.00	
8. 00	Optional travel expense rate per mile	Supervi core	Thoronists	Accietante	Ai dos	0.00	8. 00
		Supervi sors 1.00	Therapists 2.00	Assistants 3.00	Ai des 4. 00	Trai nees 5.00	
9. 00	Total hours worked	2, 193. 00	3, 834. 00		0.00		9. 00
10.00		91. 25	79. 35	51. 58	0.00		
11. 00	, ,	39. 68	39. 68	25. 79	0.00	0.00	11.00
	one-half of column 2, line 10; column 3,						
	one-half of column 3, line 10)			,			
12.00	Number of travel hours (provider site)	0	ol	0			12.00
12.01	Number of travel hours (offsite)	0	O	0			12. 01
13.00	Number of miles driven (provider site)	0	O	0			13.00
13. 01	Number of miles driven (offsite)	0	0	0			13. 01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00						200, 111	
15. 00		,				304, 228	
16. 00						108, 318	
17. 00	•	nd 15 for respi	ratory therapy	or lines 14-16	tor all	612, 657	17. 00
10.00	others)	10)					10.00
18.00	•					0	
19. 00 20. 00			thorony or lin	oc 17 and 10 fo	r all athers)	0 612, 657	
20.00	Total allowance amount (sum of lines 17-19 for lf the sum of columns 1 and 2 for respiratory						20.00
	occupational therapy, line 9, is greater than						
	the amount from line 20. Otherwise complete		no citti es on i	THES ZT and ZZ	and criter on	11110 25	
21. 00			divided by su	m of columns 1	and 2, line 9	0.00	21.00
	for respiratory therapy or columns 1 thru 3,						
22.00	Weighted allowance excluding aides and traine	es (line 2 time	es line 21)			0	22.00
23.00	Total salary equivalency (see instructions)					612, 657	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW	VANCE AND TRAVE	L EXPENSE COMP	JTATION - PROVI	DER SITE		
	Standard Travel Allowance						
24. 00						0	
25. 00						0	25. 00
26. 00	, , , , , , , , , , , , , , , , , , , ,			,		0	26.00
27. 00		for respirator	y therapy or s	um of lines 3 a	nd 4 for all	0	27.00
20.00	others)	+mayal aynanaa	a+ +ba nzavid	on oi to (oum of	Lines 24 and	ol	28. 00
28. 00	Total standard travel allowance and standard 27)	traver expense	at the provide	er Site (Sum of	Titles 20 and	١	20.00
	Optional Travel Allowance and Optional Travel	Expense					
29. 00			d 2, line 12 )			0	29.00
30.00						o	1
31.00	Subtotal (line 29 for respiratory therapy or	sum of lines 2	9 and 30 for a	II others)		0	31.00
32.00	Optional travel expense (line 8 times columns	s 1 and 2, line	13 for respira	atory therapy o	r sum of	0	32.00
	columns 1-3, line 13 for all others)						
33.00						0	33.00
34.00	Optional travel allowance and standard travel	expense (sum	of lines 27 and	d 31)		0	34.00
35. 00						0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA	ANCE AND TRAVEL	EXPENSE COMPU	ΓΑΤΙΟΝ - SERVIC	ES OUTSIDE PRO	OVI DER SITE	
	Standard Travel Expense						
36. 00						0	
37. 00						0	
38. 00			-1 ()			0	
39.00	Standard travel expense (line 7 times the sur		a 6)			0	39.00
40.00	Optional Travel Allowance and Optional Travel		2 line 10)		1	0	40.00
40.00	Therapists (sum of columns 1 and 2, line 12.0		2, TTHE 10)			i i	
41.00		1 3, 1111e 10)				0	
42. 00 43. 00		m of columns 1	3 line 12 01)				
43.00	Optional travel expense (line 8 times the sur Total Travel Allowance and Travel Expense - C			e of the follow	ing three line		j 43. UC
	or 46, as appropriate.	irsite services	s, comprete one	s of the follow	ing three rine	33 44, 40,	
44. 00		expense (sum	of lines 38 an	d 39 - see inst	ructions)	0	44.00
	Totaliaa. a traver arrowalice and Standard traver	expense (sull t	o. iiiioo oo aiii			, 01	1
45.00	Optional travel allowance and standard travel	expense (sum o	of lines 39 and	d 42 - see inst	ructions)	nl	45.00

	ABLE COST DETERMINATION FOR THERAPY SERVICES F E SUPPLIERS	FURNI SHED BY	Provider CC		Period: From 10/01/2015 To 09/30/2016		pared:
					Physical Therapy	Cost	
						1. 00	
46. 00	Optional travel allowance and optional travel	expense (sum o	f lines 42 and	d 43 – see in	structions)		46. 00
		Therapi sts	Assi stants	Ai des	Trai nees	Total	
	PART V - OVERTIME COMPUTATION	1. 00	2.00	3. 00	4. 00	5. 00	
47. 00	Overtime hours worked during reporting period (if column 5, line 47, is zero or	0. 00	0. 00	0.0	0.00	0.00	47. 00
	equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each						
10 00	column of line 56) Overtime rate (see instructions)	0. 00	0. 00	0.0	0.00		48.00
48. 00 49. 00	1	0.00	0.00	0. 0			49.00
	allowance) (multiply line 47 times line 48)				1		]
	CALCULATION OF LIMIT	9 99	2 22				
50. 00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5,	0.00	0.00	0.0	0.00	0.00	50.00
51. 00	line 47) Allocation of provider's standard work year for one full-time employee times the	0.00	0.00	0.0	0.00	0.00	51.00
	percentages on line 50) (see instructions)  DETERMINATION OF OVERTIME ALLOWANCE						1
52. 00	Adjusted hourly salary equivalency amount	79. 35	51. 58	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	0	0		0 0		55. 00
56. 00	line 47 times line 52) Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5	0	0		0 0	0	56. 00
	the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3						
	for all others.)					1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND FXCESS COST	ADJUSTMENT			1. 00	
57. 00	Salary equivalency amount (from line 23)					612, 657	57.00
58. 00	Travel allowance and expense - provider site					0	
59. 00 50. 00	Travel allowance and expense - Offsite service Overtime allowance (from column 5, line 56)	es (from lines	44, 45, or 46)	)		0	1
51. 00						0	
52. 00	Supplies (see instructions)					0	1
	Total allowance (sum of lines 57-62)					612, 657	
54.00	Total cost of outside supplier services (from	,	ontor zoro)			485, 780	1
3.00	Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION	- II negative,	enter zero)			<u> </u>	65.00
	Line 26 = line 24 for respiratory therapy or						100. 00
	Line 27 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27	therapy or sum	of lines 3 ar	nd 4 for all	others		100. 01 100. 02
101. 00	LINE 34 CALCULATION Line 27 = line 7 times line 3 for respiratory	therapy or sum	of lines 3 ar	nd 4 for all	others	0	101. 00
101. 01	Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31					0	101. 01 101. 02
	LINE 35 CALCULATION						1
	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

	ABLE COST DETERMINATION FOR THERAPY SERVICES E SUPPLIERS	FURNI SHED BY	Provi der CCI	F	eriod: rom 10/01/2015 o 09/30/2016	Worksheet A-8- Parts I-VI Date/Time Prep 2/27/2017 10:3	pared:
					Respi ratory Therapy	Cost	
						1. 00	
00	PART I - GENERAL INFORMATION	a) (ass instru	uti ono)			52	1.00
. 00 . 00	Total number of weeks worked (excluding aide: Line 1 multiplied by 15 hours per week	s) (see mstruc	.trons)			780	
. 00	Number of unduplicated days in which supervis	sor or therapis	st was on provid	ler site (see	instructions)	0	1
. 00	Number of unduplicated days in which therapy	assistant was				0	4.0
00	nor therapist was on provider site (see inst						
. 00 . 00	Number of unduplicated offsite visits - super Number of unduplicated offsite visits - there				therany	0	
	assistant and on which supervisor and/or the					Ĭ	0.0
00	instructions)					0.00	١ , ,
. 00 . 00	Standard travel expense rate Optional travel expense rate per mile					0. 00 0. 00	
. 00	optional traver expense rate per inite	Supervi sors	Therapi sts	Assi stants	Ai des	Trai nees	0.0
		1.00	2.00	3. 00	4. 00	5. 00	
. 00	Total hours worked	1, 901. 00	5, 790. 00	0.00	· ·	0.00	
0. 00 1. 00	AHSEA (see instructions) Standard travel allowance (columns 1 and 2,	71. 73 31. 19	62. 38 31. 19	0. 00 0. 00		0.00	10.0
1. 00	one-half of column 2, line 10; column 3,	01.17	01.17	0.00			'''
	one-half of column 3, line 10)	_		_			
2. 00 2. 01	Number of travel hours (provider site) Number of travel hours (offsite)	0	0	0			12. 0 12. 0
3. 00	Number of miles driven (provider site)	0	0	0			13. 0
3. 01	Number of miles driven (offsite)						13. 0
						4.00	
	Part II - SALARY EQUIVALENCY COMPUTATION					1. 00	
4. 00	Supervisors (column 1, line 9 times column 1	line 10)				136, 359	14. C
5. 00	Therapists (column 2, line 9 times column 2,					361, 180	
6. 00	Assistants (column 3, line 9 times column 3,				, 6	0	
7. 00	Subtotal allowance amount (sum of lines 14 allothers)	nd 15 for respi	ratory therapy	or lines 14-1	6 for all	497, 539	17.0
8. 00	Aides (column 4, line 9 times column 4, line	86, 637	18. 0				
	Trainees (column 5, line 9 times column 5, li					0	
0. 00	Total allowance amount (sum of lines 17-19 for the sum of columns 1 and 2 for respirators					584, 176	20.0
	occupational therapy, line 9, is greater than						
	the amount from line 20. Otherwise complete	lines 21-23.					
1. 00	Weighted average rate excluding aides and traffor respiratory therapy or columns 1 thru 3,			n of columns 1	and 2, line 9	0. 00	21. 0
2. 00	Weighted allowance excluding aides and train					0	22. 0
3. 00	Total salary equivalency (see instructions)					584, 176	23. 0
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance	VANCE AND TRAVE	L EXPENSE COMPU	ITATI ON - PROV	I DER SITE		
4. 00	Therapists (line 3 times column 2, line 11)					0	24.0
5. 00	Assistants (line 4 times column 3, line 11)					0	1
6. 00	Subtotal (line 24 for respiratory therapy or					0	1
7. 00	Standard travel expense (line 7 times line 3 others)	for respirator	ry therapy or su	ım of lines 3	and 4 for all	0	27.0
8. 00	Total standard travel allowance and standard	travel expense	at the provide	er site (sum o	f lines 26 and	0	28. 0
	27)		·	·			
0 00	Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of the su		ud 2   Lino 12			0	29. 0
9. 00 0. 00	Assistants (column 3, line 10 times the sum 3		iu z, Title iz )			0	
1. 00	Subtotal (line 29 for respiratory therapy or		9 and 30 for al	l others)		0	1
2. 00	Optional travel expense (line 8 times columns	s 1 and 2, line	13 for respira	itory therapy	or sum of	0	32. 0
	columns 1-3, line 13 for all others) Standard travel allowance and standard trave	exnense (line	28)			o	33. 0
3 00				I 31)		ő	
3. 00 4. 00	Optional travel allowance and standard travel	expense (sum				0	35.0
	Optional travel allowance and optional trave		EXPENSE COMPLIT	ATION - SERVI	CES OUTSIDE PRO	VIDER SITE	
4. 00	Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA		EXI ENGE COM OT				1
4. 00 5. 00	Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense		EM ENGE COM OT				36. N
4. 00	Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA		EXILENSE COMPOT				
4. 00 5. 00 6. 00 7. 00 8. 00	Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37)	NCE AND TRAVEL				0 0 0	37. 0 38. 0
4. 00 5. 00 6. 00 7. 00	Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum	NCE AND TRAVEL				0	37. C
4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum optional Travel Allowance and Optional Travel	n of lines 5 an	nd 6)			0 0 0 0	38. 0 39. 0
4. 00 5. 00 6. 00 7. 00 8. 00	Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0)	m of lines 5 an Expense Of times column	nd 6)			0 0 0	37. 0 38. 0 39. 0 40. 0
4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0 Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41)	m of lines 5 an Expense Of times column 1, line 10)	nd 6)			0 0 0 0	37. 0 38. 0 39. 0 40. 0 41. 0 42. 0
4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 00 1. 00	Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.04 Assistants (column 3, line 12.01 times columns	n of lines 5 an Expense D1 times column 1 3, line 10) n of columns 1-	nd 6) 1 2, line 10) 3, line 13.01)			0 0 0 0 0	37. ( 38. ( 39. ( 40. ( 41. ( 42. (

	ABLE COST DETERMINATION FOR THERAPY SERVICES F E SUPPLIERS	FURNI SHED BY	Provi der Co	CN: 15-1320	Peri od: From 10/01/2015 To 09/30/2016	Worksheet A-8 Parts I-VI Date/Time Pre 2/27/2017 10:3	pared:
					Respi ratory Therapy	Cost	
						1. 00	
5. 00	Optional travel allowance and standard travel					0	
6. 00	Optional travel allowance and optional travel	expense (sum o	of lines 42 an Assistants	d 43 - see ir Aides	nstructions) Trainees	Total	46. 0
		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 column of line 56)	8. 00	0.00	32.0	0.00	40. 00	47.0
8. 00	Overtime rate (see instructions)	93. 57	0.00				48. 0
9. 00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	748. 56	0. 00	2, 245.	0.00		49. 00
0. 00	CALCULATION OF LIMIT  Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5,	20. 00	0.00	80.0	0.00	100.00	50. 0
1. 00	line 47) Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	416. 00	0.00	1, 664. (	0.00	2, 080. 00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE	, , , , ,					
2. 00	Adjusted hourly salary equivalency amount (see instructions)	62. 38	0.00				52.0
3. 00 4. 00	Overtime cost limitation (line 51 times line 52) Maximum overtime cost (enter the lesser of	25, 950 749	0	, -			53. 0 54. 0
5. 00	line 49 or line 53) Portion of overtime already included in	499	0	,			55. 0
	hourly computation at the AHSEA (multiply line 47 times line 52)			·			
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	250	0	74	48 0	998	56. 0
	respiratory therapy and columns 1 through 3 for all others.)						
		ND 51/2522 2225	AD IIIOTHENT			1. 00	
7. 00	Part VI - COMPUTATION OF THERAPY LIMITATION A Salary equivalency amount (from line 23)	ND EXCESS COST	ADJUSTMENT			584, 176	57. C
8. 00	Travel allowance and expense - provider site	(from lines 33,	34, or 35))			0	58. C
9. 00	Travel allowance and expense - Offsite service	es (from lines	44, 45, or 46	)		0	59.0
0.00	Overtime allowance (from column 5, line 56) Equipment cost (see instructions)					998 0	1
	Supplies (see instructions)					1, 747	
. 00	Total allowance (sum of lines 57-62)					586, 921	
. 00	Total cost of outside supplier services (from					345, 050	
. 00	Excess over limitation (line 64 minus line 63	- if negative,	enter zero)			0	65.0
00	LINE 33 CALCULATION Line 26 = line 24 for respiratory therapy or	sum of lines 24	and 25 for a	II others		0	100. (
0. 01	Line 27 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27				others	0	100. ( 100. (
01. 00	LINE 34 CALCULATION Line 27 = line 7 times line 3 for respiratory	therapy or sun	n of lines 3 a	nd 4 for all	others		101. C
	Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31	sum of lines 29	and 30 for a	II others			101. 0 101. 0
02. 00	LINE 35 CALCULATION Line 31 = line 29 for respiratory therapy or						102. 0
		13 for resninat	tory therapy o	r sum of colu	umns 1-3 line	0	102. 0
	Line 32 = line 8 times columns 1 and 2, line 13 for all others	15 TOT TCSpira				Ĭ	

	NABLE COST DETERMINATION FOR THERAPY SERVICES DE SUPPLIERS	FURNI SHED BY	I SHED BY Provi der CCN: 15-1320		Peri od: From 10/01/2015 To 09/30/2016		pared:
					Occupati onal Therapy	2/27/2017 10: Cost	37 am
						1.00	
	PART I - GENERAL INFORMATION					1. 00	
1. 00	Total number of weeks worked (excluding aides	s) (see instruct	i ons)			52	1.00
2. 00	Line 1 multiplied by 15 hours per week					780	
3. 00 4. 00	Number of unduplicated days in which supervisions Number of unduplicated days in which therapy					0	3. 00 4. 00
+. 00	nor therapist was on provider site (see insti		ii provider si	te but her the	er supervisor	U	4.0
5. 00	Number of unduplicated offsite visits - super	rvisors or thera				0	5.0
5. 00	Number of unduplicated offsite visits - thera assistant and on which supervisor and/or the					0	6.0
	instructions)	iapisi was noi p	resent during	the visit(s)	) (See		
7. 00	Standard travel expense rate					0. 00	
8. 00	Optional travel expense rate per mile	Supervi sors	Therapi sts	Assi stants	Ai des	0.00 Trai nees	8.0
		1.00	2. 00	3. 00	4. 00	5. 00	
9. 00	Total hours worked	1.00	1, 885. 00	0.0		0. 00	
10.00	AHSEA (see instructions) Standard travel allowance (columns 1 and 2,	82. 74 37. 61	75. 22 37. 61	0. ( 0. (		0. 00	
11. 00	one-half of column 2, line 10; column 3,	37.01	37.01	0. (	00		11. 0
	one-half of column 3, line 10)						
12.00		0	0		0		12.0
12. 01 13. 00	Number of travel hours (offsite) Number of miles driven (provider site)	0	O O		0		12. 0 13. 0
13. 01		0	Ö		0		13.0
						1 00	
	Part II - SALARY EQUIVALENCY COMPUTATION					1. 00	
	Supervisors (column 1, line 9 times column 1,					83	
15.00	Therapists (column 2, line 9 times column 2,					141, 790	
16. 00 17. 00	Assistants (column 3, line 9 times column 3, Subtotal allowance amount (sum of lines 14 au	0 141, 873	16. 0 17. 0				
	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)						
18.00	Aides (column 4, line 9 times column 4, line					0	18.0
19. 00 20. 00	Trainees (column 5, line 9 times column 5, li Total allowance amount (sum of lines 17–19 fo		herany or line	es 17 and 18	for all others)	0 141, 873	
20.00	If the sum of columns 1 and 2 for respiratory	therapy or col	umns 1-3 for	ohysical ther	apy, speech path	nology or	20.0
	occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete		o entries on I	ines 21 and	22 and enter on	line 23	
21. 00	•		divided by sur	m of columns	1 and 2, line 9	0.00	21.0
22 00	for respiratory therapy or columns 1 thru 3,						22.0
22. 00 23. 00	Weighted allowance excluding aides and trained Total salary equivalency (see instructions)	ees (line 2 time	S TINE 21)			0 141, 873	
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW	VANCE AND TRAVEL	EXPENSE COMPL	JTATION - PRO	OVIDER SITE	,	
24 00	Standard Travel Allowance					0	24.0
24. 00 25. 00	Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11)					0	
26. 00	Subtotal (line 24 for respiratory therapy or	sum of lines 24	and 25 for al	II others)		0	26. 0
27. 00	Standard travel expense (line 7 times line 3	for respiratory	therapy or si	um of lines 3	3 and 4 for all	0	27. 0
	others) Total standard travel allowance and standard	travel expense	at the provide	er site (sum	of lines 26 and	0	28. 0
28. 00							
28. 00	27)		·				20.0
	Optional Travel Allowance and Optional Travel		2 line 12 )			0	
28. 00 29. 00 30. 00	Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of	of columns 1 and	2, line 12 )			0	29. 0
29. 00 30. 00 31. 00	Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or	of columns 1 and , line 12) sum of lines 29	and 30 for al				29. 0 30. 0 31. 0
29. 00 30. 00	Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns)	of columns 1 and , line 12) sum of lines 29	and 30 for al		or sum of	0	29. 0 30. 0 31. 0
29. 00 30. 00 31. 00	Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or	of columns 1 and , line 12) sum of lines 29 s 1 and 2, line	and 30 for al		or sum of	0 0	29. 0 30. 0 31. 0 32. 0
29. 00 30. 00 31. 00 32. 00 33. 00 34. 00	Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel	of columns 1 and, line 12) sum of lines 29 s 1 and 2, line l expense (line l expense (sum o	and 30 for al 13 for respira 28) flines 27 and	atory therapy	or sum of	0 0 0 0	29. 0 30. 0 31. 0 32. 0 33. 0 34. 0
29. 00 30. 00 31. 00 32. 00	Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and optional travel optional travel allowance and optional travel	of columns 1 and, line 12) sum of lines 29 s 1 and 2, line l expense (line l expense (sum o	and 30 for al 13 for respira 28) flines 27 and flines 31 and	atory therapy d 31) d 32)		0 0 0 0 0	29. 0 30. 0 31. 0 32. 0 33. 0 34. 0
29. 00 30. 00 31. 00 32. 00 33. 00 34. 00	Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel	of columns 1 and, line 12) sum of lines 29 s 1 and 2, line l expense (line l expense (sum o	and 30 for al 13 for respira 28) flines 27 and flines 31 and	atory therapy d 31) d 32)		0 0 0 0 0	29. 0 30. 0 31. 0 32. 0 33. 0 34. 0
29. 00 80. 00 81. 00 82. 00 83. 00 84. 00 85. 00	Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWARD Standard Travel Expense	of columns 1 and, line 12) sum of lines 29 s 1 and 2, line l expense (line l expense (sum o	and 30 for al 13 for respira 28) flines 27 and flines 31 and	atory therapy d 31) d 32)		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	29. 0 30. 0 31. 0 32. 0 34. 0 35. 0
29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00	Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Optional travel allowance and optional travel STANDARD AND OPTIONAL TRAVEL ALLOW/STANDARD TRAVEL STANDARD STANDARD STANDARD AND OPTIONAL TRAVEL ALLOW/STANDARD STANDARD STANDA	of columns 1 and, line 12) sum of lines 29 s 1 and 2, line l expense (line l expense (sum o	and 30 for al 13 for respira 28) flines 27 and flines 31 and	atory therapy d 31) d 32)		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	29. 0 30. 0 31. 0 32. 0 34. 0 35. 0 36. 0 37. 0
29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00	Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWASTANDARD TRAVEL ALLOWASTANDARD TRAVEL STANDARD STANDARD AND OPTIONAL TRAVEL ALLOWASTANDARD STANDARD STANDARD AND OPTIONAL TRAVEL ALLOWASTANDARD STANDARD STANDARD AND OPTIONAL TRAVEL ALLOWASTANDARD STANDARD STANDARD STANDARD AND OPTIONAL TRAVEL ALLOWASTANDARD STANDARD STAND	of columns 1 and, line 12) sum of lines 29 s 1 and 2, line l expense (line l expense (sum of lexpense) ance and Travel	and 30 for al 13 for respira 28) f lines 27 and f lines 31 and EXPENSE COMPU	atory therapy d 31) d 32)		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	29. 0 30. 0 31. 0 32. 0 34. 0 35. 0 36. 0 37. 0 38. 0
29. 00 30. 00 31. 00 32. 00 33. 00 34. 00	Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Optional travel allowance and optional travel STANDARD AND OPTIONAL TRAVEL ALLOW/STANDARD TRAVEL STANDARD STANDARD STANDARD AND OPTIONAL TRAVEL ALLOW/STANDARD STANDARD STANDA	of columns 1 and, line 12) sum of lines 29 s 1 and 2, line l expense (line l expense (sum of l expense (sum of l expense (sum of lines 5 and	and 30 for al 13 for respira 28) f lines 27 and f lines 31 and EXPENSE COMPU	atory therapy d 31) d 32)		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	29. 0 30. 0 31. 0 32. 0 33. 0 34. 0 35. 0 36. 0 37. 0 38. 0
29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00	Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/Standard Travel Expense  Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sur Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0	of columns 1 and, line 12) sum of lines 29 s 1 and 2, line l expense (line l expense (sum of expense (sum of ANCE AND TRAVEL m of lines 5 and Expense Of times column	and 30 for al 13 for respira 28) f lines 27 and f lines 31 and EXPENSE COMPU	atory therapy d 31) d 32)		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	29. 0 30. 0 31. 0 32. 0 34. 0 35. 0 36. 0 37. 0 38. 0 39. 0
29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00	Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel AND OPTIONAL TRAVEL ALLOW/STANDARD Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0 Assistants (column 3, line 12.01 times columns)	of columns 1 and, line 12) sum of lines 29 s 1 and 2, line l expense (line l expense (sum of expense (sum of ANCE AND TRAVEL m of lines 5 and Expense Of times column	and 30 for al 13 for respira 28) f lines 27 and f lines 31 and EXPENSE COMPU	atory therapy d 31) d 32)		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	29. 0 30. 0 31. 0 32. 0 34. 0 35. 0 36. 0 37. 0 38. 0 39. 0 40. 0 41. 0
29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00	Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/Standard Travel Expense  Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sur Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0	of columns 1 and , line 12) sum of lines 29 s 1 and 2, line l expense (line l expense (sum of ANCE AND TRAVEL  m of lines 5 and Expense O1 times column n 3, line 10)	and 30 for al 13 for respira 28) f lines 27 and f lines 31 and EXPENSE COMPUTED	atory therapy d 31) d 32)		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	29. 0 30. 0 31. 0 32. 0 34. 0 35. 0 36. 0 37. 0 38. 0 39. 0 40. 0 41. 0 42. 0
29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 37. 00 38. 00 39. 00 40. 00 41. 00	Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Optional travel allowance and optional travel Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sur Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.04 Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41)	of columns 1 and , line 12) sum of lines 29 s 1 and 2, line l expense (line l expense (sum of expense (sum of ANCE AND TRAVEL  m of lines 5 and Expense On times column n 3, line 10) m of columns 1-3	and 30 for al 13 for respira 28) f lines 27 and f lines 31 and EXPENSE COMPUT	d 31) d 32) TATION - SERV	/ICES OUTSIDE PRO	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	39. 0 31. 0 32. 0 34. 0 35. 0 36. 0 37. 0 38. 0 39. 0 40. 0 41. 0 42. 0

REASON	Financial Systems ABLE COST DETERMINATION FOR THERAPY SERVICES I E SUPPLIERS	JAY COUNTY FURNI SHED BY	Provi der C		Period: From 10/01/2015 To 09/30/2016	Date/Time Prep 2/27/2017 10:	-3 pared:
					Occupati onal Therapy	Cost	
						1. 00	
45. 00	Optional travel allowance and standard travel	expense (sum	of lines 39 an	nd 42 - see in:	structions)	0	45. 00
46. 00	Optional travel allowance and optional travel		of lines 42 an				46. 00
		Therapi sts 1.00	Assi stants 2.00	Ai des 3.00	Trai nees 4. 00	Total 5.00	
	PART V - OVERTIME COMPUTATION	1.00	2.00	3.00	4.00	3.00	
47. 00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0. 00	0. 00	0.0	0.00	0.00	47. 00
48. 00	Overtime rate (see instructions)	0. 00	0. 00	1			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				1		
50. 00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5,	0. 00	0. 00	0.0	0.00	0.00	50.00
51. 00	line 47) Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0. 00	0.00	0.0	0.00	0. 00	51. 00
	DETERMINATION OF OVERTIME ALLOWANCE						
52. 00	Adjusted hourly salary equivalency amount (see instructions)	75. 22	0. 00	0.0	0.00		52. 00
53. 00	Overtime cost limitation (line 51 times line 52)	0	0		0		53. 00
54. 00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0		0		54. 00
55. 00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	O	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	0	0		0	0	56. 00
	for all others.)						
						1. 00	
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST	ADJUSTMENT				
57.00	Salary equivalency amount (from line 23) Travel allowance and expense - provider site	(from lines 22	24 or 25))			141, 873 0	57. 00 58. 00
59. 00	Travel allowance and expense - Offsite service			)		0	59.00
60.00	Overtime allowance (from column 5, line 56)			,		0	60.00
	Equipment cost (see instructions)					0	
	Supplies (see instructions)					0	
	Total allowance (sum of lines 57-62)					141, 873	
64. 00 65. 00	Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63	,				110, 616 0	65. 00
100 00	LINE 33 CALCULATION Line 26 = line 24 for respiratory therapy or	sum of lines 2	4 and 25 for a	all others		0	100. 00
100. 01	Line 27 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27				others	0	100. 01 100. 02
101. 00	LINE 34 CALCULATION Line 27 = line 7 times line 3 for respiratory	therapy or su	m of lines 3 a	and 4 for all	others	0	101. 00
101.01	Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION						101. 01 101. 02
	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
102. 02	13 for all others Line 35 = sum of lines 31 and 32					0	102. 02

-	Speech Pathology Cost						37 alli		
				196		3331			
						1. 00			
4 00	PART I - GENERAL INFORMATION			4 00					
1. 00 2. 00	Total number of weeks worked (excluding aide: Line 1 multiplied by 15 hours per week	s) (see Instruc	tions)			52 780	1. 00 2. 00		
3.00	Number of unduplicated days in which supervi	sor or theranis	t was on provi	der site (see i	nstructions)	780			
4.00	Number of unduplicated days in which therapy		•			Ö	4. 00		
	nor therapist was on provider site (see instructions)								
5.00	Number of unduplicated offsite visits - supe		0	5. 00					
6.00	Number of unduplicated offsite visits - there		0	6. 00					
	assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)								
7. 00	Standard travel expense rate	0. 00	7. 00						
8.00	Optional travel expense rate per mile	0.00							
		Trai nees							
	T	1.00 2.00 3.00 4.00							
9.00	Total hours worked	0.00	276.00	0.00	0.00				
10. 00 11. 00	AHSEA (see instructions) Standard travel allowance (columns 1 and 2,	0. 00 36. 15	72. 30 36. 15	0. 00 0. 00	0. 00	0.00	10. 00 11. 00		
11.00	one-half of column 2, line 10; column 3,	30. 13	30. 13	0.00			11.00		
	one-half of column 3, line 10)								
12.00	Number of travel hours (provider site)	О	0	0			12.00		
12.01	Number of travel hours (offsite)	o	0	0			12. 01		
13.00	Number of miles driven (provider site)	0	0	0			13. 00		
13. 01	Number of miles driven (offsite)	0	0	0			13. 01		
						1.00			
	Part II - SALARY EQUIVALENCY COMPUTATION					1. 00			
14. 00	Supervisors (column 1, line 9 times column 1	line 10)				0	14. 00		
15. 00	Therapists (column 2, line 9 times column 2,	•				19, 955			
16. 00	Assistants (column 3, line 9 times column 3,					0			
17.00	Subtotal allowance amount (sum of lines 14 am		ratory therapy	or lines 14-16	for all	19, 955	17. 00		
	others)								
18.00	Aides (column 4, line 9 times column 4, line	•				0	18.00		
19.00	Trainees (column 5, line 9 times column 5, li	•		47 140 6		0	19.00		
20. 00	Total allowance amount (sum of lines 17-19 for the sum of columns 1 and 2 for respirators						20. 00		
	occupational therapy, line 9, is greater than					03			
	the amount from line 20. Otherwise complete		no circi i es cir	111103 21 dia 22	and enter on	11110 20			
21.00	Weighted average rate excluding aides and tra		divided by su	m of columns 1	and 2, line 9	72. 30	21. 00		
	for respiratory therapy or columns 1 thru 3,								
22. 00	Weighted allowance excluding aides and train	ees (line 2 tim	es line 21)			56, 394			
23. 00	Total salary equivalency (see instructions)	VANCE AND TRAVE	L EVDENCE COMP	ITATION DDOVI	DED CLIE	56, 394	23. 00		
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance	VANCE AND TRAVE	L EXPENSE COMP	DIAITON - PROVI	DER SITE				
24. 00	Therapists (line 3 times column 2, line 11)					0	24. 00		
25. 00	Assistants (line 4 times column 3, line 11)					o			
26.00	Subtotal (line 24 for respiratory therapy or	sum of lines 2	4 and 25 for a	II others)		0	26. 00		
27. 00	Standard travel expense (line 7 times line 3	for respirator	y therapy or s	um of lines 3 a	nd 4 for all	0	27. 00		
	others)								
28. 00	Total standard travel allowance and standard	travel expense	at the provid	er site (sum of	Tines 26 and	0	28. 00		
	27) Optional Travel Allowance and Optional Travel	Fynansa							
29. 00	Therapists (column 2, line 10 times the sum		d 2. line 12 )			0	29. 00		
30. 00	Assistants (column 3, line 10 times column 3		, ,			o			
31.00	Subtotal (line 29 for respiratory therapy or		9 and 30 for a	II others)		0	31.00		
32.00	Optional travel expense (line 8 times columns	s 1 and 2, line	13 for respir	atory therapy o	r sum of	0	32. 00		
	columns 1-3, line 13 for all others)								
33. 00							33. 00		
34. 00 35. 00							34. 00 35. 00		
33.00	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA				ES OUTSIDE PRO	OVIDER SITE	33.00		
	Standard Travel Expense	WOL THE HOUSE	EXI ENGL COM C	TATTON SERVICE	LO OUTOTBE TIME	WIDER SITE			
36.00	Therapists (line 5 times column 2, line 11)					0	36. 00		
37. 00	Assistants (line 6 times column 3, line 11)		0	37. 00					
38. 00	Subtotal (sum of lines 36 and 37)					0			
39. 00	Standard travel expense (line 7 times the sur		d 6)			0	39. 00		
40.00	Optional Travel Allowance and Optional Travel		0 11 40)				40.00		
40.00	Therapists (sum of columns 1 and 2, line 12.)		2, 11 ne 10)			0			
41. 00 42. 00	Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41)	1 3, 1111e 10)				0	41. 00 42. 00		
42.00	Optional travel expense (line 8 times the su	m of columns 1-	3. line 13 01)			0			
.5. 00	Total Travel Allowance and Travel Expense - 0			e of the follow	ing three line		. 5. 50		
	or 46, as appropriate.								
44. 00	Standard travel allowance and standard trave						44. 00		
45. 00	Optional travel allowance and standard trave	l expense (sum	of lines 39 and	d 42 – see inst	ructions)	0	45. 00		

	ABLE COST DETERMINATION FOR THERAPY SERVICES I E SUPPLIERS	FURNI SHED BY	Provi der CO	F	Period: From 10/01/2015 To 09/30/2016 peech Pathology	Worksheet A-8 Parts I-VI Date/Time Pre 2/27/2017 10: Cost	pared:
						1. 00	
46. 00	Optional travel allowance and optional travel	expense (sum o	of lines 42 an	d 43 - see ins	tructions)		46. 00
		Therapi sts	Assi stants	Ai des	Trai nees	Total	
		1. 00	2. 00	3. 00	4. 00	5. 00	
47. 00	PART V - OVERTIME COMPUTATION  Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47. 00
48.00	Overtime rate (see instructions)	0. 00	0.00	0.00	0.00		48. 00
49. 00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)  CALCULATION OF LIMIT	0. 00	0. 00	0.00	0.00		49. 00
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	0.00	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	0.00	0.00	0.00	51. 00
52. 00	Adjusted hourly salary equivalency amount	72. 30	0.00	0.00	0.00		52.00
53. 00	(see instructions) Overtime cost limitation (line 51 times line	0	0	C	0		53. 00
54. 00	52) Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	C	0		54. 00
55. 00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	C	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.)	0	0	C	0	0	56. 00
						1. 00	
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND FXCESS COST	ADJUSTMENT			1.00	
57. 00 58. 00 59. 00 60. 00 61. 00	Salary equivalency amount (from line 23) 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)	(from lines 33	, 34, or 35))	)		56, 394 0 0 0 0 0	58. 00 59. 00 60. 00 61. 00
63. 00	Total allowance (sum of lines 57-62)					56, 394	
64. 00	Total cost of outside supplier services (from					25, 667	
	Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION		,			0	
100.00 Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others 100.01 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others 100.02 Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION							100. 00 100. 01 100. 02
	Line 27 = line 7 times line 3 for respiratory				others		101. 00
	Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION	sum of lines 2	9 and 30 for a	II others			101. 01 101. 02
102 00	Line 31 = line 29 for respiratory therapy or	sum of lines 29	9 and 30 for a	II others		0	102. 00
	Line 32 = line 8 times columns 1 and 2, line 13 for all others				nns 1-3, line		102. 01

0 102. 02

13 for all others 102.02 Line 35 = sum of lines 31 and 32

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1320 

			Ic	09/30/2016	Date/lime Pre   2/27/2017 10:		
				CAPITAL REL	ATED COSTS		
	Cost Center Description	Net Expenses	NEW MVBLE	NEW MVBLE	NEW MVBLE	NEW MVBLE	
	oost conto. Boson per ch	for Cost	EQUI P	EQUI P MOB	EQUI P-POB	EQUI P- WJ	
		Allocation					
		(from Wkst A col. 7)					
		0	2. 00	2. 01	2. 02	2. 03	
	GENERAL SERVICE COST CENTERS						
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	1, 236, 269	1, 236, 269				2.00
2. 01 2. 02	00201 NEW CAP REL COSTS-MVBLE EQUIP MOB 00202 NEW CAP REL COSTS-MVBLE EQUIP-POB	8, 676 106, 456	0	8, 676 0	106, 456		2. 01 2. 02
2. 03	00203 NEW CAP REL COSTS-MVBLE EQUI P- WJ	31, 142	0	Ö	0	31, 142	2. 03
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	6, 642, 281	0	0	0	0	4. 00
5. 00 7. 00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	5, 805, 208 1, 201, 983	125, 557 100, 179		8, 850 6, 387	0	5. 00 7. 00
7. 00	00701 OPERATION OF PLANT-MOB	40, 083	100, 179	1, 2,74	0, 387	0	7. 00
7. 02	00702 OPERATION OF PLANT-POB	154, 694	0	O	o	0	7. 02
7. 03	00703 OPERATION OF PLANT-WJ	2, 545	0	0	0	0	7. 03
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	68, 452 465, 769	6, 815 7, 612		0	0	8. 00 9. 00
10. 00	01000 DI ETARY	370, 734	31, 902		o	0	10.00
11. 00	01100 CAFETERI A	118, 971	31, 473		0	0	11. 00
13.00	01300 NURSING ADMINISTRATION	1, 035, 175	25, 531		0	0	13.00
14. 00 16. 00	01400 CENTRAL SERVICES & SUPPLY 01600 MEDICAL RECORDS & LIBRARY	181, 825 405, 443	19, 267 21, 748		0	0	14. 00 16. 00
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	403, 443	21, 740	<u> </u>	<u> </u>	0	10.00
30. 00	03000 ADULTS & PEDIATRICS	1, 546, 026	182, 530	0	0	0	30. 00
31.00	03100   NTENSIVE CARE UNIT	0	70.240	-	0	0	31.00
40. 00 41. 00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF	949, 331	70, 360 0	1	0	0	40. 00 41. 00
42. 00	04200 SUBPROVI DER	0	0	o o	ő	0	42. 00
43.00	04300 NURSERY	105, 107	15, 821	0	0	0	43. 00
EO 00	ANCI LLARY SERVI CE COST CENTERS	1 (00 013	02.057	l ol	47 070	0	FO 00
50. 00 52. 00	O5000   OPERATING ROOM   O5200   DELIVERY ROOM & LABOR ROOM	1, 608, 012 17, 728	82, 857 1, 945		47, 870 0	0	50. 00 52. 00
53. 00	05300 ANESTHESI OLOGY	0	0	Ö	ő	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 352, 292	9, 588		0	0	54. 00
57. 00 58. 00	05700 CT SCAN   05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	1	0	0	57. 00 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59.00
60.00	06000 LABORATORY	1, 865, 004	39, 162		Ö	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, 309 636, 112	8, 546 1, 669		0	0	65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	110, 695	1, 009	1	0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	25, 667	0	0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	563, 382	30, 662	1	0	0	69.00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	71. 00 72. 00
	07300 DRUGS CHARGED TO PATIENTS	1, 491, 436	148, 040		o	0	73. 00
	OUTPATIENT SERVICE COST CENTERS						
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 CLINIC	209, 817	0	0	0	0	90.00
90. 01	09001 FAMILY PRACTICE OF JAY COUNTY	376, 087	0	5, 878	o	0	90. 01
90. 02	09002 JAY FAMILY MEDICINE	498, 078	132, 326		0	0	90. 02
91. 00 92. 00	O9100   EMERGENCY   O9200   OBSERVATION   BEDS (NON-DISTINCT PART)	765, 664	69, 563	0	0	0	91. 00 92. 00
93. 00	04040 OTHER OUTPATIENT SERVICE COST CENTER	11, 050	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS	,					
99. 10	09910 CORF	0	0	0	0	0	99. 10
106.00	SPECIAL PURPOSE COST CENTERS 10600 HEART ACQUISITION		0	O	0	0	106. 00
	10900 PANCREAS ACQUISITION	0	0		o		109.00
	11000 INTESTINAL ACQUISITION	0	0	0	0		110. 00
	11100   SLET ACQUI SITI ON	0	0	0	0	0	111.00
113.00	11300 INTEREST EXPENSE   SUBTOTALS (SUM OF LINES 1-117)	30, 363, 503	1, 163, 153	8, 676	63, 107	Λ	113. 00 118. 00
. 13. 00	NONREI MBURSABLE COST CENTERS		1, 100, 100	0,070	55, 167		] . 3. 30
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13, 876		0		190. 00
	19200   PHYSICIANS' PRIVATE OFFICES   19300   NONPAID WORKERS	0	0	0	0		192. 00 193. 00
	19300  NONPALD WORKERS   07950  MOB		0		0		193.00
194. 01	07951 P0B		0	Ö	Ö	0	194. 01
	07952 WEST JAY CLINIC	38, 327	0	0	0	31, 142	194. 02
194. 03	07953 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194. 03

Heal th Financial Systems

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1320
Provider CCN: 15-1320
From 10/01/2015
To 09/30/2016
Prepared:

				077 007 2010	2/27/2017 10:	
			CAPITAL REL	ATED COSTS		
	l	NEW 18/51 E	NEW 18/81 E	NEW 10/01 E	115111 1111151 5	
Cost Center Description	Net Expenses	NEW MVBLE	NEW MVBLE	NEW MVBLE	NEW MVBLE	
	for Cost	EQUI P	EQUIP MOB	EQUI P-POB	EQUIP- WJ	
	Allocation					
	(from Wkst A					
	col . 7)					
	0	2. 00	2. 01	2. 02	2. 03	
194.04 07954 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194. 04
194.05 07955 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194. 05
194. 06 07956 TRI COUNTY	1, 354, 728	0	0	43, 349	0	194. 06
194. 07 07957 HOSPI TALI ST	490, 530	0	0	0	0	194. 07
194.08 07958 FAMILY FIRST HEALTH	192, 450	59, 240	0	0	0	194. 08
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers		0	0	0	0	201. 00
202.00 TOTAL (sum lines 118-201)	32, 439, 538	1, 236, 269	8, 676	106, 456	31, 142	202. 00

Provider CCN: 15-1320

				11	0 09/30/2016	Date/lime Pre   2/27/2017 10:	
	Cost Center Description	EMPLOYEE BENEFITS	Subtotal	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT-MOB	57 diii
		DEPARTMENT					
	GENERAL SERVICE COST CENTERS	4.00	4A	5. 00	7. 00	7. 01	
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2. 00
2. 01	00201 NEW CAP REL COSTS-MVBLE EQUIP MOB						2. 01
2.02	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	6, 642, 281					4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	897, 908	6, 839, 047				5. 00
7.00	00700 OPERATION OF PLANT	112, 769	1, 422, 592		1, 802, 630	F2 4//	7.00
7. 01 7. 02	OO701   OPERATION OF PLANT-MOB   OO702   OPERATION OF PLANT-POB	2, 111 3, 278	42, 194 157, 972		0	53, 466 0	7. 01 7. 02
7. 02	00703 OPERATION OF PLANT-WJ	975	3, 520		0	0	7. 02
8. 00	00800 LAUNDRY & LINEN SERVICE	10, 354	85, 621	1	12, 158	0	8. 00
9.00	00900 HOUSEKEEPI NG	161, 518	634, 899	169, 610	13, 578	0	9. 00
10.00	01000 DI ETARY	75, 331	477, 967		56, 908	0	10.00
11.00	01100 CAFETERI A	62, 934	213, 378		56, 144	0	11.00
13. 00 14. 00	01300   NURSI NG ADMI NI STRATI ON   01400   CENTRAL SERVI CES & SUPPLY	396, 024 23, 642	1, 456, 730 224, 734		45, 543 34, 369	0	13. 00 14. 00
16. 00	01600 MEDICAL RECORDS & LI BRARY	141, 110	568, 301		38, 795	0	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS		222122	1917 911	55/		
30. 00	03000 ADULTS & PEDI ATRI CS	517, 143	2, 245, 699	599, 932	325, 605	0	30. 00
31.00	03100   I NTENSI VE CARE UNI T	0	1 207 014	0	125 510	0	31.00
40. 00 41. 00	04000   SUBPROVI DER - I PF   04100   SUBPROVI DER - I RF	267, 323	1, 287, 014	343, 819	125, 510 0	0	40. 00 41. 00
42. 00	04200 SUBPROVI DER		0	0	0	0	42.00
43.00	04300 NURSERY	34, 742	155, 670	41, 586	28, 222	0	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	330, 886	2, 069, 625		147, 804	0	50.00
52. 00 53. 00	05200   DELI VERY ROOM & LABOR ROOM   05300   ANESTHESI OLOGY	5, 889	25, 562 0	6, 829	3, 470 0	0	52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	308, 444	1, 670, 324	446, 219	17, 103	0	54.00
57. 00	05700 CT SCAN	0	0	0	0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59.00
60. 00 60. 01	06000  LABORATORY  06001  BLOOD LABORATORY	255, 462	2, 159, 628	576, 934	69, 858	0	60. 00 60. 01
65. 00	06500 RESPIRATORY THERAPY		364, 855	97, 469	15, 245	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	637, 781	170, 380	2, 978	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	110, 695	29, 572	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	25, 667		0	0	68. 00
69. 00 71. 00	06900   ELECTROCARDI OLOGY   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	83, 378	677, 422 0	180, 970	54, 696 0	0	69. 00 71. 00
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS		0	0	0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	157, 643	1, 797, 119	480, 091	264, 079	0	73. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	
89.00	08900   FEDERALLY QUALIFIED HEALTH CENTER   09000   CLINIC	129, 851	339, 668	90, 741	0	0	
	09001 FAMILY PRACTICE OF JAY COUNTY	629, 798	1, 011, 763		o	53, 466	
	09002 JAY FAMILY MEDICINE	646, 963	1, 277, 367		236, 049	0	90. 02
	09100 EMERGENCY	895, 248	1, 730, 475	462, 288	124, 089	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART) 04040 OTHER OUTPATIENT SERVICE COST CENTER	o	0 11, 050	2, 952	0	0	92. 00 93. 00
73.00	OTHER REIMBURSABLE COST CENTERS	J O	11,030	2, 732	<u> </u>	0	73.00
99. 10	09910 CORF	0	0	0	0	0	99. 10
	SPECIAL PURPOSE COST CENTERS			1			
	10600 HEART ACQUISITION	0	0		0		106. 00
	10900 PANCREAS ACQUISITION  11000 INTESTINAL ACQUISITION	0	0	0	0		109. 00 110. 00
	11100 I SLET ACQUI SI TI ON		0	0	0		111.00
	11300   NTEREST EXPENSE		_				113. 00
118.00		6, 150, 724	29, 724, 339	6, 113, 695	1, 672, 203	53, 466	118. 00
400.00	NONREI MBURSABLE COST CENTERS		40.07/	0 707	04.750		100 00
	19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   19200   PHYSICIANS' PRIVATE OFFICES		13, 876	3, 707	24, 752 0		190. 00 192. 00
	19300 NONPALD WORKERS		0	0	0		193. 00
	07950 MOB	0	0	Ō	0		194. 00
	07951 P0B	0	0	0	0		194. 01
	07952 WEST JAY CLINIC	184, 984	254, 453	67, 976	0		194. 02
	07953 OTHER NONREIMBURSABLE COST CENTERS 07954 OTHER NONREIMBURSABLE COST CENTERS		0	0	0		194. 03 194. 04
	07955 OTHER NONREIMBURSABLE COST CENTERS		0	o o	ol		194. 05
194.06	07956 TRI COUNTY	65, 853	1, 463, 930		o	0	194. 06
194. 07	07957 HOSPI TALI ST	183, 195	673, 725	179, 982	0	0	194. 07

Health Financial Systems	JAY COUNTY HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider Co		Period: From 10/01/2015 To 09/30/2016	Worksheet B Part I Date/Time Prep 2/27/2017 10:3	
Cost Center Description	EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIV & GENERAL	E OPERATION OF PLANT	OPERATION OF PLANT-MOB	

						2/27/2017 10:	37 am_
	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	
194. 08 07958	FAMILY FIRST HEALTH	57, 525	309, 215	82, 605	105, 675	0	194. 08
200.00	Cross Foot Adjustments		0				200. 00
201. 00	Negative Cost Centers	0	0	0	0	0	201. 00
202. 00	TOTAL (sum lines 118-201)	6, 642, 281	32, 439, 538	6, 839, 047	1, 802, 630	53, 466	202. 00

Provider CCN: 15-1320

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 10/01/2015 | Part I | To 09/30/2016 | Date/Time Prepared: | 2/27/2017 10: 37 am

		ODEDATION OF	ODERATION OF	L ALINDDY A	LIQUEEKEEN NO.	2/27/2017 10:	
	Cost Center Description	OPERATION OF PLANT-POB	OPERATION OF PLANT-WJ	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
		7. 02	7. 03	8.00	9. 00	10. 00	
	GENERAL SERVICE COST CENTERS						
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2. 01 2. 02	OO201 NEW CAP REL COSTS-MVBLE EQUIP MOB   OO202 NEW CAP REL COSTS-MVBLE EQUIP-POB						2. 01 2. 02
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. 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	200, 173					7. 02
7.03	00703 OPERATION OF PLANT-WJ	0	4, 460				7. 03
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	120, 652	222 / 52		8. 00
9.00	00900 HOUSEKEEPI NG	0	0	10, 566	828, 653	400 007	9.00
10. 00 11. 00	01000  DI ETARY  01100  CAFETERI A	0	0	3, 579	21, 867 20, 999	688, 007 0	10. 00 11. 00
13. 00	01300 NURSING ADMINISTRATION	0	0	0	14, 888	0	
	01400 CENTRAL SERVICES & SUPPLY	o o	0	Ö	20, 641	0	
	01600 MEDICAL RECORDS & LIBRARY	0	0	0	14, 459	0	1
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	0	0	33, 343	136, 775	469, 395	1
31. 00	03100 I NTENSI VE CARE UNI T	0	0	0	0	0	31. 00
	04000 SUBPROVI DER - I PF	0	0	9, 202	47, 373	218, 612	1
41. 00 42. 00	04100 SUBPROVI DER - I RF 04200 SUBPROVI DER	0	0	0	0	0	
43. 00	04300 NURSERY	0	0	_	10, 556	0	
43.00	ANCI LLARY SERVI CE COST CENTERS		U	37	10, 550		43.00
50.00	05000 OPERATING ROOM	105, 047	0	31, 015	121, 957	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	1, 298	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	9, 373	63, 916	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	
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	24 524	0	59. 00 60. 00
60. 00	06000  LABORATORY  06001  BLOOD LABORATORY	0	0	0	24, 524	0	60. 00
65. 00	06500 RESPIRATORY THERAPY	0	0	0	2, 861	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0	2, 045	2,001	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	o	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	852	10, 218	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	
73. 00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	0	0	11, 342	0	73. 00
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	ام	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	1
90. 00	09000 CLINIC	o o	0	Ö	42, 917	0	1
90. 01	09001 FAMILY PRACTICE OF JAY COUNTY	0	0	0	58, 909	0	90. 01
90. 02	09002 JAY FAMILY MEDICINE	0	0	0	0	0	90. 02
	09100 EMERGENCY	0	0	20, 620	47, 516	0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93. 00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93. 00
99. 10	OTHER REIMBURSABLE COST CENTERS  09910 CORF	0	0	0	o	0	99. 10
77. 10	SPECIAL PURPOSE COST CENTERS	0	U	0	U <sub>I</sub>	0	77. 10
106.00	10600 HEART ACQUISITION	0	0	0	0	0	106. 00
	10900 PANCREAS ACQUISITION	0	0	0	0		109.00
110.00	11000 INTESTINAL ACQUISITION	0	0	0	0	0	110. 00
	11100   SLET ACQUISITION	0	0	0	0	0	111. 00
	11300 I NTEREST EXPENSE						113. 00
118. 00		105, 047	0	120, 652	673, 016	688, 007	]118. 00
100.00	NONREI MBURSABLE COST CENTERS		0		F 07/		100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	5, 876		190. 00 192. 00
	19300 NONPALD WORKERS	0	0	0	0		193. 00
	07950 MOB		0	0	90, 852		194. 00
	07951 POB	0	0	Ö	58, 909		194. 01
194. 02	07952 WEST JAY CLINIC	0	4, 460	0	0	0	194. 02
	07953 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194. 03
	07954 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194. 04
	07955 OTHER NONREIMBURSABLE COST CENTERS	0 0 10	0	0	0		194. 05
	07956 TRI COUNTY 07957 HOSPI TALI ST	95, 126	0	0	0		194. 06 194. 07
	07957 HOSPITALISI 07958 FAMILY FIRST HEALTH	0	0	) O	0		194. 07
. , ,, 00	1222		0		9		1

Heal th Financial Systems

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1320
Provider CCN: 15-1320
From 10/01/2015
To 09/30/2016
Part I
Date/Time Prepared:

							2/27/2017 10:	37 am
		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	
20	0.00	Cross Foot Adjustments						200.00
20	1. 00	Negative Cost Centers	0	0	0	0	0	201.00
20	2. 00	TOTAL (sum lines 118-201)	200, 173	4, 460	120, 652	828, 653	688, 007	202. 00

Provider CCN: 15-1320

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 10/01/2015 Part I
To 09/30/2016 Date/Time Prepared: 2/27/2017 10:37 am

				09/30/2016	2/27/2017 10:	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	MEDI CAL	Subtotal	
		ADMI NI STRATI ON	SERVICES &	RECORDS &		
			SUPPLY	LIBRARY		
GENERAL SERVICE COST CENTERS	11.00	13. 00	14. 00	16. 00	24. 00	
2. 00 O0200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2. 01   00201 NEW CAP REL COSTS-MVBLE EQUIP MOB						2. 00
2. 02 00202 NEW CAP REL COSTS-MVBLE EQUIP-POB						2. 02
2. 03   00203 NEW CAP REL COSTS MVBLE EQUIP- WJ						2. 02
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						7. 01
7. 02 00702 OPERATION OF PLANT-POB						7. 02
7. 03   00703   OPERATION OF PLANT-WJ						7. 03
8. 00 00800 LAUNDRY & LINEN SERVICE						8.00
9. 00   00900   HOUSEKEEPI NG						9. 00
10. 00   01000 DI ETARY						10.00
11. 00   01100   CAFETERI A	347, 524					11.00
13.00 01300 NURSING ADMINISTRATION	25, 599	1, 931, 918				13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	3, 903		343, 684			14. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	16, 900	1	590	790, 864		16. 00
INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>			· · · ·		1
30. 00 03000 ADULTS & PEDIATRICS	53, 089	720, 242	24, 569	50, 977	4, 659, 626	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40. 00   04000   SUBPROVI DER - I PF	25, 651	347, 992	2, 131	10, 696	2, 418, 000	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	0	42. 00
43. 00 04300 NURSERY	3, 267	44, 315	0	3, 164	286, 837	43. 00
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATI NG ROOM	26, 029		97, 228	119, 737	3, 624, 456	
52.00   05200   DELIVERY ROOM & LABOR ROOM	430	5, 831	0	1, 082	44, 502	
53. 00   05300   ANESTHESI OLOGY	0	0	0	0	0	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	24, 018	0	26, 952	243, 270	2, 501, 175	1
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	0	0	0	0	59. 00
60. 00   06000   LABORATORY	27, 697	0	88, 403	163, 012	3, 110, 056	
60. 01 06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
65. 00 06500 RESPI RATORY THERAPY	0	0	1, 374	7, 570	489, 374	1
66. 00 06600 PHYSI CAL THERAPY	0	0	1, 177	19, 773	834, 134	
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	3, 596	143, 863	
68. 00 06800 SPEECH PATHOLOGY	0	0	0	909	33, 433	
69. 00   06900   ELECTROCARDI OLOGY	9, 473	0	6, 797	23, 437	963, 865	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
73. 00 O7300 DRUGS CHARGED TO PATIENTS	10, 625	0	4, 206	37, 740	2, 605, 202	73. 00
OUTPATIENT SERVICE COST CENTERS	1			اه		
88. 00 08800 RURAL HEALTH CLINIC	0	1	0	0	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	1 010	0	
90. 00   09000   CLINI C	14, 132		6, 259	1, 919	495, 636	90.00
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY	35, 364	1	31, 845	12, 088	1, 473, 722	
90.02   09002   JAY FAMILY MEDICINE 91.00   09100   EMERGENCY	37, 410		22, 471	8, 109	1, 922, 648	
	33, 937	460, 414	19, 394	83, 785	2, 982, 518	91. 00 92. 00
92.00   09200   OBSERVATION BEDS (NON-DISTINCT PART) 93.00   04040   OTHER OUTPATIENT SERVICE COST CENTER	0	0	101	0	14 102	1
OTHER REIMBURSABLE COST CENTERS	0	U	101	U	14, 103	93.00
99. 10   09910   CORF	0	0	0	0	0	99. 10
SPECIAL PURPOSE COST CENTERS		U O	U	<u> </u>		77. 10
106. 00 10600 HEART ACQUISITION	0	٥		٥	0	106. 00
109. 00 10900 PANCREAS ACQUISITION	0	0	0	0		109.00
110. 00 11000   NTESTI NAL ACQUISITION	0	0	0	0		110.00
111. 00 11100   SLET ACQUISITION	0	0	0	0		111.00
113. 00 11300   NTEREST EXPENSE	0		O	o l	O	113. 00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	347, 524	1, 931, 918	333, 497	790, 864	28, 603, 150	
NONREI MBURSABLE COST CENTERS	347,324	1, 751, 710	333, 477	770,004	20, 003, 130	1110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	n	0	nl	48 211	190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0		0	ol O		192. 00
193. 00 19300 NONPALD WORKERS	0	Ö	0	Ö		193. 00
194. 00 07950 MOB	l n	l ő	n	o o		194. 00
194. 01 07951 POB	l 0	l ő	n	o o		194. 01
194. 02 07952 WEST JAY CLINIC	l o		n	ol	326, 889	
194. 03 07953 OTHER NONREI MBURSABLE COST CENTERS	l	l ől	Ö	ol		194. 03
194. 04 07954 OTHER NONREIMBURSABLE COST CENTERS	0	l ol	Ō	o		194. 04
194. 05 07955 OTHER NONREIMBURSABLE COST CENTERS	0	l ol	Ō	o	0	194. 05
194. 06 07956 TRI COUNTY	0	ol	4, 949	o	1, 955, 087	
194. 07 07957 HOSPI TALI ST	0	o	16	О	853, 723	
			ı	'		

Health Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO		Peri od: From 10/01/2015 To 09/30/2016	Worksheet B Part I Date/Time Pre 2/27/2017 10:	
Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	MEDI CAL RECORDS & LIBRARY	Subtotal	

	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	MEDI CAL	Subtotal	
			ADMI NI STRATI ON	SERVICES &	RECORDS &		
				SUPPLY	LI BRARY		
		11. 00	13.00	14. 00	16. 00	24. 00	
194. 08 07958	FAMILY FIRST HEALTH	0	0	5, 222	0	502, 717	194. 08
200.00	Cross Foot Adjustments					0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202. 00	TOTAL (sum lines 118-201)	347, 524	1, 931, 918	343, 684	790, 864	32, 439, 538	202. 00

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

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1320 Peri od: Worksheet B From 10/01/2015 Part I Date/Time Prepared: 09/30/2016 2/27/2017 10:37 am Cost Center Description Intern & Total Residents Cost & Post Stepdown Adjustments 25.00 26.00 GENERAL SERVICE COST CENTERS 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 00201 NEW CAP REL COSTS-MVBLE EQUIP MOB 2.01 2.01 00202 NEW CAP REL COSTS-MVBLE EQUIP-POB 2.02 2.02 00203 NEW CAP REL COSTS-MVBLE EQUIP- WJ 2.03 2.03 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 7.00 00700 OPERATION OF PLANT 7.00 7.01 00701 OPERATION OF PLANT-MOB 7.01 00702 OPERATION OF PLANT-POB 7 02 7 02 00703 OPERATION OF PLANT-WJ 7.03 7.03 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10 00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14 00 14 00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 4, 659, 626 30.00 03100 INTENSIVE CARE UNIT 0 31 00 31 00 0 40.00 04000 SUBPROVI DER - I PF 2, 418, 000 40.00 04100 SUBPROVI DER - I RF 41.00 41.00 42.00 04200 SUBPROVI DER 0 42.00 04300 NURSERY 0 286, 837 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 0 05000 OPERATING ROOM 3, 624, 456 50.00 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 52.00 44, 502 53.00 05300 ANESTHESI OLOGY 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 00000000000 2, 501, 175 54.00 57.00 05700 CT SCAN 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 0 05900 CARDIAC CATHETERIZATION 59 00 59 00 06000 LABORATORY 3, 110, 056 60.00 60.00 60.01 06001 BLOOD LABORATORY 60.01 06500 RESPIRATORY THERAPY 65.00 489.374 65.00 66.00 06600 PHYSI CAL THERAPY 834, 134 66.00 67.00 06700 OCCUPATIONAL THERAPY 143,863 67.00 06800 SPEECH PATHOLOGY 68.00 33, 433 68.00 06900 ELECTROCARDI OLOGY 69.00 963, 865 69.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 2, 605, 202 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 89.00 09000 CLINIC 495, 636 90 00 90 00 90.01 09001 FAMILY PRACTICE OF JAY COUNTY 1, 473, 722 90.01 09002 JAY FAMILY MEDICINE 1, 922, 648 90.02 0 0 90.02 09100 EMERGENCY 91.00 2, 982, 518 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 93.00 04040 OTHER OUTPATIENT SERVICE COST CENTER 14, 103 93.00 OTHER REIMBURSABLE COST CENTERS 99. 10 0 0 99 10 09910 CORF SPECIAL PURPOSE COST CENTERS 106. 00 10600 HEART ACQUISITION 0 0 106.00 0 109.00 10900 PANCREAS ACQUISITION 0 109.00 0 110.00 11000 INTESTINAL ACQUISITION 110 00 0 111.00 11100 | SLET ACQUISITION 0 0 111. 00 113.00 11300 INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1-117) 118.00 0 28, 603, 150 118.00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 48, 211 190.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 192.00 193. 00 19300 NONPALD WORKERS 0 0 0 193. 00 194. 00 07950 MOB 90, 852 194.00 194. 01 07951 POB 194. 01 58, 909 0 194. 02 07952 WEST JAY CLINIC 326, 889 194. 02 194. 03 07953 OTHER NONREIMBURSABLE COST CENTERS 194. 03 Ω 0 194. 04 07954 OTHER NONREIMBURSABLE COST CENTERS 194.04 194. 05 07955 OTHER NONREIMBURSABLE COST CENTERS 194.05

Health Financial Systems	JAY COUNTY H	JAY COUNTY HOSPITAL			In Lieu of Form CMS-2552-10		
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CCN: 15-1320		Peri od: From 10/01/2015 To 09/30/2016	Worksheet B Part I Date/Time Prepared: 2/27/2017 10:37 am		
Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total					
	25. 00	26. 00					
194. 06 07956 TRI COUNTY	0	1, 955, 087			194. 06		
194. 07 07957 H0SPI TALI ST	0	853, 723			194. 07		
194.08 07958 FAMILY FIRST HEALTH	0	502, 717			194. 08		
200.00 Cross Foot Adjustments	0	0			200. 00		
201.00 Negative Cost Centers	0	0			201. 00		
202.00 TOTAL (sum lines 118-201)	0	32, 439, 538			202. 00		

| Peri od: | Worksheet B | From 10/01/2015 | Part II | To 09/30/2016 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1320

			To		Date/Time Pre 2/27/2017 10:	
			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	125, 557 100, 179	1, 524 1, 274	8, 850 6, 387	0	
7. 01   00701 OPERATION OF PLANT-MOB	0	100, 179	1, 274	0, 387	0	1
7. 02 00702 OPERATION OF PLANT-POB	0	О	0	0	0	
7.03   00703   0PERATION OF PLANT-WJ 8.00   00800   LAUNDRY & LINEN SERVICE	0	0 6, 815	0	0	0	
9. 00   00900   HOUSEKEEPI NG	O	7, 612	0	o	0	1
10. 00 01000 DI ETARY	0	31, 902	0	O	0	
11. 00   01100   CAFETERI A 13. 00   01300   NURSI NG   ADMI NI STRATI ON	0	31, 473 25, 531	0	0	0	1
14. 00 01400 CENTRAL SERVI CES & SUPPLY	O	19, 267	0	o	0	
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	21, 748	0	0	0	16. 00
30. 00 03000 ADULTS & PEDIATRICS	0	182, 530	0	ol	0	30.00
31. 00   03100   NTENSI VE CARE UNI T	o	0	0	o	0	1
40. 00   04000   SUBPROVI DER -   PF	0	70, 360	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	O	15, 821	0	o	0	1
ANCILLARY SERVICE COST CENTERS		00.057		47.070		
50.00   05000   0PERATING ROOM 52.00   05200   DELIVERY ROOM & LABOR ROOM	0	82, 857 1, 945	0	47, 870 0	0	1
53. 00 05300 ANESTHESI OLOGY	0	0	0	Ö	0	
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0	9, 588	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	Ō	0	0	0	
60. 00 06000 LABORATORY	0	39, 162	0	0	0	
60. 01   06001   BLOOD LABORATORY 65. 00   06500   RESPI RATORY THERAPY	0	8, 546	0	0	0	
66. 00   06600   PHYSI CAL THERAPY	0	1, 669	0	0	0	
67. 00   06700   OCCUPATI ONAL THERAPY 68. 00   06800   SPEECH PATHOLOGY	0	0	0	0	0	1
68. 00   06800  SPEECH PATHOLOGY 69. 00   06900  ELECTROCARDI OLOGY	0	30, 662	0	0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	O	0	71. 00
72.00   07200   IMPL. DEV. CHARGED TO PATIENTS 73.00   07300   DRUGS CHARGED TO PATIENTS	0	148 040	0	0	0	
OUTPATIENT SERVICE COST CENTERS	1 9	148, 040	U	U <sub>I</sub>	0	73.00
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	1
89. 00   08900   FEDERALLY QUALI FI ED HEALTH CENTER 90. 00   09000   CLI NI C	0	0	0	0	0	
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY	0	o	5, 878	o	0	1
90. 02 09002 JAY FAMILY MEDICINE	0	132, 326	0	o	0	1
91. 00   09100   EMERGENCY 92. 00   09200   0BSERVATI ON BEDS (NON-DI STINCT PART)	0	69, 563	0	0	0	91. 00 92. 00
93. 00   04040   OTHER OUTPATIENT SERVICE COST CENTER	0	O	0	0	0	1
OTHER REIMBURSABLE COST CENTERS						
99. 10   09910   CORF   SPECI AL PURPOSE COST CENTERS	0	0	0	0	0	99. 10
106. 00 10600 HEART ACQUI SI TI ON	0	0	0	0	0	106. 00
109.00 10900 PANCREAS ACQUISITION	0	0	0	O		109. 00
110. 00 11000  I NTESTI NAL ACQUI SI TI ON 111. 00 11100  I SLET ACQUI SI TI ON	0	0	0	0		110. 00 111. 00
113. 00 11300   NTEREST EXPENSE		O.	J	o <sub>l</sub>	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	1, 163, 153	8, 676	63, 107	0	118. 00
NONREIMBURSABLE COST CENTERS  190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13 976	0	٥	0	190. 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN  192.00 19200 PHYSICIANS' PRIVATE OFFICES		13, 876 0	0	0		190.00
193.00 19300 NONPALD WORKERS	0	О	0	0		193. 00
194. 00 07950  M0B 194. 01 07951  P0B	0	0	0	0		194. 00 194. 01
194. 02 07952 WEST JAY CLINIC		ol	0	0		194. 01
194.03 07953 OTHER NONREIMBURSABLE COST CENTERS	0	О	0	0	0	194. 03
194.04 07954 OTHER NONREIMBURSABLE COST CENTERS	0	이	0	0	0	194. 04

Heal th Financial Systems

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1320
Period: From 10/01/2015 Part II
To 09/30/2016 Date/Time Prepared:

					2/27/2017 10:	37 am
		CAPITAL RELATED COSTS				
Cost Center Description	Di rectly	NEW MVBLE	NEW MVBLE	NEW MVBLE	NEW MVBLE	
	Assigned New	EQUI P	EQUIP MOB	EQUI P-POB	EQUIP- WJ	
	Capi tal					
	Related Costs					
	0	2.00	2. 01	2. 02	2. 03	
194. 05 07955 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194. 05
194.06 07956 TRI COUNTY	0	0	0	43, 349	0	194. 06
194. 07 07957 HOSPI TALI ST	0	0	0	0	0	194. 07
194.08 07958 FAMILY FIRST HEALTH	0	59, 240	0	0	0	194. 08
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	0	1, 236, 269	8, 676	106, 456	31, 142	202.00

Provider CCN: 15-1320

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 10/01/2015 Part II
To 09/30/2016 Date/Time Prepared: 2/27/2017 10:37 am

					0 09/30/2016	2/27/2017 10:	
	Cost Center Description	Subtotal	EMPLOYEE	ADMI NI STRATI VE		OPERATION OF	
			BENEFITS DEPARTMENT	& GENERAL	PLANT	PLANT-MOB	
		2A	4. 00	5. 00	7. 00	7. 01	
	AL SERVICE COST CENTERS  NEW CAP REL COSTS-MVBLE EQUIP			1			2 00
	NEW CAP REL COSTS-MVBLE EQUIP						2. 00 2. 01
	NEW CAP REL COSTS-MVBLE EQUIP-POB						2. 02
2. 03 00203	NEW CAP REL COSTS-MVBLE EQUIP- WJ						2. 03
	EMPLOYEE BENEFITS DEPARTMENT	0	(				4. 00
	ADMINISTRATIVE & GENERAL OPERATION OF PLANT	135, 931	(	135, 931	115 204		5.00
	OPERATION OF PLANT OPERATION OF PLANT-MOB	107, 840 0	(	7, 554 224		224	7. 00 7. 01
	OPERATION OF PLANT-POB	o	(	839		0	7. 02
7. 03 00703	OPERATION OF PLANT-WJ	0	(	19	0	0	7. 03
	LAUNDRY & LINEN SERVICE	6, 815	(	455		0	8. 00
	HOUSEKEEPI NG DI ETARY	7, 612 31, 902	(	3, 371 2, 538	869 3, 643	0	9. 00 10. 00
	CAFETERI A	31, 473	(	1, 133		0	11.00
	NURSI NG ADMI NI STRATI ON	25, 531	(	7, 735		Ö	13. 00
	CENTRAL SERVICES & SUPPLY	19, 267	(	.,		0	14. 00
	MEDICAL RECORDS & LIBRARY	21, 748	(	3, 018	2, 483	0	16. 00
	I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	182, 530	(	11, 916	20, 844	0	30. 00
	INTENSIVE CARE UNIT	162, 530	(	) 11, 910	20, 844	0	31.00
	SUBPROVI DER - I PF	70, 360	(	6, 834	8, 034	0	40. 00
	SUBPROVI DER - I RF	0	(	0	0	0	41.00
	SUBPROVI DER	0	(	0	0	0	42.00
	NURSERY  LARY SERVICE COST CENTERS	15, 821	(	827	1, 807	0	43. 00
	OPERATING ROOM	130, 727	(	10, 990	9, 462	0	50.00
	DELIVERY ROOM & LABOR ROOM	1, 945	(	1		0	52.00
	ANESTHESI OLOGY	0	(	0	0	0	53. 00
	RADI OLOGY-DI AGNOSTI C	9, 588	(	8, 869	1, 095	0	54.00
	CT SCAN MAGNETIC RESONANCE IMAGING (MRI)	0	(		0	0	57. 00 58. 00
	CARDIAC CATHETERIZATION	0	(		0	0	59.00
	LABORATORY	39, 162	(	11, 468	4, 472	0	60.00
	BLOOD LABORATORY	0	(	0	0	0	60. 01
	RESPI RATORY THERAPY	8, 546	(	1, 937	976	0	65. 00
	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	1, 669	(	3, 387 588	191	0	66. 00 67. 00
	SPEECH PATHOLOGY	0	(	136		0	68. 00
	ELECTROCARDI OLOGY	30, 662	(	3, 597	3, 501	0	69. 00
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	(	0	0	0	71.00
	IMPL. DEV. CHARGED TO PATIENTS	149 040	(	) 0 9, 543	14 005	0	72.00
	DRUGS CHARGED TO PATIENTS TIENT SERVICE COST CENTERS	148, 040	(	<u>ار</u> 9, 543	16, 905	U	73. 00
	RURAL HEALTH CLINIC	0	(	0	0	0	88. 00
	FEDERALLY QUALIFIED HEALTH CENTER	0	(			0	89. 00
	CLINIC	0	(	1, 804		0	90.00
	FAMILY PRACTICE OF JAY COUNTY JAY FAMILY MEDICINE	5, 878 132, 326	(	5, 372 6, 783		224 0	90. 01 90. 02
	EMERGENCY	69, 563	(	9, 189		0	91.00
	OBSERVATION BEDS (NON-DISTINCT PART)	0			,		92.00
	OTHER OUTPATIENT SERVICE COST CENTER	0	(	59	0	0	93. 00
	REIMBURSABLE COST CENTERS				0	0	00 10
99. 10 09910 SPECIA	AL PURPOSE COST CENTERS	0		0	0	0	99. 10
	HEART ACQUISITION	0	(	0	0	0	106. 00
109. 00 10900	PANCREAS ACQUISITION	0	(	0	0	0	109. 00
	INTESTINAL ACQUISITION	0	(	0	0		110. 00
	I SLET ACQUI SI TI ON	0	(	0	0	0	111.00
	INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1-117)	1, 234, 936	(	121, 514	107, 044	224	113. 00 118. 00
	IMBURSABLE COST CENTERS	1,234,730		7 121, 514	107, 044	224	1110.00
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	13, 876	(	74	1, 585		190. 00
	PHYSICIANS' PRIVATE OFFICES	0	(	0	0		192. 00
	NONPALD WORKERS	0	(	0	0		193. 00
194. 00 07950 194. 01 07951		0	(		0		194. 00 194. 01
	WEST JAY CLINIC	31, 142	(	1, 351	0		194. 01
194. 03 07953	OTHER NONREIMBURSABLE COST CENTERS	ō	(	0	0	0	194. 03
	OTHER NONREIMBURSABLE COST CENTERS	0	(	0	0		194. 04
194. 05 07955 194. 06 07956	OTHER NONREIMBURSABLE COST CENTERS	42 240	(	0 7 770	0		194. 05 194. 06
	HOSPI TALI ST	43, 349 0	(	7, 773 3, 577			194. 06
	1	<u> </u>		0,077	, J	0	

Health Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der C		eriod: rom 10/01/2015	Worksheet B Part II	
				o 09/30/2016	Date/Time Pre 2/27/2017 10:	pared: 37 am_
Cost Center Description	Subtotal	EMPLOYEE	ADMI NI STRATI VE	OPERATION OF	OPERATION OF	
		BENEFITS	& GENERAL	PLANT	PLANT-MOB	
		DEPARTMENT				
	2A	4.00	5.00	7. 00	7. 01	
194.08 07958 FAMILY FIRST HEALTH	59, 240	0	1, 642	6, 765	0	194. 08
200.00 Cross Foot Adjustments	0					200. 00
201.00 Negative Cost Centers	0	0	0	0	0	201. 00
202.00 TOTAL (sum lines 118-201)	1, 382, 543	0	135, 931	115, 394	224	202. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1320

Peri od: Worksheet B From 10/01/2015 Part II To 09/30/2016 Date/Time Prepared:

2/27/2017 10:37 am Cost Center Description OPERATION OF OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY PLANT-POB PLANT-WJ LINEN SERVICE 9.00 10.00 7.02 7.03 8.00 GENERAL SERVICE COST CENTERS 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 00201 NEW CAP REL COSTS-MVBLE EQUIP MOB 2.01 2.01 00202 NEW CAP REL COSTS-MVBLE EQUIP-POB 2.02 2.02 00203 NEW CAP REL COSTS-MVBLE EQUIP- WJ 2 03 2 03 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00701 OPERATION OF PLANT-MOB 7.01 7 01 7.02 00702 OPERATION OF PLANT-POB 839 7.02 7.03 00703 OPERATION OF PLANT-WJ 0 19 7 03 00800 LAUNDRY & LINEN SERVICE 0 8.048 8 00 8 00 9.00 00900 HOUSEKEEPI NG 0 705 12, 557 9.00 10.00 01000 DI ETARY 0 239 331 38, 653 10.00 01100 CAFETERI A 11.00 318 11.00 C 0 01300 NURSING ADMINISTRATION 0 13.00 226 0 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 0 0 313 0 14.00 01600 MEDICAL RECORDS & LIBRARY 16.00 219 0 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 0 26, 371 03000 ADULTS & PEDIATRICS 0 2, 224 2,071 30.00 03100 INTENSIVE CARE UNIT 0 31.00 31.00 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 0 40.00 0 718 12, 282 40.00 614 0 41.00 0 C 0 0 41.00 42.00 04200 SUBPROVI DER 0 C 0 0 0 42.00 43.00 04300 NURSERY 160 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 50.00 05000 OPERATING ROOM 440 2,069 1,848 Λ 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 20 0 52.00 C 05300 ANESTHESI OLOGY 53.00 0 0 0 C 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 969 54.00 625 0 54.00 57.00 05700 CT SCAN C C 0 0 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 0 0 58.00 05900 CARDIAC CATHETERIZATION 0000000000 59.00 0 0 0 59.00 60 00 06000 LABORATORY 0 372 60 00 0 06001 BLOOD LABORATORY 60.01 0 0 0 60.01 06500 RESPIRATORY THERAPY 0 65.00 43 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 66.00 136 0 06700 OCCUPATIONAL THERAPY 0 67.00 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 57 155 0 69.00 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS Ω 71 00 0 0 0 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 172 0 73.00 OUTPATIENT SERVICE COST CENTERS 88 00 0 88 00 08800 RURAL HEALTH CLINIC 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 89.00 90.00 09000 CLI NI C 0 0 0 650 0 90.00 09001 FAMILY PRACTICE OF JAY COUNTY 0 90. 01 90.01 0 0 893 0 09002 JAY FAMILY MEDICINE 90 02 90.02 Ω 0 0 0 91.00 09100 EMERGENCY 0 C 1, 375 720 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 04040 OTHER OUTPATIENT SERVICE COST CENTER
OTHER REIMBURSABLE COST CENTERS 0 93.00 93.00 0 0 99. 10 09910 CORF 0 0 0 0 0 99. 10 SPECIAL PURPOSE COST CENTERS 106. 00 10600 HEART ACQUI SI TI ON 0 106, 00 0 0 0 109.00 10900 PANCREAS ACQUISITION 0 C 0 0 0 109, 00 110.00 11000 INTESTINAL ACQUISITION 0 0 0 0 110.00 0 0 111.00 11100 I SLET ACQUISITION 0 0 0 111.00 113.00 11300 INTEREST EXPENSE 113.00 118.00 SUBTOTALS (SUM OF LINES 1-117) 440 0 8,048 10, 198 38, 653 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190, 00 0 0 89 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 C 0 0 0 192, 00 193. 00 19300 NONPALD WORKERS 0 193.00 0 0 0 194. 00 07950 MOB 0 0 1, 377 0 194.00 194. 01 07951 POB 0 0 194, 01 C 893 0 194. 02 0 194. 02 07952 WEST JAY CLINIC 19 0 0 194. 03 07953 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 194. 03 0 0 194. 04 07954 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 194. 04 194.05 07955 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 194. 05 0 194. 06 07956 TRI COUNTY 399 0 0 0 0 194.06 194. 07 07957 HOSPI TALI ST 0 194. 07 0 0 194.08 07958 FAMILY FIRST HEALTH 0 0 194. 08

Health Financial Systems	JAY COUNTY HOS	SPI TAL	In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-1320	From 10/01/2015	Worksheet B Part II Date/Time Prepared:

						2/27/2017 10:	37 am
	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	
200.00	Cross Foot Adjustments						200.00
201. 00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	839	19	8. 048	12, 557	38, 653	202.00

Provider CCN: 15-1320

In Lieu of Form CMS-2552-10

| Period: | Worksheet B | From 10/01/2015 | Part II |
| To 09/30/2016 | Date/Time Prepared: 2/27/2017 10:37 am

					09/30/2016	2/27/2017 10:	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	MEDI CAL	Subtotal	
			ADMI NI STRATI ON	SERVICES &	RECORDS &		
		11.00	13. 00	SUPPLY 14.00	LI BRARY 16. 00	24. 00	
	GENERAL SERVICE COST CENTERS	11.00	10.00	11.00	10.00	21.00	
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 EQUI P- WJ						2. 03
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00 5. 00
7. 00	OO5OO   ADMINISTRATIVE & GENERAL   OO7OO   OPERATION OF PLANT						7. 00
7. 00	00701 OPERATION OF PLANT-MOB						7. 01
7. 02	00702 OPERATION OF PLANT-POB						7. 02
7.03	00703 OPERATION OF PLANT-WJ						7. 03
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY	0, 540					10.00
11. 00 13. 00	O1100   CAFETERI A   O1300   NURSI NG ADMI NI STRATI ON	36, 518 2, 690	1				11.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	410	1	23, 383			14. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	1, 776	1	40	29, 284		16. 00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1,775		,	27/201		10.00
30.00	03000 ADULTS & PEDI ATRI CS	5, 581	14, 576	1, 672	1, 886	269, 671	30. 00
31.00	03100 INTENSIVE CARE UNIT	0	0	0	0	0	
40. 00	04000 SUBPROVI DER - I PF	2, 695	7, 042	145	396	109, 120	1
41. 00	04100 SUBPROVI DER - I RF	0	0	0	0	0	41.00
42. 00 43. 00	04200 SUBPROVI DER 04300 NURSERY	343	897	0	0 117	0 19, 976	
43.00	ANCI LLARY SERVI CE COST CENTERS	343	097	O <sub>I</sub>	117]	17, 770	43.00
50. 00	05000 OPERATING ROOM	2, 735	7, 146	6, 615	4, 429	176, 461	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	45		0	40	2, 526	1
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 524	0	1, 834	9, 028	34, 532	1
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	
59. 00 60. 00	05900   CARDI AC   CATHETERI ZATI ON   06000   LABORATORY	2, 910	0	6, 015	6, 030	70, 429	59. 00 60. 00
60. 00	06001 BLOOD LABORATORY	2, 910	0	0, 013	0, 030	70, 429	1
65. 00	06500 RESPIRATORY THERAPY	0	Ö	93	280	11, 875	1
66. 00	06600 PHYSI CAL THERAPY	0	0	80	731	6, 194	1
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0	133	721	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	0	34	170	1
69. 00	06900 ELECTROCARDI OLOGY	995	0	462	867	40, 296	1
71. 00	07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   07200   MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	
72. 00 73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 116	0	286	1, 396	177, 458	72. 00 73. 00
73.00	OUTPATIENT SERVICE COST CENTERS	1,110	0	200	1, 370	177, 430	73.00
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00
90.00	09000 CLI NI C	1, 485		426	71	4, 436	90. 00
	09001 FAMILY PRACTICE OF JAY COUNTY	3, 716		2, 167	447	18, 697	1
90. 02	09002 JAY FAMILY MEDICINE	3, 931		1, 529	300	159, 979	1
	O9100   EMERGENCY   O9200   OBSERVATION   BEDS (NON-DISTINCT PART)	3, 566	9, 318	1, 319	3, 099	106, 092	91. 00 92. 00
	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	7	0	66	1
70.00	OTHER REIMBURSABLE COST CENTERS		<u> </u>	, ,	<u> </u>		75.00
99. 10	09910 CORF	0	0	0	0	0	99. 10
	SPECIAL PURPOSE COST CENTERS						
	10600 HEART ACQUISITION	0	0	0	0		106. 00
	10900 PANCREAS ACQUISITION	0	0	0	0		109. 00
	11000 I NTESTI NAL ACQUI SI TI ON	0	0	0	0		110.00
	11100  SLET ACQUISITION  11300  NTEREST EXPENSE	0	U	U	٩	U	111. 00 113. 00
118.00		36, 518	39, 097	22, 690	29, 284	1, 208, 699	1
110.00	NONREI MBURSABLE COST CENTERS	00,010	37, 377	22,070	27,201	1, 200, 077	1110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	15, 624	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192. 00
	19300 NONPALD WORKERS	0	0	0	0		193. 00
	07950 MOB	0	0	0	0		194. 00
	07951  POB  07952  WEST JAY CLINIC			0	0		194. 01 194. 02
	07953 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194. 02
	07954 OTHER NONREIMBURSABLE COST CENTERS	0		0	ol		194. 04
	07955 OTHER NONREIMBURSABLE COST CENTERS	0	o	O	o		194. 05
	07956 TRI COUNTY	0	0	337	0		194. 06
194. 07	07957 HOSPI TALI ST	0	0	1	0	3, 578	194. 07

Health Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CC		Peri od:	Worksheet B	
				From 10/01/2015	Part II	
				To 09/30/2016	Date/Time Pre	
					2/27/2017 10:	37 am
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	MEDI CAL	Subtotal	
		ADMI NI STRATI ON	SERVICES &	RECORDS &		
			SUPPLY	LI BRARY		
	11. 00	13.00	14. 00	16. 00	24.00	
194.08 07958 FAMILY FIRST HEALTH	0	0	35	5 0	68, 002	194. 08
200.00 Cross Foot Adjustments					0	200. 00
201.00 Negative Cost Centers	0	0		0 0	0	201. 00
202.00 TOTAL (sum lines 118-201)	36, 518	39, 097	23, 38	3 29, 284	1, 382, 543	202. 00

Health Financial Systems

ALLOCATION OF CAPITAL RELATED COSTS

JAY COUNTY HOSPITAL
Provider CCN: 15-1320
Period: Worksheet B

From 10/01/2015 Part II Date/Time Prepared: 09/30/2016 2/27/2017 10:37 am Cost Center Description Intern & Total Residents Cost & Post Stepdown Adjustments 25.00 26.00 GENERAL SERVICE COST CENTERS 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 00201 NEW CAP REL COSTS-MVBLE EQUIP MOB 2.01 2.01 00202 NEW CAP REL COSTS-MVBLE EQUIP-POB 2.02 2.02 00203 NEW CAP REL COSTS-MVBLE EQUIP- WJ 2.03 2.03 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 7.00 00700 OPERATION OF PLANT 7.00 7.01 00701 OPERATION OF PLANT-MOB 7.01 00702 OPERATION OF PLANT-POB 7 02 7 02 00703 OPERATION OF PLANT-WJ 7.03 7.03 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10 00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14 00 14 00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 269, 671 03100 INTENSIVE CARE UNIT 0 31 00 31 00 0 40.00 04000 SUBPROVI DER - I PF 109, 120 40.00 04100 SUBPROVI DER - I RF 41.00 41.00 0 42.00 04200 SUBPROVI DER 42.00 19, 976 04300 NURSERY 0 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 0 05000 OPERATING ROOM 176, 461 50.00 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 52.00 2, 526 53.00 05300 ANESTHESI OLOGY 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 00000000000 34, 532 54.00 57.00 05700 CT SCAN 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 05900 CARDIAC CATHETERIZATION 59 00 59 00 06000 LABORATORY 60.00 70, 429 60.00 60.01 06001 BLOOD LABORATORY 60.01 06500 RESPIRATORY THERAPY 65.00 11.875 65.00 66.00 06600 PHYSI CAL THERAPY 6, 194 66.00 67.00 06700 OCCUPATIONAL THERAPY 721 67.00 06800 SPEECH PATHOLOGY 68.00 170 68.00 06900 ELECTROCARDI OLOGY 69.00 40, 296 69.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 07300 DRUGS CHARGED TO PATIENTS 177, 458 73.00 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 Ω 89.00 4, 436 09000 CLINIC 90 00 90 00 90.01 09001 FAMILY PRACTICE OF JAY COUNTY 18, 697 90.01 09002 JAY FAMILY MEDICINE 0 0 90.02 159, 979 90.02 09100 EMERGENCY 91.00 106, 092 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 93.00 04040 OTHER OUTPATIENT SERVICE COST CENTER 66 93.00 OTHER REIMBURSABLE COST CENTERS 99. 10 0 0 99. 10 09910 CORF SPECIAL PURPOSE COST CENTERS 106. 00 10600 HEART ACQUISITION 0 0 106.00 0 109.00 10900 PANCREAS ACQUISITION 0 109.00 0 110.00 11000 INTESTINAL ACQUISITION 110 00 0 111.00 11100 | SLET ACQUISITION 0 0 111. 00 113.00 11300 INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1-117) 118.00 0 1, 208, 699 118.00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 15, 624 190.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 192.00 193. 00 19300 NONPALD WORKERS 0 0 0 193. 00 194. 00 07950 MOB 1, 377 194.00 194. 01 07951 POB 893 194. 01 0 194. 02 07952 WEST JAY CLINIC 32, 512 194. 02 194. 03 07953 OTHER NONREIMBURSABLE COST CENTERS 194. 03 C 0 194. 04 07954 OTHER NONREIMBURSABLE COST CENTERS 194.04 0 194. 05 07955 OTHER NONREIMBURSABLE COST CENTERS 194.05

Health Financial Systems		In Lie	u of Form CMS-	2552-10		
ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-1320		Peri od:	Worksheet B	
				From 10/01/2015 To 09/30/2016	Part II   Date/Time Pre	nared.
				10 07/30/2010	2/27/2017 10:	37 am
Cost Center Description	Intern &	Total				
	Residents Cost					
	& Post					
	Stepdown					
	Adjustments					
	25. 00	26.00				
194. 06 07956 TRI COUNTY	0	51, 858				194. 06
194. 07 07957 HOSPI TALI ST	0	3, 578				194. 07
194.08 07958 FAMILY FIRST HEALTH	0	68, 002				194. 08
200.00 Cross Foot Adjustments	O	o				200. 00
201.00 Negative Cost Centers	0	o				201. 00
202.00 TOTAL (sum lines 118-201)	o	1, 382, 543				202. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS JAY COUNTY HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-1320 Peri od: From 10/01/2015 To 09/30/2016 Worksheet B-1 Date/Time Prepared: 2/27/2017 10:37 am CAPITAL RELATED COSTS

Cost Center Description	NEW MVBLE EQUI P (SQUARE FEET)	NEW MVBLE EQUI P MOB (SQUARE FEET)	NEW MVBLE EQUI P-POB (SQUARE FEET)	NEW MVBLE EQUI P- WJ (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
GENERAL SERVICE COST CENTERS	2.00	2. 01	2. 02	2. 03	4. 00	
2. 00   00200   NEW CAP REL COSTS-MVBLE EQUI P 2. 01   00201   NEW CAP REL COSTS-MVBLE EQUI P MOB 2. 02   00202   NEW CAP REL COSTS-MVBLE EQUI P-POB	80, 720 0	8, 146 0	10, 501			2. 00 2. 01 2. 02
2.03 OO203 NEW CAP REL COSTS-MVBLE EQUIP- WJ 4.00 OO400 EMPLOYEE BENEFITS DEPARTMENT 5.00 OO500 ADMINISTRATIVE & GENERAL	0 0 8, 198	0 0 1, 431	0 0 873	3, 300 0 0	17, 345, 047 2, 344, 722	2. 03 4. 00 5. 00
7. 00   00700   0PERATION OF PLANT 7. 01   00701   0PERATION OF PLANT-MOB 7. 02   00702   0PERATION OF PLANT-POB	6, 541 0 0	1, 196 0 0	0 0	0 0 0	294, 474 5, 513 8, 561	7. 00 7. 01 7. 02
7. 03   00703   0PERATION OF PLANT-WJ 8. 00   00800   LAUNDRY & LINEN SERVICE 9. 00   00900   HOUSEKEEPING 10. 00   01000   DI ETARY	445 497 2,083	0	0 0 0	0 0 0 0	2, 545 27, 038 421, 774 196, 713	7. 03 8. 00 9. 00 10. 00
11. 00   01100   CAFETERI A 13. 00   01300   NURSI NG   ADMI NI STRATI ON 14. 00   01400   CENTRAL   SERVI CES & SUPPLY	2, 055 1, 667 1, 258	0 0	0 0 0	0 0 0	164, 340 1, 034, 141 61, 737	11. 00 13. 00 14. 00
16. 00   01600   MEDI CAL RECORDS & LI BRARY   I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1, 420	0	0	0	368, 481	16. 00
30. 00   03000   ADULTS & PEDI ATRICS 31. 00   03100   INTENSIVE CARE UNIT 40. 00   04000   SUBPROVI DER -   IPF	11, 918 0 4, 594	0	0 0 0	0 0	1, 350, 419 0 698, 062	30. 00 31. 00 40. 00
41. 00   04100   SUBPROVI DER - I RF 42. 00   04200   SUBPROVI DER 43. 00   04300   NURSERY	0 0 1, 033	0	0	0 0	90, 721	41. 00 42. 00 43. 00
ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM	5, 410	0	4, 722	0	864, 045	50. 00
52. 00   05200   DELI VERY ROOM & LABOR ROOM 53. 00   05300   ANESTHESI OLOGY 54. 00   05400   RADI OLOGY-DI AGNOSTI C	127 0 626	0 0 0	0 0 0	0 0 0	15, 377 0 805, 442	52. 00 53. 00 54. 00
57. 00   05700   CT SCAN 58. 00   05800   MAGNETIC RESONANCE I MAGING (MRI) 59. 00   05900   CARDIAC CATHETERIZATION	0 0	0 0 0	0 0 0	0 0 0	0 0 0	57. 00 58. 00 59. 00
60. 00   06000   LABORATORY 60. 01   06001   BLOOD   LABORATORY 65. 00   06500   RESPI RATORY   THERAPY	2, 557 0 558	0	0 0 0	0	667, 091 0 0	60. 00 60. 01 65. 00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	109	0	0	0	0	66. 00 67. 00 68. 00
69. 00   06900   ELECTROCARDI OLOGY 71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	2, 002	0	0	0	217, 726 0	69. 00 71. 00
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS 73. 00   07300   DRUGS CHARGED TO PATIENTS   OUTPATIENT SERVICE COST CENTERS	9, 666	0		0 0	411, 655	72. 00 73. 00
88. 00   08800   RURAL HEALTH CLINIC 89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER 90. 00   09000   CLINIC	0 0 0	0 0 0		0 0 0	0 0 339, 080	88. 00 89. 00 90. 00
90. 01   09001   FAMILY PRACTICE OF JAY COUNTY 90. 02   09002   JAY FAMILY MEDICINE 91. 00   09100   EMERGENCY	0 8, 640 4, 542	5, 519 0 0	0 0 0	0 0 0	1, 644, 595 1, 689, 420 2, 337, 768	90. 02
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 93.00 04040 OTHER OUTPATIENT SERVICE COST CENTER OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	92. 00
99. 10 09910 CORF	0	0	0	0	0	99. 10
SPECIAL PURPOSE COST CENTERS  106. 00 10600 HEART ACQUI SI TI ON	O	0	O	0	0	106. 00
109.00 10900 PANCREAS ACQUISITION 110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	109. 00 110. 00
111.00   11100   ISLET ACQUISITION 113.00   11300   INTEREST EXPENSE 118.00   SUBTOTALS (SUM OF LINES 1-117)	75, 946	0 8, 146	0 6, 225	0	0 16, 061, 440	111. 00 113. 00 118. 00
NONREI MBURSABLE COST CENTERS  190. 00   19000   GI FT, FLOWER, COFFEE SHOP & CANTEEN  192. 00   19200   PHYSI CI ANS' PRI VATE OFFI CES	906	0	0	0	0	190. 00 192. 00
193.00 19300 NONPALD WORKERS 194.00 07950 MOB 194.01 07951 POB	0	0 0 0	0 0 0	0 0 0	0	193. 00 194. 00 194. 01
194.02 07952 WEST JAY CLINIC 194.03 07953 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	3, 300 0	483, 051	•

Health Financial Systems	JAY COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-1320	Peri od: From 10/01/2015 To 09/30/2016 Date/Time Prepared: 2/27/2017 10: 37 am

				077 307 2010	2/27/2017 10:	
		CAPI TAL REL	ATED COSTS			
Cost Center Description	NEW MVBLE	NEW MVBLE	NEW MVBLE	NEW MVBLE	EMPLOYEE	
cost denter bescription	EQUI P	EQUI P MOB	EQUI P-POB	EQUIP- WJ	BENEFITS	
	(SQUARE	(SQUARE	(SQUARE	(SQUARE	DEPARTMENT	
	FEET)	FEET)	FEET)	FEET)	(GROSS	
	·	·			SALARI ES)	
	2.00	2. 01	2. 02	2. 03	4. 00	
194.04 07954 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194. 04
194.05 07955 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194. 05
194. 06 07956 TRI COUNTY	0	0	4, 276	0	171, 962	194. 06
194. 07 07957 HOSPI TALI ST	0	0	0	0	478, 379	194. 07
194.08 07958 FAMILY FIRST HEALTH	3, 868	0	0	0	150, 215	194. 08
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers						201. 00
202.00 Cost to be allocated (per Wkst. B, Part I)	1, 236, 269	8, 676	106, 456	31, 142	6, 642, 281	202. 00
203.00 Unit cost multiplier (Wkst. B, Part I)	15. 315523	1. 065063	10. 137701	9. 436970	0. 382950	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
1 )				l		

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10
Worksheet B-1 Provider CCN: 15-1320 

				To	09/30/2016	Date/Time Pre 2/27/2017 10:	
	Cost Center Description	Reconciliation	ADMI NI STRATI VE & GENERAL	PLANT	OPERATION OF PLANT-MOB	OPERATION OF PLANT-POB	
			(ACCUM. COST)	(SQUARE FEET)	(SQUARE FEET)	(SQUARE FEET)	
		5A	5. 00	7. 00	7. 01	7. 02	
	GENERAL SERVI CE COST CENTERS	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. 03	00203 NEW CAP REL COSTS-MVBLE EQUIP- WJ						2. 03
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	-6, 839, 047		/F 001			5. 00
7. 00 7. 01	00700 OPERATION OF PLANT 00701 OPERATION OF PLANT-MOB	0	1, 422, 592 42, 194	65, 981 0	5, 519		7. 00 7. 01
7. 02	00702 OPERATION OF PLANT-POB	0	157, 972	o O	0,317	8, 998	1
7.03	00703 OPERATION OF PLANT-WJ	0	3, 520	0	0	0	7. 03
8.00	00800 LAUNDRY & LINEN SERVICE	0	85, 621	445	0	0	
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	0	634, 899 477, 967	497 2, 083	0	0	9. 00 10. 00
11. 00	01100 CAFETERI A	0	213, 378	2, 063	0	0	11. 00
13. 00	01300 NURSING ADMINISTRATION	0	1, 456, 730		0	0	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	224, 734		0	0	
16. 00	01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	0	568, 301	1, 420	0	0	16. 00
30. 00	03000 ADULTS & PEDIATRICS	0	2, 245, 699	11, 918	0	0	30.00
31.00	03100 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000 SUBPROVI DER - I PF	0	1, 287, 014	4, 594	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	155, 670	1, 033	0	0	
10.00	ANCI LLARY SERVI CE COST CENTERS		100,070	1,000			10.00
50.00	05000 OPERATING ROOM	0		5, 410	0	4, 722	1
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	25, 562	127	0	0	
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0	1, 670, 324	0 626	0	)   0	53. 00 54. 00
57. 00	05700 CT SCAN	0	0	0	0	ő	57. 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	0	59.00
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	0	2, 159, 628	2, 557 0	0	0	
65. 00	06500 RESPIRATORY THERAPY	0	364, 855	558	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	637, 781	109	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	110, 695	0	0	0	67. 00
68. 00 69. 00	06800   SPEECH PATHOLOGY   06900   ELECTROCARDI OLOGY	0	25, 667 677, 422	0 2, 002	0	0	68. 00 69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	077, 422	0	0	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	1, 797, 119	9, 666	0	0	73. 00
88. 00	OUTPATIENT SERVICE COST CENTERS  08800 RURAL HEALTH CLINIC	1 0	0	0	0	0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	Ö	ő	0	Ö	
90.00	09000 CLI NI C	0	339, 668		0	0	
	09001 FAMILY PRACTICE OF JAY COUNTY	0	1, 011, 763		5, 519	0	
	09002 JAY FAMILY MEDICINE 09100 EMERGENCY	0	1, 277, 367 1, 730, 475		0	0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		1,750,170	1,012	9	J	92. 00
93. 00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	11, 050	0	0	0	93. 00
00 10	OTHER REIMBURSABLE COST CENTERS	T 0		0		0	00 10
99. 10	O9910   CORF   SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	99. 10
106.00	10600 HEART ACQUISITION	0	0	0	0	0	106. 00
	10900 PANCREAS ACQUISITION	0	0	0	0		109. 00
	11000 I NTESTI NAL ACQUI SI TI ON	0	0	0	0		110.00
	11100  SLET ACQUISITION  11300  NTEREST EXPENSE	0	0	0	Ü	0	111. 00 113. 00
118.00		-6, 839, 047	22, 885, 292	61, 207	5, 519	4, 722	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13, 876	906	0		190.00
	19200 PHYSICIANS' PRIVATE OFFICES  19300 NONPAID WORKERS	0			0		192. 00 193. 00
194.00	07950 MOB	0	0	0	0		194. 00
	07951 POB	0	0	0	0		194. 01
	07952 WEST JAY CLINIC	0	254, 453	0	0		194. 02
	07953 OTHER NONREIMBURSABLE COST CENTERS	0	0		0		194. 03 194. 04
	07955 OTHER NONREI MBURSABLE COST CENTERS	0	0	o o	0		194. 05
194.06	07956 TRI COUNTY	0	1, 463, 930	0	0	4, 276	194. 06

Health Financial Systems	JAY COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-1320	Period: Worksheet B-1 From 10/01/2015
		To 09/30/2016 Date/Time Prepared:

				'	0 077 307 2010	2/27/2017 10:	
	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	
194. 07 07957	7 HOSPI TALI ST	0	673, 725	0	0	0	194. 07
194. 08 07958	FAMILY FIRST HEALTH	0	309, 215	3, 868	0	0	194. 08
200.00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers						201. 00
202.00	Cost to be allocated (per Wkst. B,		6, 839, 047	1, 802, 630	53, 466	200, 173	202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)		0. 267145	27. 320441	9. 687625	22. 246388	203. 00
204.00	Cost to be allocated (per Wkst. B,		135, 931	115, 394	224	839	204. 00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part		0. 005310	1. 748897	0. 040587	0. 093243	205. 00
	11)						

Control   Cont		Financial Systems	JAY COUNTY		011 45 4000   5		u of Form CMS-	
Control   Cont	COST A	LLOCATION - STATISTICAL BASIS		Provi der C	F	rom 10/01/2015	Worksheet B-1 Date/Time Pre	pared:
BURNELL SURVICE COST CAUTIESS   7.03   8.00   9.00   10.00   11.00		Cost Center Description	PLANT-WJ (SQUARE	LINEN SERVICE (POUNDS OF	(SQUARE	(MEALS	CAFETERI A	J7 dill
2.00					9. 00	10. 00	11. 00	
2.01				I				
9.00   0.0900  9.0SERFERPING	2. 01 2. 02 2. 03 4. 00 5. 00 7. 00 7. 01 7. 02 7. 03	00201 NEW CAP REL COSTS-MVBLE EQUIP MOB 00202 NEW CAP REL COSTS-MVBLE EQUIP-POB 00203 NEW CAP REL COSTS-MVBLE EQUIP- WJ 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00701 OPERATION OF PLANT-MOB 00702 OPERATION OF PLANT-POB 00703 OPERATION OF PLANT-WJ	3, 300	l e				2. 01 2. 02 2. 03 4. 00 5. 00 7. 00 7. 01 7. 02 7. 03
10.00   01000   DETARY		l	0					
11.00 0 10100 CAFETERIA		l	0	1		35, 906		1
14.00			0	0	1		20, 214	1
16.00   01600 MFDICAL RECORDS & LIBRARY   0   0   1,415   0   93   16.00			0	0		0		1
IMPATI ENT ROUTINE SERVICE COST CENTERS   3,008   30,00   30,00   301,00			0			0		1
31.00   03100   INTERSIVE CARE UNIT   0   0   0   0   0   11, 409   4.00   4.000   0400   SURPROVIDER - IPF   0   0   0   0   0   0   0   0   0	10.00				1, 413	<u> </u>	703	10.00
40.00   04000 SUBPROVI DER - I PF		l		11, 740		24, 497	3, 088	
1-10   0   0   0   0   0   0   0   0   0			0	2 240	_	11 400	_	
42.00   04200   NURSERY   0   20   1,033   0   190   43.00   430		l l	0	3, 240		_		
ANCILLARY SERVICE COST CENTERS			0	o	o o			1
50.00	43. 00		0	20	1, 033	0	190	43. 00
52.00   05200   DELIVERY ROOM & LABOR ROOM   0   0   127   0   25   52.00	50.00		1 0	10. 920	11 935	0	1 514	50 00
54.00				0,720				
57.00   05700   CT SCAN		l	0	0		-1		
58.00   05800   MARCHETIC RESONANCE IMAGING (MRI)   0   0   0   0   0   58.00   0590   0590   0590   0590   0600   CARDIAC CATHETERIZATION   0   0   0   0   0   0   59.00   0590   060.00   060.01   0			0	3, 300	1	0		
60.00   0.0000   LABORATORY   0 0 0 2, 400 0 1, 51 1 1 60.00		l	Ö	Ö	-	Ö	_	
0.000   0.0001   0.000   0.0			0	0	-	0	_	
65.00   0.500   RESPIRATORY THERAPY   0   0   280   0   0   65.00			0		2, 400	0		
66.00   06600   PHYSI CAL THERAPY   0   720   0   0   0   66.00   67.00   06700   0CTOPATI ONAL THERAPY   0   0   0   0   0   0   0   0   68.00   06800   SPECH PATHOLOGY   0   0   0   0   0   0   0   68.00   69.00   06900   LEUTROCARDI OLOGY   0   0   0   0   0   0   0   0   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   0   0   0   72.00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   0   0   71.00   73.00   07300   DRUIS CHARGED TO PATIENTS   0   0   0   0   0   0   0   0   89.00   08900   REDERALRY GEOST CENTERS   80.00   08800   RURAL HEALTH CLINIC   0   0   0   0   0   0   0   88.00   89.00   08900   FEDERALLY QUALIFIED HEALTH CENTER   0   0   0   0   0   0   89.00   90.00   09000   CLINIC   0   0   0   0   0   0   0   0   89.00   90.00   09000   CLINIC   0   0   0   0   0   0   0   0   0			0		280	0	_	
88.00   06900   SPECH PATHOLOGY   0   0   0   0   0   0   0   0   0	66. 00	06600 PHYSI CAL THERAPY	0	720	0	0	_	
69-00   06900   ELECTROCARDIOLOGY   0   300   1,000   0   551   69-00		l	0	0	0	0	_	1
172.00   07200   IMPL DEV. CHARGED TO PATIENTS   0   0   0   0   0   0   0   0   0			0	300	1,000	0	_	
73.00   07300   DRUGS CHARGED TO PATIENTS   0   0   1, 110   0   618   73.00			0	0	0	0		1
DUTPATI ENT SERVICE COST CENTERS			0	0	0	0		
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   0   90. 01   09000 CLINIC   0   0   0   0   4,200   0   822   90. 00   90. 01   09001 FAMILY PRACTICE OF JAY COUNTY   0   0   0   5,765   0   2,057   90. 01   90. 02   09002 JAY FAMILY MEDICINE   0   0   0   0   0   2,176   90. 02   91. 00   09100 EMERGENCY   0   7,260   4,650   0   1,974   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   0   93. 00   00   00   0   0   0   0   0   0	73.00				η 1, 110	<u> </u>	010	73.00
99. 00   09000   CLINI C   0   0   0   4,200   0   822   90. 00   90. 01   09001   FAMI LY PRACTICE OF JAY COUNTY   0   0   5,765   0   2,057   90. 01   90.			0	0	0	0		
99. 01   09001   FAMILLY PRACTICE OF JAY COUNTY   0   0   0   5,765   0   2,057   90. 01   99. 02   09002   JAY FAMILLY MEDICINE   0   0   0   0   0   0   91. 00   09100   EMERGENCY   0   7,260   4,650   0   1,974   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   0   0   0   0   0   93. 00   OTHER REIMBURSABLE COST CENTERS   0   0   0   0   0   99. 10   OTHER REIMBURSABLE COST CENTERS   0   0   0   0   0   99. 10   OTHER REIMBURSABLE COST CENTERS   0   0   0   0   0   109. 00   10600   HEART ACQUISITION   0   0   0   0   0   0   110. 00   10000   NESTINAL ACQUISITION   0   0   0   0   0   111. 00   11100   SLET ACQUISITION   0   0   0   0   0   113. 00   1300   INTEREST EXPENSE   113. 00   118. 00   SUBTOTALS (SUM OF LINES 1-117)   0   42,480   65,863   35,906   20,214   119. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   0   194. 00   07950   MOB 194. 00   07950   MOB 194. 00   07951   ORS   OR			0		_	0		
90. 02   09002   JAY FAMILY MEDICINE   0   0   0   0   2, 176   90. 02   91. 00   09100   EMERGENCY   0   7, 260   4, 650   0   1, 974   91. 00   92. 00   09200   09SERVATI ON BEDS (NON-DISTINCT PART)   92. 00   09200   09SERVATI ON BEDS (NON-DISTINCT PART)   92. 00   00   0   0   0   0   0   93. 00   04040   OTHER OUTPATIENT SERVICE COST CENTER   0   0   0   0   0   0   93. 00   00   09910   CORF   0   0   0   0   0   0   0   99. 10   00   09910   CORF   0   0   0   0   0   0   0   0   0   01   09010   CORF   0   0   0   0   0   0   0   0   0			0			0		1
92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART)   0   0   0   0   0   0   93. 00   93. 00   04040   OTHER OUTPATI ENT SERVI CE COST CENTERS   0   0   0   0   0   0   93. 00   99. 10   OTHER REI MBURSABLE COST CENTERS   0   0   0   0   0   0   0   99. 10   OSPECIAL PURPOSE COST CENTERS   0   0   0   0   0   0   0   0   106. 00   10600   HEART ACQUI SI TI ON   0   0   0   0   0   0   106. 00   110. 00   10900   PANCREAS ACQUI SI TI ON   0   0   0   0   0   0   0   110. 00   111. 00   11000   INTESTI NAL ACQUI SI TI ON   0   0   0   0   0   0   0   111. 00   111. 00   11300   INTESTI NAL ACQUI SI TI ON   0   0   0   0   0   0   111. 00   111. 00   11300   INTERST EXPENSE   113. 00   118. 00   SUBTOTALS (SUM OF LI NES 1-117)   0   42,480   65,863   35,906   20,214   118. 00   NONNEEI MBURSABLE COST CENTERS   0   0   575   0   0   190. 00   192. 00   19200   PHYSI CI ANS* PRI VATE OFFI CES   0   0   0   0   0   193. 00   194. 00   07950   MOB   0   0   0   5,765   0   0   194. 01   194. 01   07951   POB   0   0   0   0   0   0   0   194. 01   194. 02   07952   WEST JAY CLI NI C   3,300   0   0   0   0   0   194. 01   194. 03   07953   OTHER NONREI MBURSABLE COST CENTERS   0   0   0   0   0   194. 03   194. 04   07954   OTHER NONREI MBURSABLE COST CENTERS   0   0   0   0   0   194. 05   194. 05   07955   OTHER NONREI MBURSABLE COST CENTERS   0   0   0   0   0   0   194. 05   194. 04   07955   OTHER NONREI MBURSABLE COST CENTERS   0   0   0   0   0   0   194. 05   194. 05   07955   OTHER NONREI MBURSABLE COST CENTERS   0   0   0   0   0   0   194. 05   194. 05   07955   OTHER NONREI MBURSABLE COST CENTERS   0   0   0   0   0   0   0   0   194. 05   194. 05   07955   OTHER NONREI MBURSABLE COST CENTERS   0   0   0   0   0   0   0   0   0			0	0	0	O		
93. 00   04040   OTHER OUTPATIENT SERVICE COST CENTER   0   0   0   0   0   0   0   0   0			0	7, 260	4, 650	0	1, 974	
99. 10   09910   CORF   CORF   CORF   CORF   CORF   CORF		,	0	o	o	0	0	
SPECIAL PURPOSE COST CENTERS   106. 00   10600   HEART ACQUISITION   0   0   0   0   0   0   106. 00   109. 00   10900   PANCREAS ACQUISITION   0   0   0   0   0   0   109. 00   109. 00   101000   INTESTINAL ACQUISITION   0   0   0   0   0   0   1011. 00   111. 00   11100   INTESTINAL ACQUISITION   0   0   0   0   0   0   111. 00   113.00   INTEREST EXPENSE   113. 00   113.00   INTEREST EXPENSE   113. 00   SUBTOTALS (SUM OF LINES 1-117)   0   42,480   65,863   35,906   20,214   118. 00   NONRE! MBURSABLE COST CENTERS   0   0   575   0   0   190. 00   190. 00   192. 00   192.00								
106. 00   10600   HEART ACQUI SI TI ON   0   0   0   0   0   106. 00   109. 00   10900   PANCREAS ACQUI SI TI ON   0   0   0   0   0   0   109. 00   10000   11000   INTESTI NAL ACQUI SI TI ON   0   0   0   0   0   0   0   110. 00   111. 00   111. 00   111. 00   111. 00   ISLET ACQUI SI TI ON   0   0   0   0   0   0   0   0   111. 00   111. 00   113. 00   113.00   INTEREST EXPENSE   113. 00   113. 00   113. 00   INTEREST EXPENSE   113. 00	99. 10		0	0	0	0	0	99. 10
109. 00   10900   PANCREAS ACQUISITION   0   0   0   0   109. 00   110. 00	106. 00		0	О	0	0	0	106. 00
111. 00		l	0	0	0	0	0	109. 00
113. 00			0	0	0	0		
118.00   SUBTOTALS (SUM OF LINES 1-117)   0   42,480   65,863   35,906   20,214   118.00   NONREI MBURSABLE COST CENTERS			0		,	U	0	
190. 00       19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN       0       0       575       0       0 190. 00         192. 00       19200 PHYSI CI ANS' PRI VATE OFFI CES       0       0       0       0       0 192. 00         193. 00       19300 NONPAI D WORKERS       0       0       0       0       0 193. 00         194. 00       07950 MOB       0       0       8, 891       0       0 194. 00         194. 01       07951 POB       0       0       5, 765       0       0 194. 01         194. 02       07952 WEST JAY CLINIC       3, 300       0       0       0       0 194. 01         194. 03       07953 OTHER NONREI MBURSABLE COST CENTERS       0       0       0       0       0 194. 03         194. 04       07954 OTHER NONREI MBURSABLE COST CENTERS       0       0       0       0       0       0       0       194. 04         194. 05       07955 OTHER NONREI MBURSABLE COST CENTERS       0       0       0       0       0       0       0       194. 05		SUBTOTALS (SUM OF LINES 1-117)	0	42, 480	65, 863	35, 906	20, 214	
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 192. 00 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 0 193. 00 194. 00 1950 MOB 0 0 0 8, 891 0 0 194. 00 194. 01 07951 POB 0 0 5, 765 0 0 194. 01 194. 02 07952 WEST JAY CLINI C 3, 300 0 0 0 0 194. 02 194. 03 07953 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 194. 02 194. 05 07955 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 194. 04 194. 05 07955 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 194. 05	100.00				F7E	٥	0	100.00
193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 193. 00 194. 00 194. 00 194. 01 07950 MOB 0 0 8, 891 0 0 194. 00 194. 01 07951 POB 0 0 5, 765 0 0 194. 01 194. 02 07952 WEST JAY CLINIC 3, 3300 0 0 0 0 0 194. 02 194. 03 07953 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 194. 02 194. 05 07955 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 194. 04 194. 05 07955 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 194. 05			0		1	0		
194. 01 07951 POB 0 5, 765 0 0 194. 01 194. 02 194. 02 07952 WEST JAY CLINIC 3, 300 0 0 0 194. 02 194. 03 07953 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 0 194. 03 194. 04 07954 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 0 194. 04 194. 05 07955 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 194. 05	193.00	19300 NONPALD WORKERS	0	o	0	0		
194. 02 07952 WEST JAY CLINIC 3, 300 0 0 0 194. 02 194. 03 07953 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 0 194. 03 194. 04 07954 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 0 194. 04 194. 05 07955 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 0 194. 05			0	0		0		
194. 03     07953     0THER NONREIMBURSABLE COST CENTERS     0     0     0     0     0     194. 03       194. 04     07954     0THER NONREIMBURSABLE COST CENTERS     0     0     0     0     0     0     194. 04       194. 05     07955     0THER NONREIMBURSABLE COST CENTERS     0     0     0     0     0     0     194. 05			3 300		1	O O		
194. 05 07955 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 194. 05	194. 03	07953 OTHER NONREIMBURSABLE COST CENTERS	0	0	o	ő	0	194. 03
			0	0	0	0		
, , , , , , , , , , , , , , , , , , ,			0	0	_	0		
	. , 1. 50		1	<u> </u>	-1	<u> </u>		1.700

Health Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	eu of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1	
				From 10/01/2015 To 09/30/2016		pared: 37 am
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NO	DI ETARY	CAFETERI A	
	PLANT-WJ	LINEN SERVICE	(SQUARE	(MEALS	(FTE' S)	
	(SQUARE	(POUNDS OF	FEET)	SERVED)		
	FEET)	LAUNDRY)				
	7. 03	8. 00	9. 00	10.00	11. 00	
194. 07 07957 HOSPI TALI ST	0	0		0 0	0	194. 07
194.08 07958 FAMILY FIRST HEALTH	0	0		0 0	0	194. 08
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201. 00
202.00 Cost to be allocated (per Wkst. B, Part I)	4, 460	120, 652	828, 65	3 688, 007	347, 524	202. 00
203.00 Unit cost multiplier (Wkst. B, Part I)	1. 351515	2. 840207	10. 21842	6 19. 161338	17. 192243	203. 00
204.00 Cost to be allocated (per Wkst. B,	19	8, 048	12, 55	7 38, 653	36, 518	204.00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	0. 005758	0. 189454	0. 15484	5 1. 076505	1. 806570	205. 00

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

				To	09/30/2016 Date/Time Pr 2/27/2017 10	
	Cost Center Description	NURSI NG	CENTRAL	MEDI CAL	272772017 10	7. 57 dill
		ADMI NI STRATI ON		RECORDS &		
		(DI RECT	SUPPLY (SUPPLY COST)	LI BRARY (GROSS		
		NRSING FTE)	(001121 0001)	CHARGES)		
	OFNEDAL CEDIU OF COCT OFNEDO	13. 00	14. 00	16. 00		
2. 00	GENERAL SERVICE COST CENTERS O0200 NEW CAP REL COSTS-MVBLE EQUIP	T				2.00
2. 01	00201 NEW CAP REL COSTS-MVBLE EQUIP MOB					2. 00
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	OO4OO					4.00
5. 00 7. 00	00700 OPERATION OF PLANT					5. 00 7. 00
7. 01	00701 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 9. 00	O0800   LAUNDRY & LI NEN SERVI CE   O0900   HOUSEKEEPI NG					8. 00 9. 00
10. 00	01000 DI ETARY					10.00
11. 00	01100 CAFETERI A					11. 00
13.00	01300 NURSING ADMINISTRATION	8, 283	1			13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0		00 704 000		14.00
16. 00	O1600   MEDICAL RECORDS & LIBRARY     INPATIENT ROUTINE SERVICE COST CENTERS	0	4, 089	89, 734, 939		16. 00
30. 00	03000 ADULTS & PEDIATRICS	3, 088	170, 136	5, 784, 245		30.00
31. 00	03100 I NTENSI VE CARE UNI T	0	0	0		31.00
40.00	04000 SUBPROVI DER - I PF	1, 492	14, 756	1, 213, 680		40. 00
41. 00	04100 SUBPROVIDER - IRF	0	0	0		41.00
42. 00 43. 00	04200 SUBPROVI DER 04300 NURSERY	190	1	359, 043		42. 00 43. 00
43.00	ANCI LLARY SERVI CE COST CENTERS	170	<u> Ч</u>	337, 043		43.00
50.00	05000 OPERATING ROOM	1, 514	673, 292	13, 586, 361		50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	25	1	122, 755		52.00
53. 00 54. 00	05300   ANESTHESI OLOGY   05400   RADI OLOGY-DI AGNOSTI C	0 0		27, 600, 300		53. 00 54. 00
57. 00	05700 CT SCAN		180, 040	27, 000, 300		57.00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	ō	Ō		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0		59. 00
60.00	06000 LABORATORY	0	612, 173	18, 496, 728		60.00
60. 01 65. 00	06001   BLOOD LABORATORY   06500   RESPI RATORY THERAPY	0	9, 512	858, 965		60. 01 65. 00
66. 00	06600 PHYSI CAL THERAPY	0	8, 147	2, 243, 584		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	408, 036		67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	103, 117		68. 00
69. 00 71. 00	06900  ELECTROCARDI OLOGY   07100  MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	,	2, 659, 347 0		69. 00 71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	29, 128	4, 282, 338		73. 00
	OUTPATIENT SERVICE COST CENTERS	1 0	ا	0		
	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		88. 00 89. 00
	09000 CLINIC		43, 340	217, 737		90.00
	09001 FAMILY PRACTICE OF JAY COUNTY	0	220, 519	1, 371, 652		90. 01
	09002 JAY FAMILY MEDICINE	0		920, 089		90. 02
	O9100   EMERGENCY   O9200   OBSERVATION   BEDS (NON-DISTINCT PART)	1, 974	134, 296	9, 506, 962		91. 00 92. 00
93. 00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	698	0		93. 00
	OTHER REIMBURSABLE COST CENTERS			- 11		
99. 10	09910 CORF	0	0	0		99. 10
106.00	SPECIAL PURPOSE COST CENTERS   10600   HEART ACQUISITION	1 0	l ol	0		106. 00
	10900 PANCREAS ACQUISITION			0		100.00
	11000   NTESTINAL ACQUISITION	Ö	Ö	Ö		110.00
	11100 ISLET ACQUISITION	0	0	0		111. 00
	11300 I NTEREST EXPENSE	0 202	2 200 207	00 724 020		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)   NONREIMBURSABLE COST CENTERS	8, 283	2, 309, 397	89, 734, 939		118. 00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	o	0		192. 00
	19300 NONPALD WORKERS	0	0	0		193. 00
	07950 MOB 07951 POB			0		194. 00 194. 01
	07952 WEST JAY CLINIC			0		194. 01
194. 03	07953 OTHER NONREIMBURSABLE COST CENTERS	0	0	0		194. 03
	07954 OTHER NONREIMBURSABLE COST CENTERS	0	0	0		194. 04
194. 05	07955 OTHER NONREIMBURSABLE COST CENTERS	0	0	0		194. 05

Health Financial Systems

OST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-1320
Prov

				'	0 09/30/2010	2/27/2017 10:37 am
	Cost Center Description	NURSI NG	CENTRAL	MEDI CAL		
		ADMI NI STRATI ON	SERVICES &	RECORDS &		
			SUPPLY	LI BRARY		
		(DI RECT	(SUPPLY COST)	(GROSS		
		NRSING FTE)		CHARGES)		
		13.00	14.00	16.00		
194. 06 07956	TRI COUNTY	0	34, 269	C		194. 06
194. 07 07957	HOSPI TALI ST	0	113	C		194. 07
194. 08 07958	FAMILY FIRST HEALTH	0	36, 162	C		194. 08
200.00	Cross Foot Adjustments					200. 00
201.00	Negative Cost Centers					201. 00
202.00	Cost to be allocated (per Wkst. B,	1, 931, 918	343, 684	790, 864	1	202. 00
	Part I)					
203.00	Unit cost multiplier (Wkst. B, Part I)	233. 238923	0. 144409	0. 008813	3	203. 00
204.00	Cost to be allocated (per Wkst. B,	39, 097	23, 383	29, 284	1	204. 00
	Part II)					
205.00	Unit cost multiplier (Wkst. B, Part	4. 720150	0. 009825	0.000326	<b>5</b>	205. 00
	[11]					

From 10/01/2015 Part I 09/30/2016 Date/Time Prepared: 2/27/2017 10:37 am Title XVIII Hospi tal Cost Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 4. 00 1.00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 30 00 03000 ADULTS & PEDIATRICS 4, 659, 626 4, 659, 626 4, 659, 626 03100 INTENSIVE CARE UNIT 0 31.00 31.00 04000 SUBPROVIDER - IPF 0 40.00 2, 418, 000 2, 418, 000 2, 418, 000 40.00 04100 SUBPROVI DER - I RF 0 41.00 41.00 0 0 0 04200 SUBPROVI DER 42.00 Λ 0 Λ 42.00 43.00 04300 NURSERY 286, 837 286, 837 0 286, 837 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATI NG ROOM 50.00 50.00 3, 624, 456 3, 624, 456 0 3, 624, 456 52.00 05200 DELIVERY ROOM & LABOR ROOM 44, 502 44, 502 0 44, 502 52.00 53.00 05300 ANESTHESI OLOGY 0 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 2, 501, 175 2, 501, 175 2, 501, 175 54.00 54.00 05700 CT SCAN 57.00 0 0 Ω 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 0 0 58.00 05900 CARDIAC CATHETERIZATION 59.00 0 0 59.00 06000 LABORATORY 60 00 3, 110, 056 3, 110, 056 3, 110, 056 60 00 60.01 06001 BLOOD LABORATORY Λ 60.01 06500 RESPIRATORY THERAPY 489, 374 489, 374 489, 374 65.00 65.00 0 66.00 06600 PHYSI CAL THERAPY 834, 134 834, 134 834, 134 66.00 06700 OCCUPATIONAL THERAPY 143, 863 143, 863 67 00 67 00 143 863 0 68.00 06800 SPEECH PATHOLOGY 33, 433 33, 433 33, 433 68.00 0 06900 ELECTROCARDI OLOGY 69.00 963, 865 963, 865 963, 865 69.00 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 O 71 00 0 07200 I MPL. DEV. CHARGED TO PATIENTS 0 72.00 Ω Λ 72.00 2, 605, 202 07300 DRUGS CHARGED TO PATIENTS 2,605,202 2, 605, 202 73.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88 00 0 88 00 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89.00 09000 CLI NI C 495, 636 495, 636 0 495, 636 90.00 90.00 0 90.01 09001 FAMILY PRACTICE OF JAY COUNTY 1, 473, 722 1, 473, 722 1, 473, 722 90.01 09002 JAY FAMILY MEDICINE 1. 922, 648 1. 922, 648 90 02 1, 922, 648 90 02 91.00 09100 EMERGENCY 2, 982, 518 2, 982, 518 2, 982, 518 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 202, 207 202, 207 92.00 202, 207 92.00 04040 OTHER OUTPATIENT SERVICE COST CENTER OTHER REIMBURSABLE COST CENTERS <u>14,</u> 103 93.00 14, 103 14, 103 93.00 99. 10 09910 CORF 0 0 0 99. 10 SPECIAL PURPOSE COST CENTERS 106. 00 10600 HEART ACQUISITION 0 106.00 0 0 109.00 10900 PANCREAS ACQUISITION 0 0 0 109, 00 110.00 11000 INTESTINAL ACQUISITION 0 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 111. 00 113.00 11300 INTEREST EXPENSE 113.00 28, 805, 357 200. 00 200.00 Subtotal (see instructions) 28, 805, 357 0 28, 805, 357 201.00 Less Observation Beds 202, 207 202, 207 202, 207 201. 00 202.00 Total (see instructions) 28, 603, 150 28, 603, 150 28, 603, 150 202. 00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-1320 Peri od: Worksheet C From 10/01/2015 Part I Date/Time Prepared: 09/30/2016 2/27/2017 10:37 am Title XVIII Hospi tal Cost Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other **TFFRA** I npati ent + col . 7) Ratio Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 5, 648, 973 30.00 30.00 5, 648, 973 31.00 03100 INTENSIVE CARE UNIT 31.00 04000 SUBPROVI DER - I PF 40.00 1, 213, 680 1, 213, 680 40.00 41.00 04100 SUBPROVI DER - I RF 41.00 C 0 04200 SUBPROVI DER 42.00 0 42.00 43.00 04300 NURSERY 359, 043 359, 043 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 3, 355, 663 10, 230, 698 13, 586, 361 0.266772 0.000000 50.00 05200 DELIVERY ROOM & LABOR ROOM 52 00 122, 755 122, 755 0.362527 0.000000 52 00 53.00 05300 ANESTHESI OLOGY 0.000000 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 884, 314 25, 715, 986 27, 600, 300 0.090621 0.000000 54.00 05700 CT SCAN 0.000000 0.000000 57.00 57.00 0 C 0 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 0 0 0.000000 0.000000 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.000000 0.000000 59.00 60.00 06000 LABORATORY 2, 869, 463 15, 627, 265 18, 496, 728 0.168141 0.000000 60.00 06001 BLOOD LABORATORY 0.000000 60.01 0.000000 60.01 65.00 06500 RESPIRATORY THERAPY 592, 525 266, 440 858, 965 0.569725 0.000000 65.00 06600 PHYSI CAL THERAPY 709, 385 1, 534, 199 2, 243, 584 0.000000 66.00 0.371786 66.00 06700 OCCUPATIONAL THERAPY 200, 958 207, 078 408, 036 0.000000 67.00 0.352574 67.00 06800 SPEECH PATHOLOGY 68.00 21, 324 81, 793 103, 117 0.324224 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 258, 269 2, 401, 078 2, 659, 347 0.362444 0.000000 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 0.000000 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 72 00 0.000000 0 000000 72 00 07300 DRUGS CHARGED TO PATIENTS 2, 550, 217 73.00 1, 732, 121 4, 282, 338 0.608360 0.000000 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 0 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 Ω 89.00 90.00 09000 CLI NI C 12, 916 204, 821 217, 737 2. 276306 0.000000 90.00 09001 FAMILY PRACTICE OF JAY COUNTY 90. 01 1, 371, 652 1, 371, 652 1.074414 0.000000 90.01 90 02 09002 JAY FAMILY MEDICINE 920 089 920 089 2. 089633 0 000000 90 02 91.00 09100 EMERGENCY 308, 915 9, 198, 047 9, 506, 962 0.313719 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 135, 272 135, 272 1. 494818 0.000000 92.00 92.00 04040 OTHER OUTPATIENT SERVICE COST CENTER 93.00 0.000000 0.000000 93.00 OTHER REIMBURSABLE COST CENTERS 99.10 09910 CORF 0 0 0 99.10 SPECIAL PURPOSE COST CENTERS 106. 00 10600 HEART ACQUISITION Э 0 0 106.00 109. 00 10900 PANCREAS ACQUISITION 0 0 109 00 Ω 110.00 11000 INTESTINAL ACQUISITION 0 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 0 111.00 113.00 11300 INTEREST EXPENSE 113. 00

19, 290, 304

19, 290, 304

70.444.635

70, 444, 635

89, 734, 939

89, 734, 939

200. 00

201. 00

202.00

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201.00

202.00

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

Heal th Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES

A Provider CCN: 15-1320

Part I

Date/Time Prepared:

2/27/2017 10:37 am 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 03100 INTENSIVE CARE UNIT 31.00 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. 266772 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.362527 52.00 53. 00 | 05300 | ANESTHESI OLOGY 0.000000 53 00 54. 00 | 05400 | RADI OLOGY-DI AGNOSTI C 0.090621 54.00 57.00 05700 CT SCAN 0.000000 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0.000000 58.00 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 59.00 0.000000 60.00 06000 LABORATORY 0.168141 60.00 06001 BLOOD LABORATORY 0.000000 60.01 60.01 06500 RESPIRATORY THERAPY 0.569725 65.00 65.00 06600 PHYSI CAL THERAPY 66.00 0. 371786 66 00 67.00 06700 OCCUPATIONAL THERAPY 0. 352574 67.00 06800 SPEECH PATHOLOGY 68.00 0. 324224 68.00 06900 ELECTROCARDI OLOGY 69.00 69.00 0.362444 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0.608360 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 89.00 90.00 09000 CLI NI C 2. 276306 90.00 09001 FAMILY PRACTICE OF JAY COUNTY 1.074414 90.01 90.01 90.02 09002 JAY FAMILY MEDICINE 2.089633 90.02 09100 EMERGENCY 91.00 0. 313719 91.00 92 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1. 494818 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 10900 PANCREAS ACQUISITION 109. 00 110.00 11000 INTESTINAL ACQUISITION 110 00 111.00 11100 | SLET ACQUISITION 111. 00

113. 00

200.00

201.00

202.00

113.00 11300 I NTEREST EXPENSE

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

200.00

201 00

202.00

From 10/01/2015 Part I 09/30/2016 Date/Time Prepared: 2/27/2017 10:37 am Title XIX Hospi tal Cost Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 4. 00 1.00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 30 00 03000 ADULTS & PEDIATRICS 4, 659, 626 4, 659, 626 4, 659, 626 03100 INTENSIVE CARE UNIT 0 31.00 31.00 04000 SUBPROVI DER - I PF 0 40.00 2, 418, 000 2, 418, 000 2, 418, 000 40.00 04100 SUBPROVI DER - I RF 0 41.00 41.00 0 0 0 04200 SUBPROVI DER 42.00 Λ 0 Λ 42.00 43.00 04300 NURSERY 286, 837 286, 837 0 286, 837 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATI NG ROOM 50.00 50.00 3, 624, 456 3, 624, 456 0 3, 624, 456 52.00 05200 DELIVERY ROOM & LABOR ROOM 44, 502 44, 502 0 44, 502 52.00 53.00 05300 ANESTHESI OLOGY 0 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 2, 501, 175 2, 501, 175 2, 501, 175 54.00 54.00 05700 CT SCAN 57.00 0 0 Ω 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 0 0 58.00 05900 CARDIAC CATHETERIZATION 59.00 0 0 59.00 06000 LABORATORY 60 00 3, 110, 056 3, 110, 056 3, 110, 056 60 00 60.01 06001 BLOOD LABORATORY Λ 60.01 06500 RESPIRATORY THERAPY 489, 374 489, 374 489, 374 65.00 65.00 0 66.00 06600 PHYSI CAL THERAPY 834, 134 834, 134 834, 134 66.00 06700 OCCUPATIONAL THERAPY 143, 863 143, 863 67 00 67 00 143 863 0 68.00 06800 SPEECH PATHOLOGY 33, 433 33, 433 33, 433 68.00 0 06900 ELECTROCARDI OLOGY 69.00 963, 865 963, 865 963, 865 69.00 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 O 71 00 0 07200 I MPL. DEV. CHARGED TO PATIENTS 0 72.00 Ω Λ 72.00 2, 605, 202 07300 DRUGS CHARGED TO PATIENTS 2, 605, 202 2, 605, 202 73.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88 00 0 88 00 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89.00 09000 CLI NI C 495, 636 495, 636 0 495, 636 90.00 90.00 0 90.01 09001 FAMILY PRACTICE OF JAY COUNTY 1, 473, 722 1, 473, 722 1, 473, 722 90.01 09002 JAY FAMILY MEDICINE 1. 922, 648 1. 922, 648 90 02 1, 922, 648 90 02 91.00 09100 EMERGENCY 2, 982, 518 2, 982, 518 2, 982, 518 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 202, 207 202, 207 92.00 202, 207 92.00 04040 OTHER OUTPATIENT SERVICE COST CENTER OTHER REIMBURSABLE COST CENTERS <u>14,</u> 103 93.00 14, 103 14, 103 93.00 99. 10 09910 CORF 0 0 0 99. 10 SPECIAL PURPOSE COST CENTERS 106. 00 10600 HEART ACQUISITION 0 106.00 0 0 109.00 10900 PANCREAS ACQUISITION 0 0 0 109, 00 110.00 11000 INTESTINAL ACQUISITION 0 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 111. 00 113.00 11300 INTEREST EXPENSE 113.00 28, 805, 357 200. 00 200.00 Subtotal (see instructions) 28, 805, 357 0 28, 805, 357 201.00 Less Observation Beds 202, 207 202, 207 202, 207 201. 00

28, 603, 150

28, 603, 150

28, 603, 150 202. 00

202.00

Total (see instructions)

Provider CCN: 15-1320 From 10/01/2015 Part I Date/Time Prepared: 09/30/2016 2/27/2017 10:37 am Title XIX Hospi tal Cost Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other **TFFRA** I npati ent + col . 7) Ratio Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 5, 648, 973 30.00 30.00 5, 648, 973 31.00 03100 INTENSIVE CARE UNIT 31.00 04000 SUBPROVI DER - I PF 40.00 1, 213, 680 1, 213, 680 40.00 41.00 04100 SUBPROVI DER - I RF 41.00 C 0 04200 SUBPROVI DER 42.00 0 42.00 43.00 04300 NURSERY 359, 043 359, 043 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 3, 355, 663 10, 230, 698 13, 586, 361 0.266772 0.000000 50.00 05200 DELIVERY ROOM & LABOR ROOM 52 00 122, 755 122, 755 0.362527 0.000000 52 00 53.00 05300 ANESTHESI OLOGY 0.000000 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 884, 314 25, 715, 986 27, 600, 300 0.090621 0.000000 54.00 05700 CT SCAN 0.000000 0.000000 57.00 57.00 0 C 0 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 0 0 0.000000 0.000000 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.000000 0.000000 59.00 60.00 06000 LABORATORY 2, 869, 463 15, 627, 265 18, 496, 728 0.168141 0.000000 60.00 06001 BLOOD LABORATORY 0.000000 60.01 0.000000 60.01 65.00 06500 RESPIRATORY THERAPY 592, 525 266, 440 858, 965 0.569725 0.000000 65.00 06600 PHYSI CAL THERAPY 709, 385 1, 534, 199 2, 243, 584 0.000000 66.00 0.371786 66.00 06700 OCCUPATIONAL THERAPY 200, 958 207, 078 408, 036 0.000000 67.00 0.352574 67.00 06800 SPEECH PATHOLOGY 68.00 21, 324 81, 793 103, 117 0.324224 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 258, 269 2, 401, 078 2, 659, 347 0.362444 0.000000 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 0.000000 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 72 00 0.000000 0 000000 72 00 07300 DRUGS CHARGED TO PATIENTS 2, 550, 217 73.00 1, 732, 121 4, 282, 338 0.608360 0.000000 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0.000000 0.000000 88.00 0 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 89.00 Ω 0.000000 89 00 90.00 09000 CLI NI C 12, 916 204, 821 217, 737 2.276306 0.000000 90.00 09001 FAMILY PRACTICE OF JAY COUNTY 90. 01 1, 371, 652 1, 371, 652 1.074414 0.000000 90.01 90 02 09002 JAY FAMILY MEDICINE 920 089 920 089 2 089633 0 000000 90 02 91.00 09100 EMERGENCY 308, 915 9, 198, 047 9, 506, 962 0.313719 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 135, 272 135, 272 1. 494818 0.000000 92.00 92.00 04040 OTHER OUTPATIENT SERVICE COST CENTER 93.00 0.000000 0.000000 93.00 OTHER REIMBURSABLE COST CENTERS 99.10 09910 CORF 0 0 0 99.10 SPECIAL PURPOSE COST CENTERS 106. 00 10600 HEART ACQUISITION Э 0 0 106.00 109. 00 10900 PANCREAS ACQUISITION 0 0 109 00 Ω 110.00 11000 INTESTINAL ACQUISITION 0 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 0 111.00 113.00 11300 INTEREST EXPENSE 113. 00

19, 290, 304

19, 290, 304

70.444.635

70, 444, 635

89, 734, 939

89, 734, 939

200. 00

201. 00

202.00

200.00

201.00

202.00

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

Heal th Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1320
Period: Worksheet C From 10/01/2015 To 09/30/2016 Date/Time Prepared:

			10 09/30/2010	2/27/2017 10: 37 am
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient		<del>'</del>	
· ·	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 - 1 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
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATING ROOM	0. 000000			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
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 RESPIRATORY THERAPY	0. 000000			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0. 000000			88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000			89.00
90. 00   09000   CLI NI C	0. 000000			90.00
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	0. 000000			90. 01
90.02 09002 JAY FAMILY MEDICINE	0. 000000			90. 02
91. 00 09100 EMERGENCY	0. 000000			91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.00
93.00 04040 OTHER OUTPATIENT SERVICE COST CENTER	0. 000000			93.00
OTHER REIMBURSABLE COST CENTERS				
99. 10 09910 CORF				99. 10
SPECIAL PURPOSE COST CENTERS				
106. 00 10600 HEART ACQUI SI TI ON				106. 00
109.00 10900 PANCREAS ACQUISITION				109. 00
110.00 11000 INTESTINAL ACQUISITION				110.00
111.00 11100 ISLET 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 Total (see instructions)				202. 00

Health Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der C		Peri od:	Worksheet D	
				From 10/01/2015	Part II	
				To 09/30/2016	Date/Time Pre 2/27/2017 10:	pared: 37 am
		Title	XVIII	Hospi tal	Cost	37 dili
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,		(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCI LLARY SERVI CE COST CENTERS	T	T				
50.00   05000   OPERATING ROOM	176, 461				13, 342	
52.00   05200   DELIVERY ROOM & LABOR ROOM	2, 526	1			0	
53. 00 05300 ANESTHESI OLOGY	0	0	0. 00000		0	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	34, 532	27, 600, 300		· ·	902	54. 00
57. 00  05700 CT SCAN	0	0	0. 00000		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	59. 00
60. 00   06000   LABORATORY	70, 429	18, 496, 728			4, 076	
60. 01  06001 BL00D LABORATORY	0	0	0. 00000		0	
65. 00 06500 RESPIRATORY THERAPY	11, 875				3, 276	
66. 00 06600 PHYSI CAL THERAPY	6, 194			· ·	394	66. 00
67. 00  06700 OCCUPATI ONAL THERAPY	721	408, 036		· ·	125	
68. 00   06800   SPEECH PATHOLOGY	170				17	68. 00
69. 00   06900   ELECTROCARDI OLOGY	40, 296	2, 659, 347			3, 613	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.0000		0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0. 00000		0	72. 00
73. 00 O7300 DRUGS CHARGED TO PATIENTS	177, 458	4, 282, 338	0. 04144	0 609, 729	25, 267	73. 00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	0. 00000		0	00.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0. 00000		0	89. 00
90. 00   09000   CLI NI C	4, 436				39	90. 00
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY	18, 697				0	
90. 02  09002 JAY FAMILY MEDICINE	159, 979	· ·			0	90. 02
91. 00   09100   EMERGENCY	106, 092			· ·	78	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	11, 703	1			0	,
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTER	66	l e	0. 00000		0	93. 00
200.00   Total (lines 50-199)	821, 635	82, 513, 243		4, 136, 101	51, 129	200. 00

| Peri od: | Worksheet D | Part IV | To | 09/30/2016 | Date/Time Prepared: Health Financial Systems JAY COUNTY HOAPPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-1320 THROUGH COSTS

Title XVIII	ed: am
Anesthetist Cost	
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  ANCI LLARY SERVI CE COST CENTERS  50. 00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 52. 00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 0 52. 00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	
ANCI LLARY SERVI CE COST CENTERS  50. 00   05000   0PERATI NG ROOM   0   0   0   50   52. 00   05200   DELI VERY ROOM & LABOR ROOM   0   0   0   52    50. 00   05200	
50. 00 05000 0PERATING ROOM 0 0 0 50 50 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 50 52	
52. 00   05200   DELI VERY ROOM & LABOR ROOM   0   0   0   52	
	0. 00
53. 00   05300   ANESTHESI OLOGY   0  0  0  53	2. 00
	3. 00
	4. 00
	7. 00
	8. 00
	9. 00
	0. 00
	0. 01
	5. 00
	6. 00
	7. 00
	8. 00
	9. 00
	1. 00
	2. 00
	3. 00
OUTPATIENT SERVICE COST CENTERS	
	8. 00
	9. 00
	0. 00
	0. 01
	0. 02
	1. 00
	2. 00
	3. 00
200.00   Total (lines 50-199)   0   0   0   0   0   200	Э. 00

Health Financial Systems	JAY COUNTY HO	SPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIEN	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1320	Peri od:	Worksheet D
TUDOUGU GOCTO			Erom 10/01/2015	Dart IV

	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF H COSTS	RVICE OTHER PAS	S Provider C	F	Period: From 10/01/2015 Fo 09/30/2016		pared: 37 am
				XVIII	Hospi tal Co		
	Cost Center Description	Total	Total Charges	Ratio of Cost	Outpati ent	I npati ent	
			(from Wkst. C,		Ratio of Cost	Program	
		Cost (sum of		(col. 5 ÷ 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	T	T	T			
	05000 OPERATING ROOM	0	13, 586, 361	•		1, 027, 275	
	05200 DELIVERY ROOM & LABOR ROOM	0	122, 755			0	52.00
53.00	05300 ANESTHESI OLOGY	0	0	0.00000		0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	27, 600, 300			721, 138	
	05700 CT SCAN	0	0	0. 000000		0	07.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0. 000000		0	58. 00
	05900 CARDI AC CATHETERI ZATI ON	0	0	0. 000000		0	59. 00
	06000 LABORATORY	0	18, 496, 728			1, 070, 376	
	06001 BLOOD LABORATORY	0	0	0.00000		0	
	06500 RESPI RATORY THERAPY	0	858, 965			236, 951	
66.00	06600 PHYSI CAL THERAPY	0	2, 243, 584			142, 529	
67. 00	06700 OCCUPATI ONAL THERAPY	0	408, 036			70, 645	
	06800 SPEECH PATHOLOGY	0	103, 117			10, 103	
69.00	06900 ELECTROCARDI OLOGY	0	2, 659, 347	0.000000	0. 000000	238, 456	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0. 000000	0. 000000	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0. 000000	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	4, 282, 338	0. 000000	0. 000000	609, 729	73. 00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0	0. 000000	0. 000000	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0. 000000	0	89. 00
90.00	09000  CLI NI C	0	217, 737	0.000000	0. 000000	1, 937	90.00
90. 01	09001 FAMILY PRACTICE OF JAY COUNTY	0	1, 371, 652	0. 000000	0. 000000	0	90. 01
90. 02	09002 JAY FAMILY MEDICINE	0	920, 089	0. 000000	0. 000000	0	90. 02
91.00	09100 EMERGENCY	0	9, 506, 962	0. 000000	0. 000000	6, 962	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	135, 272	0. 000000	0. 000000	0	92. 00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0. 000000	0. 000000	0	93. 00
200.00	Total (lines 50-199)	0	82, 513, 243			4, 136, 101	200.00

Health Financial Systems JAY COUNTY HOAPPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS JAY COUNTY HOSPITAL Provider CCN: 15-1320

| Peri od: | Worksheet D | From 10/01/2015 | Part IV | To 09/30/2016 | Date/Time Prepared: THROUGH COSTS

					10	09/30/2016	2/27/2017 10:	
			Ti tl e	XVIII	. Н	lospi tal	Cost	
	Cost Center Description	I npati ent	Outpati ent	Outpati ent				
		Program	Program	Program				
		Pass-Through	Charges	Pass-Through				
		Costs (col. 8		Costs (col.	9			
		x col. 10)		x col. 12)				
		11. 00	12. 00	13. 00				
	NCILLARY SERVICE COST CENTERS							
	5000 OPERATING ROOM	0	C	)	0			50. 00
	5200 DELIVERY ROOM & LABOR ROOM	0	C	)	0			52. 00
	5300 ANESTHESI OLOGY	0	C	1	0			53. 00
	5400 RADI OLOGY-DI AGNOSTI C	0	C	1	0			54.00
57. 00 0	5700 CT SCAN	0	C		0			57. 00
58. 00 0	5800 MAGNETIC RESONANCE IMAGING (MRI)	0	C	)	0			58. 00
59. 00 0	5900 CARDI AC CATHETERI ZATI ON	0	C	)	0			59. 00
60.00 0	6000 LABORATORY	0	C	)	0			60.00
60. 01 0	6001 BLOOD LABORATORY	0	C	)	0			60. 01
65. 00 0	6500 RESPI RATORY THERAPY	0	C	)	0			65. 00
66.00 0	6600 PHYSI CAL THERAPY	0	C	)	0			66. 00
67. 00 0	6700 OCCUPATIONAL THERAPY	0	C	)	0			67. 00
68. 00 0	6800 SPEECH PATHOLOGY	0	C	)	0			68. 00
69. 00 0	6900 ELECTROCARDI OLOGY	O	C	)	0			69. 00
71. 00 0	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	C	)	0			71. 00
72. 00 0	7200 IMPL. DEV. CHARGED TO PATIENTS	o	C	)	0			72. 00
73. 00 0	7300 DRUGS CHARGED TO PATIENTS	o	C	)	0			73. 00
Ol	UTPATIENT SERVICE COST CENTERS							
88. 00 0	8800 RURAL HEALTH CLINIC	0	C		0			88. 00
89. 00 0	8900 FEDERALLY QUALIFIED HEALTH CENTER	0	C	)	0			89. 00
90. 00 0	9000 CLI NI C	o	C	)	0			90. 00
90. 01 0	9001 FAMILY PRACTICE OF JAY COUNTY	o	C	)	0			90. 01
90. 02 0	9002 JAY FAMILY MEDICINE	o	C	)	0			90. 02
91. 00 0	9100 EMERGENCY	o	C	)	0			91.00
92. 00 0	9200 OBSERVATION BEDS (NON-DISTINCT PART)	0	C		0			92. 00
93. 00 0	4040 OTHER OUTPATIENT SERVICE COST CENTER	o	C	)	0			93. 00
200.00	Total (lines 50-199)	0	C	)	0			200. 00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider Co	1	Period: From 10/01/2015 Fo 09/30/2016	Worksheet D Part V Date/Time Pre 2/27/2017 10:	
		Title	XVIII	Hospi tal	Cost	
·			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		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				_		
50. 00   05000   OPERATING ROOM	0. 266772		2, 386, 66		0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 362527			0	0	1 02.00
53. 00   05300   ANESTHESI OLOGY	0. 000000		(	0	0	
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 090621		7, 645, 978	3 0	0	1
57. 00   05700   CT   SCAN	0. 000000	0	(	0	0	1 07.00
58. 00   05800   MAGNETIC RESONANCE I MAGING (MRI)	0. 000000		(	0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0	(	0	0	59. 00
60. 00   06000   LABORATORY	0. 168141	0	5, 554, 300	6 0	0	60.00
60. 01   06001   BLOOD LABORATORY	0. 000000	0	(	0	0	60. 01
65. 00 06500 RESPIRATORY THERAPY	0. 569725	0	32, 772	2 0	0	65. 00
66. 00   06600   PHYSI CAL THERAPY	0. 371786	0	654, 086	6 0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 352574	. 0	26, 87	3 0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 324224	. 0	17, 432	2 0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 362444	. 0	1, 078, 140	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0	(	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0	(	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 608360	0	1, 061, 132	115, 066	0	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
90. 00   09000   CLI NI C	2. 276306	0	17, 170	23, 593	0	90.00
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY	1. 074414	. 0	118, 09	7 0	0	90. 01
90. 02 09002 JAY FAMILY MEDICINE	2. 089633	0	166, 16°	1 0	0	90. 02
91. 00 09100 EMERGENCY	0. 313719	0	1, 684, 859	9 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 494818		66, 220		0	92.00
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTER	0. 000000	0		0	0	93.00
200.00 Subtotal (see instructions)		0	20, 509, 893	3 138, 659	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0		201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)		0	20, 509, 893	3 138, 659	0	202. 00

					То	09/30/2016	Date/Time Pro 2/27/2017 10	
			Title	XVIII	l l	Hospi tal	Cost	
		Cost	S					
	Cost Center Description	Cost	Cost					
		Rei mbursed	Reimbursed					
			Servi ces Not					
		Subject To	Subject To					
			Ded. & Coins.					
		(see inst.)	(see inst.)					
	ANOLILARY OF BUILDE AGOT OF WITTERS	6.00	7. 00					
FO 00	ANCILLARY SERVICE COST CENTERS	(2/ (04						
	05000 OPERATING ROOM	636, 694	0					50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0					52. 00
	05300 ANESTHESI OLOGY	(02,004	0					53. 00 54. 00
	05400   RADI OLOGY-DI AGNOSTI C   05700   CT   SCAN	692, 886	0					54.00
57. 00		0	0					•
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0					58. 00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON	022 007	0					59.00
	06000 LABORATORY	933, 907	0					60.00
	06001 BLOOD LABORATORY 06500 RESPI RATORY THERAPY	18, 671	0					60. 01 65. 00
66. 00	06600 PHYSI CAL THERAPY	243, 180	0					66. 00
67. 00	06700 OCCUPATIONAL THERAPY	9, 475	0					67.00
	06800 SPEECH PATHOLOGY	5, 652	0					68. 00
	06900 ELECTROCARDI OLOGY	390, 765	0					69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	370, 703	0					71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS		0					72.00
	07300 DRUGS CHARGED TO PATIENTS	645, 550	70, 002					73.00
73.00	OUTPATIENT SERVICE COST CENTERS	043, 330	70,002					73.00
88. 00	08800 RURAL HEALTH CLINIC	0	0					88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	l ol	0					89. 00
	09000 CLI NI C	39, 084	53, 705					90.00
90. 01	09001 FAMILY PRACTICE OF JAY COUNTY	126, 885	0					90. 01
90. 02	09002 JAY FAMILY MEDICINE	347, 216	0					90. 02
91.00	09100 EMERGENCY	528, 572	0					91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	98, 996	0					92. 00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0					93. 00
200.00	Subtotal (see instructions)	4, 717, 533	123, 707					200. 00
201.00	Less PBP Clinic Lab. Services-Program	0						201. 00
	Only Charges							
202.00	Net Charges (line 200 +/- line 201)	4, 717, 533	123, 707					202. 00

	Financial Systems	JAY COUNTY				u of Form CMS-2	2552-10
APPORT	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der Co	CN: 15-1320	Peri od: From 10/01/2015	Worksheet D Part II	
			Component	CCN: 15-M320	To 09/30/2016	Date/Time Pre 2/27/2017 10:	pared: 37 am
			Title	: XVIII	Subprovi der - I PF	PPS	<u> </u>
	Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
			(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,			l. Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
	T	1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS		10 50/ 0/4		20		
50.00	05000 OPERATING ROOM	176, 461				0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2, 526				0	52. 00
53. 00	05300 ANESTHESI OLOGY	0		0.0000		0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	34, 532	27, 600, 300			62	54.00
57. 00	05700 CT SCAN	0	0	0.00000		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 06000 LABORATORY	70 400	0	0.00000		0	59.00
60. 00 60. 01	06000 LABORATORY	70, 429				655	60. 00 60. 01
	06500 RESPIRATORY THERAPY	11 075	ľ	0. 00000 0. 01382		0	65. 00
65. 00 66. 00	06600 PHYSI CAL THERAPY	11, 875				194 48	
67. 00	06700 OCCUPATI ONAL THERAPY	6, 194 721	408, 036				67.00
68. 00	06800 SPEECH PATHOLOGY	170				14	68.00
69. 00	06900 ELECTROCARDI OLOGY	40, 296				181	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	40, 290	2,039,347	0. 00000		0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0. 00000		0	72.00
	07300 DRUGS CHARGED TO PATIENTS	177, 458	4, 282, 338			_	
73.00	OUTPATIENT SERVICE COST CENTERS	177, 430	4, 202, 330	0.0414	102, 470	0, 317	73.00
88. 00	08800 RURAL HEALTH CLINIC	0	0	0.0000	00	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.00000		0	89. 00
90.00	09000 CLI NI C	4, 436	217, 737			195	
90. 01	09001 FAMILY PRACTICE OF JAY COUNTY	18, 697				0	90. 01
90. 02	09002 JAY FAMILY MEDICINE	159, 979				Ö	90. 02
91. 00	09100 EMERGENCY	106, 092				181	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0				0	
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	66	l			0	93. 00
200.00	I I	809, 932	82, 513, 243		458, 265	7 860	200. 00

Health Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	JAY COUNTY RVICE OTHER PASS	Provider C	CN: 15-1320 CCN: 15-M320	Period: From 10/01/2015 To 09/30/2016		epared:
		Titl∈	e XVIII	Subprovi der - I PF	PPS	
Cost Center Description	Non Physician Nanesthetist Cost	Nursing School	Allied Heal	Medical Education Cost	Total Cost (sum of col 1 through col. 4) 5.00	
ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4. 00	5.00	
50. 00   05000   0PERATI NG ROOM   52. 00   05200   DELI VERY ROOM & LABOR ROOM   53. 00   05300   ANESTHESI OLOGY   54. 00   05400   RADI OLOGY-DI AGNOSTI C   57. 00   05700   CT SCAN   58. 00   05800   MAGNETI C RESONANCE   I MAGI NG (MRI )   60. 00   06900   CARDI AC CATHETERI ZATI ON   06. 00   06000   LABORATORY   06. 01   06001   BLOOD   LABORATORY   06. 01   06500   RESPI RATORY   THERAPY   06. 00   06600   PHYSI CAL   THERAPY   06. 00   06600   PHYSI CAL   THERAPY   06. 00   06600   SPEECH   PATHOLOGY   06900   ELECTROCARDI OLOGY   07100   MEDI CAL   SUPPLIES   CHARGED   TO   PATI ENTS   72. 00   07200   IMPL.   DEV. CHARGED   TO   PATI ENTS   000   DRUGS   CHARGED   COST   CENTERS   000	0 0 0 0 0 0 0 0 0 0 0 0 0 0			0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		52. 00 53. 00 54. 00 57. 00 58. 00 59. 00 60. 01 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00
88.00 08800 RURAL HEALTH CLINIC 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90.00 09000 CLINIC 90.01 09001 FAMILY PRACTICE OF JAY COUNTY 90.02 09002 JAY FAMILY MEDICINE 91.00 09100 EMERGENCY 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 93.00 04040 OTHER OUTPATIENT SERVICE COST CENTER TOTAL (lines 50-199)	0 0 0 0 0 0 0 0	0 0 0 0 0 0 0		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	000000000000000000000000000000000000000	89. 00 90. 00 90. 01 90. 02 91. 00 92. 00

		LANC COUNTY				6.5	
	Financial Systems	JAY COUNTY		ON 15 1220		u of Form CMS-2	2552-10
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER SH COSTS	VICE OTHER PAS	S Provider C		Peri od: From 10/01/2015	Worksheet D Part IV	
THROOC	11 00313		Component		To 09/30/2016	Date/Time Pre	
			T: 11	V0/11 1	0 1 1 1	2/27/2017 10:	<u>37 am</u>
			IITIE	· XVIII	Subprovi der  - I PF	PPS	
	Cost Center Description	Total	Total Charges	Ratio of Cos		Inpati ent	
	505 Comton 55551 Pt. 511	Outpati ent	(from Wkst. C,		Ratio of Cost		
		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	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	13, 586, 361	0.00000	0.00000	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	122, 755	0.00000		0	
53.00	05300 ANESTHESI OLOGY	0	0	0.00000		0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	27, 600, 300	0.00000	0. 000000	49, 863	54.00
57.00	05700 CT SCAN	0	0	0.00000	0. 000000	0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.00000		0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0.00000		0	59. 00
60.00	06000 LABORATORY	0	18, 496, 728			171, 914	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0.0000		0	60. 01
65.00	06500 RESPI RATORY THERAPY	0	000,700			14, 024	65. 00
66.00	06600 PHYSI CAL THERAPY	0					
67. 00	06700 OCCUPATI ONAL THERAPY	0	408, 036	•		6, 443	
68. 00	06800 SPEECH PATHOLOGY	0	100/11/			8, 540	
69. 00	06900 ELECTROCARDI OLOGY	0	2, 659, 347			11, 964	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1				
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0.00000			72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	4, 282, 338	0.00000	0.00000	152, 490	73. 00
	OUTPATIENT SERVICE COST CENTERS		1	ı			
88. 00	08800 RURAL HEALTH CLINIC	0	_				
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0.0000		0	89. 00
90. 00	09000 CLI NI C	0	,			9, 548	90.00
90. 01	09001 FAMILY PRACTICE OF JAY COUNTY	0	., ,			0	
90. 02	09002 JAY FAMILY MEDICINE	0	,20,00,				90. 02
91.00	09100 EMERGENCY	0	7,000,702			16, 224	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1 .00, 2, 2			0	
	04040 OTHER OUTPATIENT SERVICE COST CENTER	0			0. 000000	0	
200.00	Total (lines 50-199)	0	82, 513, 243	I		458, 265	J200. 00

Health Financial Systems	Financial Systems JAY COUNTY HOSPITAL In Lieu						
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI	RVICE OTHER PASS	Provi der C		Period: From 10/01/2015	Worksheet D Part IV		
		Component	CCN: 15-M320	To 09/30/2016	Date/Time Pre 2/27/2017 10:	pared: 37 am_	
		Title	e XVIII	Subprovi der  - I PF	PPS		
Cost Center Description	Inpatient Program Pass-Through	Outpatient Program Charges	Outpatient Program Pass-Through	ı			

					I PF	
	Cost Center Description	I npati ent	Outpati ent	Outpati ent		
		Program	Program	Program		
		Pass-Through	Charges	Pass-Through		
		Costs (col. 8		Costs (col. 9		
		x col. 10)		x col. 12)		
		11. 00	12. 00	13. 00		
	LARY SERVICE COST CENTERS					
	OPERATING ROOM	0	C	0		50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	C	0		52. 00
	ANESTHESI OLOGY	0	C	0		53. 00
	RADI OLOGY-DI AGNOSTI C	0	C	0		54. 00
	CT SCAN	0	C	0		57. 00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	C	0		58. 00
59.00 05900	CARDIAC CATHETERIZATION	0	C	0		59. 00
60.00 06000	LABORATORY	0	C	0		60.00
60. 01 06001	BLOOD LABORATORY	0	C	0		60. 01
65.00 06500	RESPI RATORY THERAPY	0	C	0		65. 00
66.00 06600	PHYSI CAL THERAPY	0	C	0		66. 00
67.00 06700	OCCUPATIONAL THERAPY	0	C	0		67. 00
68.00 06800	SPEECH PATHOLOGY	0	C	0		68. 00
69.00 06900	ELECTROCARDI OLOGY	0	C	0		69. 00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C	0		71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	C	0		72. 00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	C	0		73. 00
OUTPA	TIENT SERVICE COST CENTERS					
88. 00 08800	RURAL HEALTH CLINIC	0	C	0		88. 00
89. 00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	C	0		89. 00
90.00 09000	CLINIC	0	C	0		90.00
90. 01 09001	FAMILY PRACTICE OF JAY COUNTY	0	C	0		90. 01
90. 02 09002	JAY FAMILY MEDICINE	0	C	0		90. 02
91.00 09100	EMERGENCY	0	C	0		91. 00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	C	0		92. 00
93.00 04040	OTHER OUTPATIENT SERVICE COST CENTER	0	C	0		93. 00
200. 00	Total (lines 50-199)	o	C	0		200. 00
'				•		· ·

Health Financial Systems JAY COUNTY HOSPITAL In Lieu of Form CMS-2552-10 APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-1320 Peri od: Worksheet D From 10/01/2015 Part V Component CCN: 15-Z320 09/30/2016 Date/Time Prepared: To 2/27/2017 10:37 am Title XVIII Swing Beds - SNF Cost Costs Charges 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.) 3.00 (see inst.) 1. 00 2.00 5. 00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 266772 0 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.362527 0 0 0 0 0 0 0 0 0 0 0 0 0 0 52.00 53. 00 | 05300 | ANESTHESI OLOGY 0 0.000000 0 53 00 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.090621 0 0 54.00 57. 00 05700 CT SCAN 0.000000 0 57.00 0 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0.000000 0 58.00 0 0 05900 CARDIAC CATHETERIZATION 0 59.00 0.000000 0 59.00 60.00 06000 LABORATORY 0. 168141 0 60.00 06001 BLOOD LABORATORY 0 60.01 0.000000 0 0 60.01 0 06500 RESPIRATORY THERAPY 0.569725 0 65 00 65 00 0 66.00 06600 PHYSI CAL THERAPY 0.371786 0 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 0. 352574 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.324224 0 0 68.00 0 0 69.00 06900 ELECTROCARDI OLOGY 0 0.362444 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 0 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 0 0 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 0.608360 0 0 73.00 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 89.00 09000 CLI NI C 90.00 90.00 2. 276306 0 0 0 0 0 0 0 0 0 09001 FAMILY PRACTICE OF JAY COUNTY 0 90.01 90.01 1.074414 0 90.02 09002 JAY FAMILY MEDICINE 2.089633 0 0 0 90.02 09100 EMERGENCY 0 91.00 0. 313719 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 92.00 92.00 1.494818 0 04040 OTHER OUTPATIENT SERVICE COST CENTER 0 93.00 0.000000 0 0 93.00 200.00 Subtotal (see instructions) 0 0 200.00

0

0

201.00

0 202. 00

201.00

202.00

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 +/- line 201)

Only Charges

Health Financial Systems	JAY COUNTY HO	In Lie	u of Form CMS-2552-10	
APPORTIONMENT OF MEDICAL, OTHE	ER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1320	Peri od: From 10/01/2015	Worksheet D
		Component CCN: 15-Z320		
		Title XVIII	Swing Beds - SNF	

		Component C	CCN: 15-Z320	To 09/30/2016	Date/Time Pre 2/27/2017 10:	
		Title	XVIII	Swing Beds - SNF		<u> </u>
	Cost			, J		
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
		Services Not				
	Subj ect To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
ANCILLARY SERVICE COST CENTERS	6. 00	7. 00				
50. 00 05000 OPERATING ROOM	0	0				50.00
52. 00   05200   DELIVERY ROOM & LABOR ROOM		0				52.00
53. 00   05300   ANESTHESI OLOGY		0				53. 00
54. 00   05400   RADI OLOGY - DI AGNOSTI C		0				54. 00
57. 00   05700   CT   SCAN		0				57.00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0				58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0				59.00
60. 00   06000   LABORATORY		0				60.00
60. 01   06001   BLOOD LABORATORY	0	0				60. 01
65. 00 06500 RESPIRATORY THERAPY	o o	0				65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	o	0				67. 00
68. 00 06800 SPEECH PATHOLOGY	o	o				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	o				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	o	O				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	o				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				89. 00
90. 00   09000   CLI NI C	0	0				90. 00
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	0	0				90. 01
90. 02   09002   JAY FAMILY MEDICINE	0	0				90. 02
91. 00   09100   EMERGENCY	0	0				91.00
92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92. 00
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0				93. 00
200.00 Subtotal (see instructions)	0	0				200. 00
201.00 Less PBP Clinic Lab. Services-Program						201. 00
Only Charges 202.00 Net Charges (line 200 +/- line 201)	o	o				202. 00
202.00   Net Glarges (True 200 +/- True 201)	ı V	υĮ				1202.00

Health Financial Systems	JAY COUNTY HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1320	From 10/01/2015	Date/Time Prepared:
	Title XVIII	Hospi tal	2/27/2017 10:37 am Cost

DATE   ALL PROVIDER COMPONENTS   1,00			TI II 20011		2/27/2017 10:	37 am
NART SET UNAL   RROWINGER COMPONENTS		Cost Center Description	Title XVIII	Hospi tal	Cost	
NAMELING MASS   NAMELING		cost center bescription			1. 00	
Impatient days (including private room days and saing-bed days, excluding newborn)   3,355   1,000		PART I - ALL PROVIDER COMPONENTS				
Inpatient days (including private room days, excluding saing-bed and newborn days)   2,657   2,00   3.00   Private room days (secluding swing-bed and observation bed days)   17 you have only private room days.   3.00   3.00   2.00   3.00						
Private room days (excluding swing-bed and observation bed days). If you have only private room days.  4.00 Semi-private room days (excluding swing-bed and observation bed days).  5.01 Total swing-bed SMF type inpatient days (including private room days) through December 31 of the cost reporting period (if cale alendar year, enter 0 on this line).  7.00 Total swing-bed SMF type inpatient days (including private room days) after December 31 of the cost reporting period (if cale alendar year, enter 0 on this line).  7.00 Total swing-bed MF type inpatient days (including private room days) after December 31 of the cost reporting period (if cale alendar year, enter 0 on this line).  8.00 Total swing-bed MF type inpatient days (including private room days) after December 31 of the cost reporting period (in line).  9.00 Total inpatient days including private room days) after December 31 of the cost reporting period (in line).  9.01 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days).  10.02 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days).  11.03 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days).  12.03 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days).  13.04 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days).  14.05 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days).  15.06 Total more room days applicable to title XVIII only (including private room days).  16.07 Total swing-bed SMF type inpatient days applicable to title XVIII only (including private room days).  17.08 Wind-care room days applicable to title XVIII only (including private room days).  18.00 Total swing-bed SMF type inpatient days applicable to title XVIII only (including private room days).  18.00 Total swing-bed SMF type inpatient days applicable to title XVIII only (including private r					· ·	
do not complete this line.  4. Os Sein-private room days (excluding swing-bed and observation bed days)  Total swing-bed SM type inputient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  7. O Total swing-bed SM type inputient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  7. O Total swing-bed M type inputient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  8. O Total swing-bed M type inputient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  9. O Total inputient days including private room days applicable to the Program (excluding swing-bed and next of the cost reporting period (see instruction) and including private room days)  10. OS sing-bed SM type inputient days applicable to title XVIII only (including private room days) after Swing-bed SM type inputient days applicable to title XVIII only (including private room days) after Swing-bed SM type inputient days applicable to title XVIII only (including private room days) after Swing-bed SM type inputient days applicable to title XVIII only (including private room days) after Swing-bed SM type inputient days applicable to title XVIII only (including private room days) after Swing-bed SM type inputient days applicable to title XVIII only (including private room days)  13. OS Swing-bed SM type inputient days applicable to title XVIII only (including private room days)  14. On Swing-bed SM type inputient days applicable to title XVIII only (including private room days)  15. O Total university days (title V or XXI only)  16. OS Swing-bed Ni type inputient days applicable to title XVIII only (including private room days)  17. O Modicare rate for swing-bed SM services applicable to services through December 31 of the cost reporting period (including private room days)						
Semi-perivate room days (excluding swing-bed and observation bed days)  5.00 Total swing-bed SMF type inpatient days (including private room days) through December 31 of the cost reporting period SMF type inpatient days (including private room days) after December 31 of the cost reporting period SMF type inpatient days (including private room days) after December 31 of the cost reporting period (in clean days year, enter 0 on this line)  7.00 Total swing-bed MF type inpatient days (including private room days) through December 31 of the cost reporting period (in clean day year, enter 0 on this line)  8.00 Total swing-bed MF type inpatient days (including private room days) after December 31 of the cost reporting period (in clean day year, enter 0 on this line)  9.00 Total inpatient days applicable to the Intle XVIII only (including private room days)  10.00 Swing-bed SMF type inpatient days applicable to the Intle XVIII only (including private room days) after December 31 of the cost reporting period (if call endar year, enter 0 on this line)  10.00 Swing-bed MF type Inpatient days applicable to Ittle XVII only (including private room days) after December 31 of the cost reporting period (if call endar year, enter 0 on this line)  10.00 Swing-bed MF type Inpatient days applicable to Ittles V or XIX only (including private room days)  10.00 Swing-bed MF type Inpatient days applicable to Ittles V or XIX only (including private room days)  10.00 Total sembler 31 of the cost reporting period (if call endar year, enter 0 on this line)  10.00 Total sembler 31 of the cost reporting period (if call endar year, enter 0 on this line)  10.00 Total sembler 31 of the cost reporting period (if call endar year, enter 0 on this line)  10.00 Total sembler 31 of the cost reporting period (if call endar year, enter 0 on this line)  10.00 Total sembler 31 of the cost reporting period (if call endar year, enter 0 on this line)  10.00 Total sembler 31 of the cost sembler 31 of the cost reporting period (in sembler 31 of the cost repo	3.00		/s). If you have only pr	ivate room days,	0	3.00
1 Total 'swing-bed SNF 'type inpatient days' (including private room days) after December 31 of the cost reporting period of Circ clandar year, enter 0 on this line)  7.00 Total 'swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  7.00 Total 'swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  9.00 Total inputient days including private room days after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  10.00 Swing-bed SNF type inpatient days (ancluding private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  11.00 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and newborn days)  11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  14.00 Through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  15.00 Swing-bed NF type inpatient days applicable to the Program (excluding private room days)  15.00 Total nursery days (title V or XIX only)  16.00 Newsery days (title V or XIX only)  17.00 Medicare rate for swing-bed NF services applicable to services through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  18.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (including period (including private room days)  18.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (including period	4 00	· ·	ad days)		2 512	4 00
reporting period ("Fe calendar year, enter 0 on this line)  7.00				r 31 of the cost		
1. Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)   7. Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period   7. Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost   7. Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost   7. Total swing-bed NF type inpatient days (including private room days)   7. Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)   7. Total inpatient days applicable to the Program (excluding private room days)   7. Total inpatient days applicable to the Program (excluding private room days)   7. Total inpatient days applicable to the Program (excluding private room days)   7. Total period (including period Proper)   7. Total inpatient days applicable to title XVIII only (including private room days)   7. Total period Proper inpatient days applicable to title SV IV AX only (including private room days)   7. Total period Proper inpatient days applicable to titles V or XX only (including private room days)   7. Total period Proper inpatient days applicable to titles V or XX only (including private room days)   7. Total period Proper inpatient days applicable to the Program (excluding swing-bed days)   7. Total period Proper inpatient days applicable to services after December 31 of the cost reporting period   7. Total period Proper inpatient days applicable to services after December 31 of the cost reporting period   7. Total period Proper inpatient days applicable to services after December 31 of the cost reporting period   7. Total period Proper inpatient days applicable to SP Everycles through December 31 of the cost reporting period   7. Total Proper inpatient routine service cost (see instructions)   7. Total Proper inpatient Proper inpatient Proper inpatient Prop	5.00		om days) trii odgir beecimbe	1 31 01 1110 0031		3.00
reporting period (if calendar year, enter 0 on this line)  7.00 Total swin, bed Mi Type Inpatient days (Including private room days) strough December 31 of the cost 1 period (I total swin, bed Mi Type Inpatient days (Including private room days) after December 31 of the cost 1 period (I total codar year, enter 0 on this I ine)  8.00 I total swin, abod Mi Type Inpatient days applicable to the Program (excluding swing-bed and newborn days) including private room days applicable to the Program (excluding swing-bed and newborn days)  8.00 Swing-bed SNF type Inpatient days applicable to title XVIII only (Including private room days)  8.00 Swing-bed SNF type Inpatient days applicable to title XVIII only (Including private room days)  8.00 Swing-bed SNF type Inpatient days applicable to title XVIII only (Including private room days)  8.00 Swing-bed SNF type Inpatient days applicable to title XVIII only (Including private room days)  8.01 1.00 Swing-bed SNF type Inpatient days applicable to title XVIII only (Including private room days)  8.01 1.00 Swing-bed SNF type Inpatient days applicable to title XVIII only (Including private room days)  8.01 1.00 Swing-bed SNF type Inpatient days applicable to the Program (excluding swing-bed days)  8.02 1.00 Including December 31 of the cost reporting period (I calendar year, enter 0 on this I ine)  8.00 Swing-bed SNF type pratient days applicable to the Program (excluding swing-bed days)  9.01 1.00 Including private room days)  9.01 1.00 Including private room days)  9.01 1.00 Including private room days  9.02 1.00 Including private room days  9.03 1.00 Including private room days  9.03 1.00 Including private room days  9.03 1.00 Including private room days  9.04 1.00 Including private room days  9.05 1.00 Including private room days  9.07 1.00 Including private room days  9.08 1.00 Including private room days  9.08 1.00 Including private room days  9.09 1.00 Including private room days  9.00 Including private room days applicable to services after December 31 of the cost report	6.00		om days) after December	31 of the cost	683	6. 00
reporting period  8. 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  9. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)  10. 00 Swing-bed SMbr type inpatient days applicable to title XVIII only (including private room days) after period (if calendar year, enter 0 on this line)  11. 00 Swing-bed SMbr type inpatient days applicable to title XVIII only (including private room days) after period (if calendar year, enter 0 on this line)  12. 00 Swing-bed SMbr type inpatient days applicable to titles XVIII only (including private room days) after period (if calendar year, enter 0 on this line)  13. 00 Swing-bed SMbr type inpatient days applicable to titles V or XIX only (including private room days) after period (if calendar year, enter 0 on this line)  14. 00 Medically necessary private room days applicable to titles V or XIX only (including private room days) after period (if calendar year, enter 0 on this line)  14. 00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  15. 00 Total nursery days (title V or XIX only)  16. 00 Swing-bed SMbr type inpatient days applicable to the Program (excluding swing-bed days)  17. 00 Medically necessary private room days applicable to services through December 31 of the cost reporting period  18. 00 Medical care rate for swing-bed SMF services applicable to services after December 31 of the cost reporting period  19. 00 Medical or rate for swing-bed SMF services applicable to services after December 31 of the cost reporting period  20. 00 Medical or rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line x in x			<i>3</i> ,			
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reporting period (if callendar year, enter 0 on this line)  10.00 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and newborn days)  10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see Instructions)  11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see Instructions)  12.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see Instructions)  13.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (if callendar year, enter 0 on this line)  14.00 Medically necessary private room days applicable to titles X or XIX only (including private room days) 15.00 Total nursery days (title Y or XIX only) 16.00 Nersery days (title Y or XIX only) 17.00 Nersery days (						
1.264   1.00   1.264   1.00   1.264   1.264   1.265	8.00		n days) after December 3	1 of the cost	01	8.00
newborn days)  newborn days)  newborn days)  10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions)  11.00 Swing-bed SNF type inpatient days applicable to titlet XVIII only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line)  12.00 Swing-bed NF type inpatient days applicable to titlet 8 V or XIX only (including private room days)  13.00 Swing-bed NF type inpatient days applicable to titlet 8 V or XIX only (including private room days)  14.00 Swing-bed NF type inpatient days applicable to titlet 8 V or XIX only (including private room days)  15.00 Total nursery days (title V or XIX only)  16.00 Nursery days (title V or XIX only)  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  18.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (including swing-bed SNF services applicable to services after December 31 of the cost reporting period (including swing-bed SNF services applicable to services after December 31 of the cost reporting period (including swing-bed SNF services applicable to services after December 31 of the cost reporting period (including swing-bed SNF services applicable to services after December 31 of the cost reporting period (including private room days)  18.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 6 v. X including swing-bed SNF services applicable to services after December 31 of the cost reporting period (line 6 v. X including swing-bed SNF services applicable to services after December 31 of the cost reporting period (line 8 v. X including swing-bed sylvates)  18.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (lin	0.00		the Dreamen (evaluding	owing had and	1 2/4	0 00
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through December 31 of the cost reporting period  13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  15.00 Total nursery days (title V or XIX only)  16.00 Total nursery days (title V or XIX only)  17.00 Medicare rate for swing-bed SNF services applicable to the Program (excluding swing-bed days)  18.00 SWING BED ADJUSTMENT  18.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period  20.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line day a service)  21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 Private room charges (excluding swing-bed charges)  28.00 Private room charges (excluding swing-bed charges)  29.00 Private room cost differential (line 29 + line 3)  30.00 Average peri diem private room cost differential (line 27 + line 28)  30.00 Private room cost differential adjustment (line 3 x line 35)  30.00 Program general inpatient routine service cost reported cost a				-		
13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (Including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 16.00 Total nursery days (title V or XIX only) 17.00 Nursery days (title V or XIX only) 18.00 Nursery days (title V or XIX only) 18.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 19.00 Medicaid rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 20.00 Medicaid rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 20) 27.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 28.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 29.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 29.00 Swing-b	12. 00		( only (including privat	e room days)	0	12. 00
after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  14.00 Motically necessary private room days applicable to the Program (excluding swing-bed days)  15.00 Total nursery days (title V or XIX only)  16.00 Nursery days (title V or XIX only)  17.00 Nursery days (title V or XIX only)  18.00 Moticare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period reporting period reporting period services applicable to services after December 31 of the cost reporting period reporting	12.00	1 31	/! /!!!!			12 00
14.00   Modically necessary private room days applicable to the Program (excluding swing-bed days)   0   14.00   15.00   16.00   15.	13.00					13.00
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reporting period  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 l. 895 at line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service costs net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service cost net of swing-bed and observation bed charges)  29.00 Optivate room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Average private room per diem charge (line 29 * line 3)  30.00 Average per diem private room charge (line 29 * line 3)  30.00 Average per diem private room charge (line 3 x line 31)  30.00 Average per diem private room cost differential (line 3 x line 31)  30.00 Average per diem private room cost differential (line 3 x line 31)  30.00 Average per diem private room cost differential (line 3 x line 31)  30.00 Average per diem private room cost differential (line 3 x line 31)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Ave		SWING BED ADJUSTMENT				
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x line 20)  26. 00  Total swing-bed cost (see instructions)  General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28. 00  29. 00  Private room charges (excluding swing-bed and observation bed charges)  Semi-private room charges (excluding swing-bed charges)  30. 00  30. 00  31. 00  General inpatient routine service cost/charge ratio (line 27 + line 28)  32. 00  Average private room per diem charge (line 29 + line 3)  33. 00  Average semi-private room per diem charge (line 30 + line 4)  44. 00  Average per diem private room charge differential (line 34 x line 31)  Average per diem private room cost differential (line 34 x line 31)  Private room cost differential adjustment (line 3 x line 35)  The private room cost differential adjustment (line 3 x line 35)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost (line 9 x line 38)  Adjusted general inpatient routine service cost per diem (see instructions)  1, 394. 53  38. 00  Medically necessary private room cost applicable to the Program (line 14 x line 35)  954. 00  26. 00  27. 00  Private room charges (excluding swing-bed cost (line 21 minus line 26)  97. 00  28. 00  29. 00  29. 00  29. 00  29. 00  30. 00			·			
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27. 00   Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26)   3,705,267   27. 00     PRIVATE ROOM DIFFERENTIAL ADJUSTMENT   28. 00     General inpatient routine service charges (excluding swing-bed and observation bed charges)   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. 0000000   31. 00     32. 00   Average private room per diem charge (line 29 ÷ line 3)   0. 00   32. 00     33. 00   Average semi-private room per diem charge (line 30 ÷ line 4)   0. 00   33. 00     34. 00   Average per diem private room charge differential (line 32 minus line 33) (see instructions)   0. 00   34. 00     35. 00   Average per diem private room cost differential (line 34 x line 31)   0. 00   35. 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 private room cost differential (line 37. 705, 267   27. minus line 36)     PART II - HOSPITAL AND SUBPROVIDERS ONLY     PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS   1,394. 53   38. 00     39. 00   Program general inpatient routine service cost (line 9 x line 38)   1,762,686   39. 00     40. 00   Medically necessary private room cost applicable to the Program (line 14 x line 35)   0. 40. 00     40. 00   Medically necessary private room cost applicable to the Program (line 14 x line 35)   0. 40. 00     40. 00   Medically necessary private room cost applicable to the Program (line 14 x line 35)   0. 40. 00     40. 00   Medically necessary private room cost applicable to the Program (line 14 x line 35)   0. 40. 00     40. 00   Medically necessary private room cost applicable to the Program (line 14 x line 35)   0. 40. 00     40. 00   Medically necessary private room cost applicable to the Program (line 21 m						
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29. 00 Private room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32. 00 Average private room per diem charge (line 29 ÷ line 3)  33. 00 Average semi-private room per diem charge (line 30 ÷ line 4)  34. 00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35. 00 Average per diem private room cost differential (line 34 x line 31)  36. 00 Private room cost differential adjustment (line 3 x line 35)  37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 705, 267)  38. 00 Adjusted general inpatient routine service cost per diem (see instructions)  39. 00 Program general inpatient routine service cost (line 9 x line 38)  40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 28. 00  29. 00  20. 00		, ,	(line 21 minus line 24)		·	
28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29. 00 Private room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  30. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32. 00 Average private room per diem charge (line 29 ÷ line 3)  33. 00 Average semi-private room per diem charge (line 30 ÷ line 4)  34. 00 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  35. 00 Average per diem private room cost differential (line 34 x line 31)  36. 00 Private room cost differential adjustment (line 3 x line 35)  37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 705, 267)  37. 00 PART II - HOSPITAL AND SUBPROVI DERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38. 00 Adjusted general inpatient routine service cost per diem (see instructions)  39. 00 Program general inpatient routine service cost (line 9 x line 38)  1, 762, 686 39. 00  40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40. 00	27.00		(Tine 21 minus Tine 26)		3, 705, 267	27.00
29. 00 Pri vate room charges (excluding swing-bed charges)  30. 00 Semi-pri vate room charges (excluding swing-bed charges)  31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32. 00 Average pri vate room per diem charge (line 29 ÷ line 3)  33. 00 Average semi-pri vate room per diem charge (line 29 ÷ line 3)  34. 00 Average per diem pri vate room charge differential (line 32 minus line 33) (see instructions)  35. 00 Average per diem pri vate room cost differential (line 34 x line 31)  36. 00 Pri vate room cost differential adjustment (line 3 x line 35)  37. 00 General inpatient routine service cost net of swing-bed cost and pri vate room cost differential (line 3, 705, 267)  38. 00 Adjusted general inpatient routine service cost per diem (see instructions)  39. 00 Program general inpatient routine service cost (line 9 x line 38)  40. 00 Medically necessary pri vate room cost applicable to the Program (line 14 x line 35)  0 29. 00  30. 00  30. 00  0 0. 00 000  31. 00  0 0. 00 00  32. 00  32. 00  32. 00  33. 00  40. 00	28 00		d and observation hed ch	arges)	0	28 00
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 33.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 705, 267)  38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0.00 0.00 0.00 0.00 0.00 0.00 0.00			a and observation bed on	ar ges)		
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  32.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 705, 267)  37.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 0.00 32.00  0.00 32.00  0.00 33.00  0.00 33.00  0.00 34.00  0.00 35.00  0.00 36.00  0.00 37.00  0.00 36.00  0.00 37.00  1.394.50  1.394.53  38.00  0.00 39.00  1.762,686  1.762,686						30.00
33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 705, 267)  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 instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 .00 33.00  0 .00 34.00  37.00 36.00  37.00 37.00  37.00 37.00  37.00 37.00  37.00 37.00	31.00		+ line 28)		0.000000	31. 00
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 705, 267)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32. 00
35. 00 Average per diem private room cost differential (line 34 x line 31)  36. 00 Private room cost differential adjustment (line 3 x line 35)  37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 705, 267)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38. 00 Adjusted general inpatient routine service cost per diem (see instructions)  39. 00 Program general inpatient routine service cost (line 9 x line 38)  40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	33.00				0.00	33. 00
36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 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 instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 36.00 37.00 3		, , ,		tions)		34.00
37. 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 instructions)  79. 00 Program general inpatient routine service cost (line 9 x line 38)  40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  37. 00  37. 00  37. 00  37. 00  37. 00  37. 00  37. 00  40. 00		,				
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 instructions)  1,394.53 38.00 Program general inpatient routine service cost (line 9 x line 38)  1,762,686 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00			and private mass asst di	fforontial (1:		
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,394.53 38.00  Program general inpatient routine service cost (line 9 x line 38)  1,762,686 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00	37.00		and private room cost di	rrentral (IINe	3, 705, 267	37.00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,394.53 38.00  Program general inpatient routine service cost (line 9 x line 38)  1,762,686 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00						
38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,394.53 38.00  Program general inpatient routine service cost (line 9 x line 38)  1,762,686 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00			ISTMENTS			
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  1,762,686 39.00 40.00	38. 00				1, 394. 53	38. 00
	39. 00	, , , , , , , , , , , , , , , , , , , ,	•			39. 00
41.00   Iotal Program general inpatient routine service cost (line 39 + line 40)   1,762,686   41.00						40.00
	41. 00	Total Program general inpatient routine service cost (line 39	+ IIne 40)		1, 762, 686	41.00

Heal th	n Financial Systems JAY COUNTY HOSPITAL In	n Lieu of Form CMS-	2552-10
COMPUT	TATION OF INPATIENT OPERATING COST Provider CCN: 15-1320 Period: From 10/01/	Worksheet D-1	1
	To 09/30/	2016 Date/Time Pre	epared:
	Title XVIII Hospital	2/27/2017 10: Cost	37 am
	Cost Center Description Total Total Average Per Program D	ays Program Cost	
	Inpati ent Cost   Inpati ent Days   Di em (col. 1 ÷   col. 2)	(col. 3 x col. 4)	
	1.00 2.00 3.00 4.00	5. 00	
42. 00	NURSERY (title V & XIX only) 0 0 0.00 Intensive Care Type Inpatient Hospital Units	0 0	42. 00
43.00		0 0	43. 00
44.00			44. 00
45. 00 46. 00			45. 00 46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)		47. 00
	Cost Center Description	1.00	
48. 00		1, 199, 498	1
49. 00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)  PASS THROUGH COST ADJUSTMENTS	2, 962, 184	49. 00
50.00		and 0	50.00
51. 00		11 0	51.00
31.00	and IV)		31.00
52. 00 53. 00	Total Program excludable cost (sum of lines 50 and 51)	0	
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
E 4 .00	TARGET AMOUNT AND LIMIT COMPUTATION		54.00
54. 00 55. 00		0.00	
56. 00	Target amount (line 54 x line 55)	Q	
57. 00 58. 00		0	
59. 00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by		
60. 00	market basket Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61. 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 0	1
	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)		
62. 00		o	
63. 00	Allowable Inpatient cost plus incentive payment (see instructions)  PROGRAM INPATIENT ROUTINE SWING BED COST	0	63. 00
64. 00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (	See 0	64. 00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (Se	e 780, 937	65.00
03.00	instructions)(title XVIII only)		
66. 00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). Fo CAH (see instructions)	r 780, 937	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting per	i od 0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting perior	d C	68. 00
00.00	(line 13 x line 20)		
69. 00	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/IID ONLY	0	69. 00
70. 00			70. 00
71. 00 72. 00			71. 00 72. 00
73.00	,		73. 00
74.00			74.00
75. 00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, coll 26, line 45)	umn	75. 00
76. 00			76. 00
77. 00 78. 00			77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for excess costs (from provider records)		79. 00
80. 00 81. 00			80. 00 81. 00
82. 00	Inpatient routine service cost limitation (line 9 x line 81)		82. 00
83. 00 84. 00			83. 00 84. 00
85. 00			85. 00
86. 00	Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		86. 00
87. 00		145	87. 00
88.00		1, 394. 53	
υ <del>9</del> . UU	Observation bed cost (line 87 x line 88) (see instructions)	1 202, 207	7   89. 00

Health Financial Systems	HOSPI TAL		In Lie	u of Form CMS-2	2552-10	
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 10/01/2015	5	
				To 09/30/2016	Date/Time Prep 2/27/2017 10:	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	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	269, 671	4, 659, 626	0. 05787	4 202, 207	11, 703	90.00
91.00 Nursing School cost	0	4, 659, 626	0.00000	0 202, 207	0	91.00
92.00 Allied health cost	0	4, 659, 626	0.00000	0 202, 207	0	92.00
93.00 All other Medical Education	0	4, 659, 626	0.00000	0 202, 207	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: 15-1320	Peri od:	Worksheet D-1
	Component CCN: 15-M320	From 10/01/2015 To 09/30/2016	Date/Time Prepared:
			2/27/2017 10:37 am
	Title XVIII	Subprovi der -	PPS
		I PF	

			. I PF		
	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			1, 495	1. 00
2.00	Inpatient days (including private room days, excluding swing-k			1, 495	2.00
3. 00	Private room days (excluding swing-bed and observation bed day do not complete this line.	(S). If you have only priv	ate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		1, 495	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo	om days) through December	31 of the cost	0	5. 00
4 00	reporting period Total swing-bed SNF type inpatient days (including private room)	om days) after December 21	l of the cost	0	4 00
6. 00	reporting period (if calendar year, enter 0 on this line)	on days) after becember 3	of the cost	U	6. 00
7.00	Total swing-bed NF type inpatient days (including private room	n days) through December 3	31 of the cost	0	7. 00
	reporting period			_	
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	n days) after December 31	of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to	the Program (excluding s	swing-bed and	848	9. 00
	newborn days)				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		om days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII or		om davs) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, er		augo, arto.		
12.00	Swing-bed NF type inpatient days applicable to titles V or XI)	only (including private	room days)	0	12.00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI)	( only (including private	room days)	0	13. 00
13.00	after December 31 of the cost reporting period (if calendar ye			U	13.00
14.00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed da	ays)	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) SWING BED ADJUSTMENT			0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 of	the cost		17. 00
.,. 00	reporting period	oe till dagit bedelinger et et			
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of th	ne cost		18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	through December 31 of t	the cost	0.00	19. 00
17.00	reporting period	till odgir becember 31 or 1	ine cost	0.00	17.00
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of the	e cost	0. 00	20.00
21. 00	reporting period Total general inpatient routine service cost (see instructions	-1		2, 418, 000	21 00
22. 00	Swing-bed cost applicable to SNF type services through December		na period (line	2, 418, 000	22. 00
	5 x line 17)		.9		
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	period (line 6	0	23. 00
24. 00	x line 18)   Swing-bed cost applicable to NF type services through December	31 of the cost reporting	n period (line	0	24. 00
24.00	7 x line 19)	or the cost reporting	g perrou (Trie	Ö	24.00
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting $\mu$	period (line 8	0	25. 00
24 00	x line 20)			0	26. 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (	line 21 minus line 26)		2, 418, 000	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-bed	d and observation bed char	ges)		28. 00
29. 00	Pri vate room charges (excluding swing-bed charges)			0	
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges)   General inpatient routine service cost/charge ratio (line 27 -	- line 28)		0. 000000	30. 00 31. 00
32. 00	Average private room per diem charge (line 29 ÷ line 3)	11116 20)		0. 00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.00
34. 00	Average per diem private room charge differential (line 32 mir	, ,	ons)	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)	ie 31)		0.00	35. 00 36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost diff	erential (line	2, 418, 000	
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ICTMENTS			
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU Adjusted general inpatient routine service cost per diem (see			1, 617. 39	38. 00
39. 00	Program general inpatient routine service cost per drem (see			1, 371, 547	
40. 00	Medically necessary private room cost applicable to the Progra	am (line 14 x line 35)		0	40.00
41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		1, 371, 547	41. 00

Health Financ	ial Systems	JAY COUNTY F	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION (	OF INPATIENT OPERATING COST			F	eri od: rom 10/01/2015	Worksheet D-1	
			·		o 09/30/2016 Subprovi der -	Date/Time Pre 2/27/2017 10: PPS	
					. I PF		
,	Cost Center Description	Total Inpatient Cost	Total npatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
40.00 NUDGE	N/ (IIII W a WIW II )	1.00	2.00	3.00	4. 00	5. 00	10.00
	RY (title V & XIX only) ive Care Type Inpatient Hospital Units	0	С	0.00	0	0	42. 00
	SIVE CARE UNIT	0	C	0.00	0	0	
	RY CARE UNIT NTENSIVE CARE UNIT						44. 00 45. 00
	CAL INTENSIVE CARE UNIT						46. 00
	SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
	·					1. 00	
	m inpatient ancillary service cost (Wk Program inpatient costs (sum of lines			ons)		176, 800 1, 548, 347	1
PASS T	HROUGH COST ADJUSTMENTS	<u> </u>		,			
50.00 Pass t	through costs applicable to Program inp	atient routine s	ervices (from	n Wkst. D, sum	of Parts I and	0	50. 00
	hrough costs applicable to Program inp ')	atient ancillary	services (fr	rom Wkst. D, su	m of Parts II	7, 860	51. 00
52. 00 Total	Program excludable cost (sum of lines					7, 860	1
medi ca	Program inpatient operating cost excluil education costs (line 49 minus line AMOUNT AND LIMIT COMPUTATION	J 1	ated, non-phy	sician anesthe	tist, and	1, 540, 487	53. 00
	ım discharges					0	54. 00
	amount per discharge					0.00	1
	: amount (line 54 x line 55) rence between adjusted inpatient operat	ing cost and tar	get amount (I	ine 56 minus I	ine 53)	0	56. 00 57. 00
	payment (see instructions)		" 100/			0	58. 00
	of lines 53/54 or 55 from the cost re basket	porting period e	ending 1996, L	ipdated and com	pounded by the	0. 00	59. 00
	of lines 53/54 or 55 from prior year					0.00	1
whi ch	ne 53/54 is less than the lower of line operating costs (line 53) are less tha	n expected costs				0	61. 00
	(line 56), otherwise enter zero (see payment (see instructions)	instructions)				0	62. 00
63. 00 Allowa	ble Inpatient cost plus incentive paym	ent (see instruc	tions)			0	1
64.00 Medica	M INPATIENT ROUTINE SWING BED COST are swing-bed SNF inpatient routine cos	ts through Decem	ber 31 of the	cost reportin	g period (See	0	64. 00
	uctions)(title XVIII only) ure swing-bed SNF inpatient routine cos	ts after Decembe	er 31 of the d	cost reporting	period (See	0	65. 00
	uctions)(title XVIII only)	no costs (lino 4	4 plus line 4	E) (+i +l o V/IIII	only) For	0	66. 00
	Medicare swing-bed SNF inpatient routi see instructions)	ne costs (Title o	4 prus rine c	os)(title xviii	only). For	Ü	
	V or XIX swing-bed NF inpatient routin 12 x line 19)	e costs through	December 31 c	of the cost rep	orting period	0	67. 00
68.00 Title	V or XIX swing-bed NF inpatient routin 13 x line 20)	e costs after De	ecember 31 of	the cost repor	ting period	0	68. 00
69. 00 <u>Total</u>	title V or XIX swing-bed NF inpatient					0	69. 00
	<u>II - SKILLED NURSING FACILITY, OTHER N</u> ed nursing facility/other nursing facil						70. 00
-	red general inpatient routine service c		ne 70 ÷ line	2)			71.00
	um routine service cost (line 9 x line ully necessary private room cost applic	•	(line 14 x li	ne 35)			72. 00 73. 00
74. 00 Total	Program general inpatient routine serv	ice costs (line	72 + line 73)				74. 00
	Il-related cost allocated to inpatient ne 45)	routine service	costs (from V	Vorksheet B, Pa	rt II, column		75. 00
76.00 Per di	em capital-related costs (line 75 ÷ li						76. 00
	<pre>im capital-related costs (line 9 x line ent routine service cost (line 74 minu</pre>						77. 00 78. 00
79.00 Aggreg	ate charges to beneficiaries for exces	s costs (from pr					79. 00
1	Program routine service costs for comp ent routine service cost per diem limi		st limitation	n (line 78 minu	s line 79)		80. 00 81. 00
	ent routine service cost per drein film ent routine service cost limitation (I						82. 00
1	mable inpatient routine service costs (		5)				83.00
-	m inpatient ancillary services (see in ation review - physician compensation		ıs)				84. 00 85. 00
86. 00 Total	Program inpatient operating costs (sum	of lines 83 thr					86. 00
	V - COMPUTATION OF OBSERVATION BED PASS observation bed days (see instructions					0	87. 00
88.00 Adjust	ed general inpatient routine cost per	diem (line 27 ÷	line 2)			0.00	88. 00
89.00   Observ	ration bed cost (line 87 x line 88) (se	e instructions)			ļ	0	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 CO		Peri od:	Worksheet D-1	
		Component (		From 10/01/2015 To 09/30/2016	Date/Time Pre	narod:
		Component	JCIN. 13-W320	10 09/30/2010	2/27/2017 10:	
		Title	XVIII	Subprovi der -	PPS	
				I PF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	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	0	2, 418, 000	0.00000	0 0	0	90.00
91.00 Nursing School cost	0	2, 418, 000	0.00000	0	0	91.00
92.00 Allied health cost	0	2, 418, 000	0.00000	0	0	92.00
93.00 All other Medical Education	0	2, 418, 000	0.00000	0 0	0	93.00

Health Financial Systems	JAY COUNTY HOSP	PLTAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	F	Provider CCN: 15-1320	From 10/01/2015	Worksheet D-1 Date/Time Prepared: 2/27/2017 10:37 am
		Title XIX	Hospi tal	Cost

				2/27/2017 10:	37 am
	Cost Contor Description	Title XIX	Hospi tal	Cost	
	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			3, 355	1.00
2. 00	Inpatient days (including private room days, excluding swing-b			2, 657	2. 00
3. 00	Private room days (excluding swing-bed and observation bed day	/s). If you have only pr	ivate room days,	0	3. 00
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	od dave)		2, 512	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private roo		r 31 of the cost	2, 312	5. 00
3.00	reporting period	on days) through becembe	1 31 01 the cost		3.00
6. 00	Total swing-bed SNF type inpatient days (including private roo	om davs) after December	31 of the cost	683	6. 00
	reporting period (if calendar year, enter 0 on this line)	,			
7.00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	15	7. 00
	reporting period				
8. 00	Total swing-bed NF type inpatient days (including private room	n days) after December 3	1 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	- th- D (	and an include		0.00
9. 00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	Swing-bed and	0	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	alv (including private r	oom days)	0	10. 00
	through December 31 of the cost reporting period (see instruct		oom dayo,		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, er				
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI)	only (including privat)	e room days)	0	12.00
40.00	through December 31 of the cost reporting period				40.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI)			0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra			o	14. 00
15. 00	Total nursery days (title V or XIX only)	iii (excluding swing-bed	uays)	126	15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
	SWI NG BED ADJUSTMENT			-	
17.00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost		17. 00
	reporting period				
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost		18. 00
10.00	reporting period	- +b	. 414	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 or	the cost	0.00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	he cost	0.00	20. 00
	reporting period				
21. 00	Total general inpatient routine service cost (see instructions			4, 659, 626	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost report	ing period (line	0	22. 00
00.00	5 x line 17)	04 6 11			00.00
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reportin	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	- 31 of the cost reporti	ng period (line	0	24. 00
21.00	7 x line 19)	or or the cost reporti	ing period (inte		21.00
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
	x line 20)				
26. 00	Total swing-bed cost (see instructions)			952, 853	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (	(line 21 minus line 26)		3, 706, 773	27. 00
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	A and observation had	argos)	0	20 00
29. 00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	a and observation bed ch	arges)	0	28. 00 29. 00
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	31.00
32. 00	Average private room per diem charge (line 29 ÷ line 3)	11110 20)		0.00	32. 00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33. 00
34.00	Average per diem private room charge differential (line 32 mir	nus line 33)(see instruc	tions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x lin	ne 31)		0. 00	35. 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 a	and private room cost di	fferential (line	3, 706, 773	37. 00
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 395. 10	38. 00
39. 00	Program general inpatient routine service cost per drem (see	•		1, 343. 10	39.00
40. 00	Medically necessary private room cost applicable to the Progra	•		Ö	40. 00
	Total Program general inpatient routine service cost (line 39			Ö	41. 00
			'	'	,

Heal th	Financial Systems	JAY COUNTY	HOSPI TAL			In Lie	eu of Form CMS-	2552-10
	ATION OF INPATIENT OPERATING COST			der CC	N: 15-1320	Peri od: From 10/01/2015	Worksheet D-1	
						To 09/30/2016	Date/Time Pre	
				Titl€	e XIX	Hospi tal	2/27/2017 10: Cost	37 am
	Cost Center Description	Total	Total		Average Per	Program Days	Program Cost	
		Inpatient Cost	Inpati ent	Days	Diem (col. 1 col. 2)	÷	(col. 3 x col. 4)	
		1.00	2. 00		3.00	4. 00	5. 00	
42.00	NURSERY (title V & XIX only)	286, 837		126	2, 276. 4	18 0	0	42. 00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	l ol		0	0.0	00 0	0	43.00
44. 00	CORONARY CARE UNIT						_	44. 00
45. 00	BURN INTENSIVE CARE UNIT							45. 00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)							46. 00 47. 00
	Cost Center Description							
48. 00	Program inpatient ancillary service cost (Wk	st D-3 col 3	line 20	0)			1.00	48. 00
	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS				ns)			49. 00
50. 00	Pass through costs applicable to Program inp.	atient routine	servi ces	(from	Wkst. D, sun	n of Parts I and	0	50. 00
51. 00	Pass through costs applicable to Program inpand IV)		y service	s (fro	om Wkst. D, s	sum of Parts II	0	
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu-		lated, no	n-phvs	sician anesth	netist, and	0 0	
	medical education costs (line 49 minus line	J 1	,	1				1
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges						0	54.00
55. 00	Target amount per discharge							55. 00
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and ta	raot amou	nt (Li	no 56 minus	lino 52)	0	
58. 00	Bonus payment (see instructions)	ing cost and ta	iget alliou	111 (11	ne so ilimias	111le 53)		1
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 19	96, up	odated and co	ompounded by the	0.00	59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report. up	dated by	the ma	arket basket		0.00	60.00
	If line 53/54 is less than the lower of line	s 55, 59 or 60	enter the	Lesse	er of 50% of	-	0	1
	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)							
62. 00	Relief payment (see instructions)	ŕ					0	62. 00
63. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ctions)				0	63. 00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 o	f the	cost reporti	ng period (See	0	64. 00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of	the co	ost reportino	period (See	0	65. 00
66. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi</pre>	ne costs (line	64 plus l	ine 65	5)(title XVII	I only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	e costs through	December	31 of	the cost re	eporting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after D	ecember 3	1 of t	he cost repo	ortina period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient					3 1	0	
70.05	PART III - SKILLED NURSING FACILITY, OTHER N	JRSING FACILITY,	AND ICF	/IID C	NLY		I	
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of	-						70. 00 71. 00
72. 00	Program routine service cost (line 9 x line				/			72. 00
73. 00 74. 00	Medically necessary private room cost applic				ne 35)			73.00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient 26, line 45)	•		,	orksheet B, F	Part II, column		74. 00 75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)						76. 00
77. 00	Program capital -related costs (line 9 x line							77.00
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		rovi der r	ecords	s)			78. 00 79. 00
80.00	Total Program routine service costs for comp	arison to the c				nus line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I		)					81. 00 82. 00
83. 00	Reasonable inpatient routine service costs (		•					83. 00
84. 00	Program inpatient ancillary services (see in	structions)						84. 00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum							85. 00 86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST						
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per		line 2)				145 1, 395. 10	87.00
	Observation bed cost (line 87 x line 88) (se						202, 290	1

Health Financial Systems	JAY COUNTY I	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 10/01/2015		
				To 09/30/2016	Date/Time Prep 2/27/2017 10:	
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	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	1 COST					
90.00 Capital -related cost	269, 671	4, 659, 626	0. 05787	4 202, 290	11, 707	90.00
91.00 Nursing School cost	0	4, 659, 626	0.00000	0 202, 290	0	91.00
92.00 Allied health cost	0	4, 659, 626	0.00000	0 202, 290	0	92.00
93.00 All other Medical Education	0	4, 659, 626	0.00000	0 202, 290	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: 15-1320	Peri od: From 10/01/2015	Worksheet D-1
	Component CCN: 15-M320	To 09/30/2016	Date/Time Prepared: 2/27/2017 10:37 am
	Title XIX	Subprovi der -	Cost

		II the XIX	I PF	COST	
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		1, 495	1. 00
2.00	Inpatient days (including private room days, excluding swing-b			1, 495	
3. 00	Private room days (excluding swing-bed and observation bed day	ys). If you have only pri	vate room days,	0	3. 00
4.00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	ed days)		1, 495	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room		31 of the cost	0	5. 00
	reporting period				
6. 00	Total swing-bed SNF type inpatient days (including private room	om days) after December 3	1 of the cost	0	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	0	7. 00
7.00	reporting period	adys) through becomber	or or the cost	١	7.00
8.00	Total swing-bed NF type inpatient days (including private room	n days) after December 31	of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)			0.4	0.00
9. 00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	swing-bed and	24	9. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private ro	om days)	0	10.00
	through December 31 of the cost reporting period (see instruct	tions)	,		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private ro	om days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, er Swing-bed NF type inpatient days applicable to titles V or XI)		room days)	0	12. 00
12.00	through December 31 of the cost reporting period	Comy (Therdaing private	1 com days)	١	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI)			0	13. 00
14 00	after December 31 of the cost reporting period (if calendar ye	· ·	,	0	14 00
14. 00 15. 00	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	all (excluding swing-bed d	ays)		14. 00 15. 00
16. 00	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 of	the cost		17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	es after December 31 of t	he cost		18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0. 00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s after December 31 of th	e cost	0.00	20. 00
	reporting period			-	
21. 00	Total general inpatient routine service cost (see instructions			2, 418, 000	
22. 00	Swing-bed cost applicable to SNF type services through December $5 \times 1$ ine 17)	er 31 of the cost reporti	ng period (line	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	period (line 6	0	23. 00
	x line 18)	·			
24. 00	Swing-bed cost applicable to NF type services through December $7 \times 1$ ine 19)	31 of the cost reportin	g period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
	x line 20)	or and accordance		-	
26. 00	Total swing-bed cost (see instructions)	(1)		0	
27. 00	General inpatient routine service cost net of swing-bed cost ( PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		2, 418, 000	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	rges)	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 32. 00	General inpatient routine service cost/charge ratio (line 27 - Average private room per diem charge (line 29 + line 3)	Fline 28)		0. 000000 0. 00	1
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 mir	nus line 33)(see instruct	i ons)	0.00	
35. 00	Average per diem private room cost differential (line 34 x lin	ne 31)		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 a 27 minus line 36)	anu private room cost dit	recentral (TIME	2, 418, 000	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU				
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 617. 39	
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program			38, 817 0	
	Total Program general inpatient routine service cost (line 39)	,		38, 817	
	·	•			

	Financial Systems ATION OF INPATIENT OPERATING COST	JAY COUNTY H	Provider Co	CN: 15-1320	Peri od: From 10/01/2015	w of Form CMS-2 Worksheet D-1	
			Component (	CCN: 15-M320	To 09/30/2016	Date/Time Pre 2/27/2017 10:	
			Ti tl	e XIX	Subprovider - IPF	Cost	
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost Ir		col . 2)		(col. 3 x col. 4)	
42. 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4. 00	5. 00	42. 00
	Intensive Care Type Inpatient Hospital Units						
43. 00 44. 00	INTENSIVE CARE UNIT	0	0	0.0	00 0	0	43.00
45.00	BURN INTENSIVE CARE UNIT						45. 00
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
47.00	Cost Center Description						47.00
48. 00	Program inpatient ancillary service cost (Wk	st D 2 col 2	Lino 200)			1. 00 5, 286	48. 00
49. 00	Total Program inpatient costs (sum of lines			ns)		44, 103	
F0 00	PASS THROUGH COST ADJUSTMENTS			WI 1 B			
50. 00	Pass through costs applicable to Program inp	atient routine se	ervices (Trom	⊓WKST. D, SUM	OT Parts I and	0	50.00
51. 00	Pass through costs applicable to Program inp	atient ancillary	services (fr	om Wkst. D, s	um of Parts II	0	51. 00
52. 00	and IV)  Total Program excludable cost (sum of lines	50 and 51)				0	52.00
53.00	Total Program inpatient operating cost exclu	ding capital rela	ated, non-phy	sician anesth	etist, and	0	53. 00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
	Program di scharges					0	
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)					0. 00 0	1
57.00	Difference between adjusted inpatient operat	ing cost and targ	get amount (I	ine 56 minus	line 53)	0	57. 00
58. 00 59. 00	Bonus payment (see instructions)	norting period e	ndina 1006 u	ndated and co	mnounded by the	0 0. 00	
37.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						37.00
60. 00 61. 00							60.00
01.00	which operating costs (line 53) are less that					0	01.00
62. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62. 00
63. 00	Allowable Inpatient cost plus incentive paym	ent (see instruc	tions)			0	
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Docomb	or 21 of the	cost roporti	ng poriod (Soc	0	64. 00
04.00	instructions)(title XVIII only)	Ü		•			04.00
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decembe	r 31 of the c	ost reporting	period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 64	4 plus line 6	5)(title XVII	I only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	a costs through [	December 31 o	f the cost re	norting period	0	67.00
07.00	(line 12 x line 19)	J			. 31		07.00
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs after Dec	cember 31 of	the cost repo	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient	routine costs (li	ne 67 + line	68)		0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil						70.00
71.00	Adjusted general inpatient routine service of						71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic	•	(line 14 v li	ne 35)			72. 00 73. 00
74. 00	Total Program general inpatient routine serv		•	,			74. 00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service (	costs (from W	orksheet B, P	Part II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77.00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77. 00 78. 00
	Aggregate charges to beneficiaries for exces		ovi der record	s)			79.00
	Total Program routine service costs for comp.		st limitation	(line 78 min	us line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I						81. 00 82. 00
83. 00	Reasonable inpatient routine service costs (	see instructions	)				83. 00
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		s)				84. 00 85. 00
	Total Program inpatient operating costs (sum	of lines 83 thro					86.00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					0	87. 00
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷ l	ine 2)			0.00	88. 00
89.00	Observation bed cost (line 87 x line 88) (se	e instructions)				0	89. 00

COMPUTATION OF INPATIENT OPERATING COST Provider CCN: 15-1320 Period: Worksheet D-1	
Component CCN: 15-M320 From 10/01/2015 To 09/30/2016 Date/Time Prepared 2/27/2017 10: 37 at	
Title XIX Subprovider - Cost	
IPF	
Cost Center Description   Cost   Routine Cost   column 1 ÷   Total   Observation	
(from line 21) column 2   Observation   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 109, 120 2, 418, 000 0. 045128 0 0 90.	. 00
91.00 Nursing School cost 0 2,418,000 0.000000 0 0 91.	. 00
92.00 Allied health cost 0 2,418,000 0.000000 0 0 92.	. 00
93.00 All other Medical Education 0 2,418,000 0.000000 0 93.	. 00

Health Financial Systems	JAY COUNTY HOS	SPI TAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der Co	CN: 15-1320	Period: From 10/01/2015	Worksheet D-3	pared:
		Title	XVIII	Hospi tal	Cost	
Cost Center Description			Ratio of Cos To Charges	Program	Inpatient Program Costs (col. 1 x col. 2)	

NPATI ENT ROUTI NE SERVI CE COST CENTERS   NATIONAL SUBPROVIDER - I PP   1.00						2/2//2017 10:	<u>3/ am</u>
To Charges			Titl∈				
INPATIENT ROUTINE SERVICE COST CENTERS   1.00   2.00   3		Cost Center Description				Inpati ent	
NAME				To Charges	Program		
NPATI ENT ROUTI NE SERVI CE COST CENTERS					Charges		
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00				1.00	2. 00	3. 00	
31. 00   03100   INTENSIVE CARE UNIT   0   040.00   04000   SUBPROVI DER - I PF   0   0   41.00   040.00   04100   SUBPROVI DER - I RF   0   0   41.00   04200   SUBPROVI DER - I RF   0   0   42.00   04300   NURSERY   0   05200   052							
40.00   04000   SUBPROVI DER - I PF   0 0   41.00   041.00   041.00   041.00   041.00   042		l .			2, 243, 240		
41. 00   04100   SUBPROVI DER - I RF   0   042. 00   04200   SUBPROVI DER   0   042. 00   042.					0		
42. 00   43. 00   04200   SUBPROVI DER   0   04300   NURSERY   043. 00   04300   NURSERY   05000   05000   0FERATI NG ROOM   0.362527   0   0.00000   0   0.52.00   05200   DELI VERY ROOM & LABOR ROOM   0.362527   0   0.000000   0   0   0.53. 00   05300   ANESTHESI OLOGY   0.000000   0   0   0.000000   0   0					0		
43. 00   04300   NURSERY   ANCI LLARY SERVICE COST CENTERS					0		
ANCILLARY SERVICE COST CENTERS   50.00   05000   OPERATI NG ROOM   0.266772   1,027,275   274,048   50.00   52.00   52.00   05000   DELIVERY ROOM & LABOR ROOM   0.362527   0.000000   0.52.00   53.00   05300   ANESTHESI OLOGY   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000		l .			0		
50. 00         05000   OPERATI NG ROOM         0.266772         1,027,275         274,048         50.00           52. 00         05200   DELI VERY ROOM & LABOR ROOM         0.362527         0         0         52.00           53. 00         05300   ANESTHESI OLOGY         0.000000         0         0         53.00           54. 00         05400   RADI OLOGY-DI AGNOSTI C         0.090621         721,138         65,350         54.00           57. 00         05700   CT SCAN         0.000000         0         0         57.00           58. 00         05800   MAGNETI C RESONANCE   IMAGI NG (MRI)         0.000000         0         0         57.00           59. 00         05900   CARDI AC CATHETEI ZATI ON         0.000000         0         0         59.00           60. 01         06000   LABORATORY         0.168141         1,070,376         179,974         60.00           60. 01         06001   BLOOD LABORATORY         0.000000         0         0         60.01           65. 00         05500   RESPI RATORY THERAPY         0.569725         236,951         134,997         65.00           66. 00         06600   PHYSI CAL THERAPY         0.352574         70,645         24,908         67.00           67. 00         06700   OCU							43. 00
52. 00         05200         DELI VERY ROOM & LABOR ROOM         0.362527         0         0         52. 00           53. 00         05300         ANESTHESI OLOGY         0.000000         0         0         53. 00           54. 00         05400         RADI OLOGY-DI AGNOSTI C         0.090621         721, 138         65, 350         54. 00           57. 00         05700         CT SCAN         0.000000         0         0         57. 00           58. 00         05800         MAGNETI C RESONANCE I MAGI NG (MRI)         0.000000         0         0         58. 00           59. 00         05900         CARDI AC CATHETERI ZATI ON         0.000000         0         0         59. 00           60. 00         06000         LABORATORY         0.168141         1,070,376         179,974         60. 00           60. 01         06500         RESPI RATORY THERAPY         0.569725         236,951         134,997         65. 00           65. 00         06500         PHYSI CAL THERAPY         0.371786         142,529         52,990         66. 00           67. 00         06700         OCCUPATI ONAL THERAPY         0.352574         70,645         24,908         67. 00           68. 00         DEECH PATHOLOGY <td></td> <td></td> <td></td> <td></td> <td>_</td> <td></td> <td></td>					_		
53. 00         05300         ANESTHESI OLOGY         0.000000         0         0.53.00           54. 00         05400         RADI OLOGY-DI AGNOSTI C         0.090621         721, 138         65, 350         54.00           57. 00         05700         CT SCAN         0.000000         0         0.57.00         57.00           58. 00         05800         MAGNETI C RESONANCE I MAGI NG (MRI)         0.000000         0         0.58.00         59.00         0.000000         0         0.58.00         59.00         0.000000         0         0.58.00         59.00         0.000000         0         0.58.00         59.00         0.000000         0         0.58.00         59.00         0.000000         0         0.58.00         59.00         0.000000         0         0.00000         0         0.00000         0         0.00000         0         0.00000         0         0.00000         0         0.00000         0         0.00000         0         0.00000         0         0.00000         0         0.00000         0         0.00000         0         0.00000         0         0.00000         0         0.00000         0         0.00000         0         0.00000         0         0.00000         0         0.00000				0. 266772	1, 027, 275	274, 048	50.00
54. 00         05400         RADI OLOGY-DI AGNOSTI C         0.090621         721,138         65,350         54. 00           57. 00         05700         CT SCAN         0.000000         0         0.57. 00           58. 00         05800         MAGNETI C RESONANCE I MAGI NG (MRI)         0.000000         0         0         58. 00           59. 00         O5900         CARDIA C CATHETERI ZATI ON         0.000000         0         0         59. 00           60. 01         06000         LABORATORY         0.168141         1,070,376         179,974         60. 00           60. 01         06500         RESPI RATORY THERAPY         0.569725         236,951         134,997         65. 00           66. 00         06600         PHYSI CAL THERAPY         0.371786         142,529         52,990         66. 00           67. 00         06700         OCCUPATI ONAL THERAPY         0.352574         70,645         24,908         67. 00           68. 00         D6900         SPECH PATHOLOGY         0.324224         10,103         3,276         68. 00           69. 00         O6900         SPECH PATHOLOGY         0.362444         238,456         86,427         69.00           71. 00         07100         MEDI CA						0	
57. 00       05700 CT SCAN       0.000000       0       57. 00         58. 00       05800 MAGNETI C RESONANCE I MAGI NG (MRI)       0.000000       0       58. 00         59. 00       05900 CARDI AC CATHETERI ZATI ON       0.000000       0       0       59. 00         60. 00       06000 LABORATORY       0.168141       1,070,376       179,974       60. 00         60. 01       06001 BLOOD LABORATORY       0.000000       0       0       60. 01         65. 00       06500 RESPI RATORY THERAPY       0.569725       236,951       134,997       65. 00         66. 00       06600 PHYSI CAL THERAPY       0.371786       142,529       52,990       66. 00         67. 00       06700 OCCUPATI ONAL THERAPY       0.352574       70,645       24,908       67. 00         68. 00       06800 SPEECH PATHOLOGY       0.324224       10,103       3,276       68. 00         69. 00       06900 ELECTROCARDI OLOGY       0.362444       238,456       86,427       69. 00         71. 00       07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0.000000       0       0       72. 00         73. 00       07200 I MPL. DEV. CHARGED TO PATI ENTS       0.608360       609,729       370,935       73. 00 <t< td=""><td></td><td></td><td></td><td>0.000000</td><td>0</td><td>0</td><td>53.00</td></t<>				0.000000	0	0	53.00
58. 00       05800 MAGNETI C RESONANCE I MAGI NG (MRI)       0.0000000       0       58. 00         59. 00       05900 CARDI AC CATHETERI ZATI ON       0.000000       0       59. 00         60. 00       06000 LABORATORY       0.168141       1,070,376       179,974       60. 00         60. 01       06001 BLOOD LABORATORY       0.000000       0       0       60. 01         65. 00       06500 RESPI RATORY THERAPY       0.569725       236,951       134,997       65. 00         66. 00       06600 PHYSI CAL THERAPY       0.371786       142,529       52,990       66. 00         67. 00       06700 OCCUPATI ONAL THERAPY       0.352574       70,645       24,908       67. 00         68. 00       06800 SPECH PATHOLOGY       0.324224       10,103       3,276       68. 00         69. 00       06900 ELECTROCARDI OLOGY       0.362444       238,456       86,427       69. 00         71. 00       07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0.000000       0       72. 00         72. 00       07200 I MPL. DEV. CHARGED TO PATI ENTS       0.000000       0       72. 00         73. 00 DUTPATI ENT SERVI CE COST CENTERS       0.000000       0       73. 00         088. 00       08800 RURAL HEALTH CLINIC	54.00 0540	DO RADI OLOGY-DI AGNOSTI C		0. 090621	721, 138	65, 350	54. 00
59.00       05900 CARDI AC CATHETERI ZATI ON       0.0000000       0       59.00         60.00       06000 LABORATORY       0.168141       1,070,376       179,974       60.00         60.01       06001 BLOOD LABORATORY       0.000000       0       0       60.01         65.00       06500 RESPI RATORY THERAPY       0.569725       236,951       134,997       65.00         66.00       06600 PHYSI CAL THERAPY       0.371786       142,529       52,990       65.00         67.00       06700 OCCUPATI ONAL THERAPY       0.352574       70,645       24,908       67.00         68.00       06800 SPECH PATHOLOGY       0.324224       10,103       3,276       68.00         69.00       06900 ELECTROCARDI OLOGY       0.362444       238,456       86,427       69.00         71.00       07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0.000000       0       71.00         72.00       07200 I MPL. DEV. CHARGED TO PATI ENTS       0.000000       0       72.00         73.00       DUTPATI ENT SERVI CE 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 <td>57. 00 0570</td> <td>DO CT SCAN</td> <td></td> <td>0.000000</td> <td>0</td> <td>0</td> <td>57. 00</td>	57. 00 0570	DO CT SCAN		0.000000	0	0	57. 00
60. 00       06000 LABORATORY       0. 168141       1, 070, 376       179, 974       60. 00         60. 01       06001 BLOOD LABORATORY       0. 000000       0       0 60. 01         65. 00       06500 RESPI RATORY THERAPY       0. 569725       236, 951       134, 997       65. 00         66. 00       06000 PHYSI CAL THERAPY       0. 371786       142, 529       52, 990       66. 00         67. 00       06700 OCCUPATI ONAL THERAPY       0. 352574       70, 645       24, 908       67. 00         68. 00       08800 SPEECH PATHOLOGY       0. 324224       10, 103       3, 276       68. 00         69. 00       06900 ELECTROCARDI OLOGY       0. 362444       238, 456       86, 427       69. 00         71. 00       07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0. 000000       0       0       71. 00         72. 00       07200 I MPL. DEV. CHARGED TO PATI ENTS       0. 000000       0       0       72. 00         73. 00       000 DRUGS CHARGED TO PATI ENTS       0. 608360       609, 729       370, 935       73. 00         00 TEAL TEAL THE CLINIC COST CENTERS       0. 000000       0       0       88. 00         89. 00       08900 FEDERALLY QUALIFIED HEALTH CENTER       0. 000000       0       89. 00	58. 00 0580	DO MAGNETIC RESONANCE IMAGING (MRI)		0.000000	0	0	58. 00
60. 01       06001       BL00D LABORATORY       0.000000       0       0       60. 01         65. 00       06500       RESPI RATORY THERAPY       0.569725       236, 951       134, 997       65. 00         66. 00       06600       PHYSI CAL THERAPY       0.371786       142, 529       52, 990       66. 00         67. 00       06700       OCCUPATI ONAL THERAPY       0.352574       70, 645       24, 908       67. 00         68. 00       06800       SPECH PATHOLOGY       0.324224       10, 103       3, 276       68. 00         69. 00       06900       ELECTROCARDI OLOGY       0.362444       238, 456       86, 427       69. 00         71. 00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0.000000       0       0       71. 00         72. 00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0.000000       0       0       72. 00         73. 00       07300       DRUGS CHARGED TO PATI ENTS       0.608360       609, 729       370, 935       73. 00         88. 00       08800       RURAL HEALTH CLINIC       0.000000       0       0       88. 00         89. 00       08900       FEDERALLY QUALI FI ED HEALTH CENTER       0.000000       0       98	59. 00 0590	OO CARDIAC CATHETERIZATION		0.000000	0	0	59. 00
65. 00 06500 RESPIRATORY THERAPY 0.569725 236, 951 134, 997 65. 00 66. 00 06600 PHYSI CAL THERAPY 0.371786 142, 529 52, 990 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0.352574 70, 645 24, 908 67. 00 68. 00 06800 SPECH PATHOLOGY 0.324224 10, 103 3, 276 68. 00 06900 ELECTROCARDI OLOGY 0.362444 238, 456 86, 427 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 0 0 71. 00 72. 00 7200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 0 0 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0.608360 609, 729 370, 935 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	60.00 0600	OO LABORATORY		0. 168141	1, 070, 376	179, 974	60.00
66. 00 06600 PHYSI CAL THERAPY 0. 371786 142, 529 52, 990 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0. 352574 70, 645 24, 908 67. 00 68. 00 06800 SPEECH PATHOLOGY 0. 324224 10, 103 3, 276 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0. 362444 238, 456 86, 427 69. 00 71. 00 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 000000 0 0 71. 00 72. 00 7200 I MPL. DEV. CHARGED TO PATI ENTS 0. 000000 0 0 72. 00 73. 00 DRUGS CHARGED TO PATI ENTS 0. 000000 0 0 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 000000 0 0 72. 00 OCCUPATI ENT SERVI CE COST CENTERS 0. 000000 0 0 0 0 0 0 0 0 0 0 0 0 0 0	60. 01 0600	D1 BLOOD LABORATORY		0.000000	0	0	60. 01
67. 00	65. 00 0650	00 RESPI RATORY THERAPY		0. 569725	236, 951	134, 997	65.00
68. 00 06800 SPECH PATHOLOGY 0. 324224 10, 103 3, 276 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0. 362444 238, 456 86, 427 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0. 0000000 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 0000000 0 0 72. 00 73. 00 DRUGS CHARGED TO PATIENTS 0. 608360 609, 729 370, 935 000000 0 0 72. 00 000000 0 0 0 0 0 0 0 0 0 0 0 0 0 0	66. 00 0660	DO PHYSI CAL THERAPY		0. 371786	142, 529	52, 990	66.00
69. 00 06900 ELECTROCARDIOLOGY 0. 362444 238, 456 86, 427 69. 00 71. 00 71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS 0. 000000 0 0 72. 00 72. 00 7200 IMPL. DEV. CHARGED TO PATIENTS 0. 000000 0 0 72. 00 00000 0 0 72. 00 00000 0 0 0 72. 00 00000 0 0 0 0 72. 00 00000 0 0 0 0 0 0 0 0 0 0 0 0 0 0	67. 00 0670	OO OCCUPATIONAL THERAPY		0. 352574	70, 645	24, 908	67.00
71. 00	68. 00 0680	OO SPEECH PATHOLOGY		0. 324224	10, 103	3, 276	68. 00
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0.000000   0   0   72. 00   07300   DRUGS CHARGED TO PATIENTS   0.608360   609, 729   370, 935   73. 00   07300   DRUGS CHARGED TO PATIENTS   0.000000   0   72. 00   073. 00	69. 00 0690	DO ELECTROCARDI OLOGY		0. 362444	238, 456	86, 427	69. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 608360 609, 729 370, 935 73. 00 000000 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0. 0000000 0 89. 00 89. 00	71. 00 0710	MEDICAL SUPPLIES CHARGED TO PATIENTS		0.000000	0	0	71. 00
OUTPATIENT SERVICE COST CENTERS         0.000000         0.000000         88.00           88.00         08900 RURAL HEALTH CLINIC         0.000000         0.00000         88.00           89.00         08900 FEDERALLY QUALIFIED HEALTH CENTER         0.000000         0.00000         0.00000	72. 00 0720	DO IMPL. DEV. CHARGED TO PATIENTS		0.000000	0	0	72. 00
88. 00 08800 RURAL HEALTH CLINIC 0.000000 0 88. 00 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 0 89. 00	73.00 0730	DO DRUGS CHARGED TO PATIENTS		0. 608360	609, 729	370, 935	73. 00
89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER   0.000000   0   89. 00	OUTP	PATIENT SERVICE COST CENTERS					
	88. 00 0880	OO RURAL HEALTH CLINIC		0.000000		0	88. 00
90. 00   09000   CLINIC   2. 276306   1, 937   4, 409   90. 00	89. 00 0890	po FEDERALLY QUALIFIED HEALTH CENTER		0.000000	)	0	89. 00
	90.00 0900	DO CLI NI C		2. 276306	1, 937	4, 409	90. 00
90. 01   09001   FAMILY PRACTICE OF JAY COUNTY   1. 074414   0   90. 01	90. 01 0900	pol FAMILY PRACTICE OF JAY COUNTY		1. 074414	. 0	0	90. 01
90. 02   09002   JAY FAMI LY MEDI CI NE   2. 089633   0   90. 02				2. 089633	0	0	90. 02
91. 00   09100   EMERGENCY   0. 313719   6, 962   2, 184   91. 00	91. 00 0910	DO EMERGENCY		0. 313719	6, 962	2, 184	91.00
92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   1.494818   0   92. 00	92. 00 0920	OO OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
93. 00   04040   OTHER OUTPATI ENT SERVI CE COST CENTER   0.000000   0   93. 00				•		0	
200.00 Total (sum of lines 50-94 and 96-98) 4,136,101 1,199,498 200.00						1, 199, 498	
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00			(line 61)				
202.00 Net Charges (Line 200 minus Line 201) 4,136,101 202.00			. ,		4, 136, 101		

Health Financial Systems JAY CC INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	DUNTY HOSPITAL Provider C	CN: 15-1320	Peri od:	eu of Form CMS-2 Worksheet D-3	
THE ATTENT AND LEARLY SERVICE GOST ATTORT ON MENT			From 10/01/2015		
	Component	CCN: 15-M320	To 09/30/2016	Date/Time Pre 2/27/2017 10:	
	Titl€	e XVIII	Subprovider -	PPS	0, a
Cost Center Description		Ratio of Cost		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2. 00	2) 3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS			0		30.00
31. 00   03100   NTENSI VE CARE UNI T			o o	l	31.00
40. 00   04000   SUBPROVI DER - I PF			678, 400		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
ANCI LLARY SERVI CE COST CENTERS					
50. 00   05000   OPERATI NG ROOM		0. 26677	2 0	0	50.00
52.00   05200   DELI VERY ROOM & LABOR ROOM		0. 36252		-	
53. 00   05300   ANESTHESI OLOGY		0.00000		0	
54. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 09062			
57. 00 05700 CT SCAN		0.00000		-	
58. 00   05800   MAGNETI C RESONANCE I MAGING (MRI)		0.00000			00.00
59. 00   05900   CARDI AC CATHETERI ZATI ON		0.00000		0	1
60. 00   06000   LABORATORY 60. 01   06001   BLOOD   LABORATORY		0. 16814 0. 00000		28, 906 0	1
65. 00   06500   RESPI RATORY   THERAPY		0. 56972		7, 990	
66. 00   06600   PHYSI CAL THERAPY		0. 30472		6, 415	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 37178			•
68. 00   06800  SPEECH PATHOLOGY		0. 32422		l	•
69. 00   06900   ELECTROCARDI OLOGY		0. 36244			
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.00000			
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS		0.00000		0	1
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 60836	0 152, 490	92, 769	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	
90. 00   09000   CLI NI C		2. 27630			1
90. 01   09001   FAMILY PRACTICE OF JAY COUNTY		1. 07441		0	1
90. 02   09002   JAY FAMILY MEDICINE		2. 08963		0	
91. 00 09100 EMERGENCY		0. 31371		5, 090	
92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)		1. 49481		1	
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTER		0.00000		17/ 000	
200.00 Total (sum of lines 50-94 and 96-98)	changes (line (1)		458, 265	176, 800	
201.00 Less PBP Clinic Laboratory Services-Program only	charges (Tine 61)		450 245		201. 00 202. 00
202.00   Net Charges (line 200 minus line 201)		I	458, 265	I	<sub>1</sub> 202.

Health Financial Systems	JAY COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CCN: 15-1320	Peri od: Worksheet D-3

From 10/01/2015 To 09/30/2016 Component CCN: 15-Z320 Date/Time Prepared: 2/27/2017 10:37 am Title XVIII Swing Beds - SNF Inpatient Inpati ent Cost Center Description Ratio of Cost To Charges Program Costs Program (col. 1 x col Charges 2) 1.00 2.00 3.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 30.00 03100 INTENSIVE CARE UNIT 31.00 31 00 40.00 04000 SUBPROVIDER - IPF 40.00 0 04100 SUBPROVI DER - I RF 41.00 41.00 04200 SUBPROVI DER 42.00 42.00 04300 NURSERY 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 266772 141 38 50.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0.362527 Ω 52.00 53.00 05300 ANESTHESI OLOGY 0.000000 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.090621 32,066 2, 906 54.00 57.00 05700 CT SCAN 0.000000 57.00 0 0 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.000000 58.00 0 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.000000 0 59.00 06000 LABORATORY 60.00 0.168141 96, 087 16, 156 60.00 06001 BLOOD LABORATORY 0.000000 60 01 60 01 0 65.00 06500 RESPIRATORY THERAPY 0.569725 65, 889 37, 539 65.00 66.00 06600 PHYSI CAL THERAPY 0.371786 173, 255 64, 414 66.00 06700 OCCUPATIONAL THERAPY 67.00 0.352574 123, 870 43,673 67.00 06800 SPEECH PATHOLOGY 68 00 0.324224 2, 681 869 68 00 69.00 06900 ELECTROCARDI OLOGY 0.362444 7,849 2,845 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0.000000 0 71.00 72 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 Ω 72 00 07300 DRUGS CHARGED TO PATIENTS 84, 534 73.00 0.608360 138, 954 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89 00 0.000000 89 00 0 90.00 09000 CLI NI C 2.276306 1, 431 3, 257 90.00 09001 FAMILY PRACTICE OF JAY COUNTY 1.074414 90.01 90.01 0 90.02 09002 JAY FAMILY MEDICINE 2.089633 0 90.02 09100 EMERGENCY 91.00 0.313719 0 91.00 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1.494818 0 0 92.00 93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTER 0.000000 93.00 200.00 Total (sum of lines 50-94 and 96-98) 256, 231 200.00 642, 223

201. 00

202.00

642, 223

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

Net Charges (line 200 minus line 201)

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: 15-1320	Period: Worksheet D-3

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-1320	Peri od: From 10/01/2015	Worksheet D-3	1
			Lrom 10/01/2015		
			To 09/30/2016	Date/Time Pre 2/27/2017 10:	pared:
	Ti +I	e XIX	Hospi tal	Cost	37 alli
Cost Center Description	11 (1	Ratio of Cost		Inpati ent	
oust defiter bescription		To Charges	Program	Program Costs	
		10 charges	Charges	(col. 1 x col.	
			Charges	2)	
		1.00	2. 00	3. 00	-
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	0.00	
30. 00 03000 ADULTS & PEDI ATRI CS			0		30.00
31. 00 03100 INTENSIVE CARE UNIT			0	J	31.00
40. 00   04000   SUBPROVI DER - 1 PF			0	J	40.00
41. 00   04100   SUBPROVI DER -   RF			0	J	41. 00
42. 00   04200   SUBPROVI DER			0	,	42. 00
43. 00   04300   NURSERY			0	,	43. 00
ANCI LLARY SERVI CE COST CENTERS		1		1	10.00
50, 00 05000 OPERATI NG ROOM		0. 26677	2 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 36252		0	52. 00
53. 00   05300   ANESTHESI OLOGY		0.00000		0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 09062		0	54.00
57. 00  05700 CT SCAN		0.00000		0	1
58. 00   05800   MAGNETIC RESONANCE   MAGING (MRI)		0.00000		0	
59. 00   05900 CARDI AC CATHETERI ZATI ON		0.00000		0	
60. 00   06000   LABORATORY		0. 16814			1
60. 01   06001   BLOOD LABORATORY		0.00000			
65. 00 06500 RESPI RATORY THERAPY		0. 56972			1
66. 00   06600   PHYSI CAL THERAPY		0. 37178		1	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 35257	-		1
68. 00   06800  SPEECH PATHOLOGY		0. 32422			1
69. 00   06900   ELECTROCARDI OLOGY		0. 36244		_	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 00000		1	1
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS		0.00000			1
73. 00 07300 DRUGS CHARGED TO PATTENTS		0. 60836		•	
OUTPATIENT SERVICE COST CENTERS		0.00030	0 0	0	73.00
88. 00 08800 RURAL HEALTH CLINIC		0.00000	0 0	0	88. 00
89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER		0.00000		1	
90. 00   09000   CLI NI C		2. 27630			
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY		1. 07441			
90. 02   09002   JAY FAMILY MEDICINE		2. 08963		_	1
91. 00   09100   EMERGENCY		0. 31371		1	
92.00   09200   OBSERVATION BEDS (NON-DISTINCT PART)		1. 49481		1	
		1		1	
93.00 04040 OTHER OUTPATIENT SERVICE COST CENTER		0.00000			
200.00 Total (sum of lines 50-94 and 96-98)	o (lin- (1)		0		200.00
201.00 Less PBP Clinic Laboratory Services-Program only charge	s (line ol)		0	l .	201. 00
202.00   Net Charges (line 200 minus line 201)		I	0	1	202. 00

Health Financial Systems INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	JAY COUNTY HOSPITAL	CN: 15-1320	Peri od:	eu of Form CMS-2 Worksheet D-3	
INFAITENT ANCIELART SERVICE COST AFFORTIONMENT	Frovider C	CN. 15-1320	From 10/01/2015	WOLKSHEET D-3	
	Component	CCN: 15-M320	To 09/30/2016	Date/Time Pre 2/27/2017 10:	pared:
	Ti tI	e XIX	Subprovi der -	Cost	37 dili
			. I PF		
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs (col. 1 x col.	
			Charges	2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS			0		30.00
1.00 03100 INTENSIVE CARE UNIT			0		31.00
0. 00   04000   SUBPROVI DER - 1 PF			21, 385		40.00
1. 00   04100   SUBPROVI DER - I RF			0		41.00
2. 00   04200   SUBPROVI DER			0		42.00
3. 00   04300   NURSERY			0		43.00
ANCILLARY SERVICE COST CENTERS 05.00 OF OFFICE OF OFFICE O		0.2//7	72 0	0	- 0
0.00   05000   OPERATING ROOM 2.00   05200   DELIVERY ROOM & LABOR ROOM		0. 26677 0. 36252			
3. 00   05300   ANESTHESI OLOGY		0. 30232		0	53.00
4. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 09062			54.00
7. 00   05700 CT SCAN		0. 00000		0	
88.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0.00000		Ō	58.00
9. 00 05900 CARDI AC CATHETERI ZATI ON		0.00000	00	0	59.00
0. 00   06000   LABORATORY		0. 16814	9, 019	1, 516	60.00
0. 01   06001   BL00D LABORATORY		0.00000	00	0	60.01
55. 00 06500 RESPI RATORY THERAPY		0. 56972		309	
6. 00   06600   PHYSI CAL THERAPY		0. 37178		l	
7. 00 06700 OCCUPATI ONAL THERAPY		0. 35257		0	
98. 00   06800   SPEECH PATHOLOGY		0. 32422		0	68. 00 69. 00
9.00  06900 ELECTROCARDIOLOGY 11.00  07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 36244 0. 00000		0 0	71.00
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0.00000			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 60836		1	
OUTPATIENT SERVICE COST CENTERS		0.0000	0,000	0,000	70.00
88. 00 08800 RURAL HEALTH CLINIC		0.00000	00 0	0	88. 00
9.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000	00	0	89.00
00. 00   09000   CLI NI C		2. 27630	06	0	90.00
0.01 09001 FAMILY PRACTICE OF JAY COUNTY		1. 07441	0	0	90. 01
0.02 09002 JAY FAMILY MEDICINE		2. 08963		0	90. 02
21. 00   09100   EMERGENCY		0. 3137		0	91.00
22. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)		1. 49481		0	92.00
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTER		0.00000			93.00
200.00   Total (sum of lines $50-94$ and $96-98$ )		1	17 221	1 5 286	LIND OC

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)

5, 286 200. 00 201. 00 202. 00

17, 321

200. 00 201. 00

202.00

Health Financial Systems	JAY COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-1320 Pe	eriod: Worksheet D-3

From 10/01/2015 Component CCN: 15-Z320 09/30/2016 Date/Time Prepared: 2/27/2017 10:37 am Title XIX Swing Beds - SNF Ratio of Cost Inpatient Inpati ent Cost Center Description To Charges Program Costs Program (col. 1 x col Charges 2) 1.00 2.00 3.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 0 0 0 0 03100 INTENSIVE CARE UNIT 31.00 31 00 40.00 04000 SUBPROVIDER - IPF 40.00 04100 SUBPROVI DER - I RF 41.00 41.00 04200 SUBPROVI DER 42.00 42.00 04300 NURSERY 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 266772 0 0 0 0 0 0 0 0 0 0 0 0 0 50.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0.362527 0 52.00 53.00 05300 ANESTHESI OLOGY 0.000000 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.090621 54.00 57.00 05700 CT SCAN 0.000000 57.00 0 05800 MAGNETIC RESONANCE I MAGING (MRI) 0.000000 58.00 58.00 0 59.00 05900 CARDIAC CATHETERIZATION 0.000000 0 59.00 06000 LABORATORY 60.00 60.00 0.168141 0 06001 BLOOD LABORATORY 0.000000 60 01 0 60 01 65.00 06500 RESPIRATORY THERAPY 0.569725 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.371786 0 66.00 06700 OCCUPATIONAL THERAPY 67.00 0.352574 0 67.00 06800 SPEECH PATHOLOGY 68.00 0.324224 Ω 68 00 69.00 06900 ELECTROCARDI OLOGY 0.362444 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0.000000 0 71.00 72 00 07200 I MPL. DEV. CHARGED TO PATIENTS 0.000000 Ω 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0.608360 0 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.000000 000000000000 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89. 00 89 00 0.000000 0 90.00 09000 CLI NI C 2.276306 0 90.00 90.01 09001 FAMILY PRACTICE OF JAY COUNTY 1.074414 0 90.01 09002 JAY FAMILY MEDICINE 90.02 2.089633 0 90.02 09100 EMERGENCY 91.00 91.00 0.313719 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1.494818 0 92.00 93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTER 0.000000 93.00 200.00 Total (sum of lines 50-94 and 96-98) 0 200. 00

201.00

202. 00

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

Net Charges (line 200 minus line 201)

201.00 202.00

Health Financial Systems	JAY COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1320	Peri od: Worksheet E From 10/01/2015 Part B To 09/30/2016 Date/Time Prepared:

Description   Part   Mart				To 09/30/2016	Date/Time Pre 2/27/2017 10:	
PART 8 - MEDICAL AND OTHER REALTH SERVICES   4, HA1, 240   1.00   Well cell and other services (see instructions)   4, HA1, 240   1.00   2.0			Title XVIII	Hospi tal		
PART 8 - MEDICAL AND OTHER REALTH SERVICES   4, HA1, 240   1.00   Well cell and other services (see instructions)   4, HA1, 240   1.00   2.0					1 00	
Modical and other services reinbursed under OPPS (see instructions)		PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
Description						1
0.00   0.00		· · · · · · · · · · · · · · · · · · ·	tions)		_	1
Inter the fixes pital specific payment to cost ratio (see instructions)   0.000   5.00   6.00   1.00   1.00   5.00   6.00   1.00   5.00   7.00   5.00   7.00   5.00   7.00   5.00   7.00   5.00   7.00   5.00   7.00   5.00   7.00   5.00   7.00   5.00   7.00   5.00   7.00   5.00   7.00   5.00   7.						1
Line 2 times line 5   0   6.00   7.00   5.00   7.00   5.00   7.00   5.00   7.00   5.00   7.00   5.00   7.00   5.00   7.00   5.00   7.00   5.00   7.00   5.00   7.00   5.00   7.00   5.00   7.00   5.00   7.00   5.00   7.00   5.00   7.			ctions)		_	1
Transitional corridor payment (see instructions)		, , , , , , , , , , , , , , , , , , , ,	31. 3.13)			1
9.00   Ancillary service other pass through costs from Wkst. D. Pt. IV, col. 13, line 200   0   9.00	7.00	Sum of line 3 plus line 4 divided by line 6			0. 00	7. 00
0.00   organ acquisitions						ł
1.00   Total cost (sum of lines 1 and 10) (see instructions)			V, col. 13, line 200		_	1
COMPUTATION OF LESSER OF COST OR CHARGES   Reasonable charges   Reasonable charges   Cost of charges		9			_	1
Reasonable charges   0   12.00     0   12.00     0   13.00   0	11.00				4, 041, 240	11.00
13.00   Organ acquisition charges (from Wkst. D-4, Pt. III., col. 4, line 69)						
14.00   Total reasonable charges (sum of lines 12 and 13)   14.00   14.00   14.00   15.00		, ,				
Country charges   15.00   Agrogate amount actually collected from patients   Iable for payment for services on a charge basis   0   15.00   Amounts that would have been real ized from patients   Iable for payment for services on a chargebasis   0   16.00   16.			ne 69)			
15.00   Aggregate amount actually collected from patients liable for payment for services on a charge basis   0   15.00	14.00				0	14.00
16.00   Amounts that would have been realized from patients   1able for payment for services on a chargebasis   na dave payment been made in accordance with 42 CFR \$431.313(e)   0.000000   17.00   18.00	15 00		payment for services on	a charge basis	0	15 00
17.00					_	
18. 00   Total customary charges (see instructions)			e)	-		
19. 00   Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see   19. 00   1						
instructions		,	vifling 10 avegade li	no 11) (coo		ł
20.00   Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see   0   20.00   1   1   1   1   1   1   1   1   1	19.00		y II IIIle 18 exceeds II	ne II) (See	U	19.00
21.00   Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)   4,889,652   21.00   22.00   23.00   20.00   2	20. 00		y if line 11 exceeds li	ne 18) (see	0	20. 00
22.00   Interns and residents (see instructions)   0   22.00   23.00   Cost of physic clams' services in a teaching hospital (see instructions)   0   23.00   23.00   Cost of physic clams' services in a teaching hospital (see instructions)   0   24.00   24.00   25.00   Deductible sand coinsurance (for CAH, see instructions)   86.032   25.00   Deductible sand coinsurance (for CAH, see instructions)   86.032   25.00   Deductible sand coinsurance relating to amount on line 24 (for CAH, see instructions)   3.031,510   26.00   Deductible sand coinsurance relating to amount on line 24 (for CAH, see instructions)   3.031,510   26.00   Deductible sand coinsurance relating to amount on line 24 (for CAH, see instructions)   3.031,510   26.00   Deductible sand coinsurance relating to amount on line 24 (for CAH, see instructions)   3.031,510   26.00   Deductible sand coinsurance relating to amount on line 24 (for CAH, see instructions)   3.031,510   26.00   Deductible sand coinsurance relating to amount on line 24 (for CAH, see instructions)   27.00   Deductible sand coinsurance relating to amount on line 25 (for CAH, see instructions)   27.00   Deductible sand coinsurance relating to amount on line 24 (for CAH, see instructions)   28.00   Deductible sand coinsurance relating to amount on line 24 (for CAH, see instructions)   28.00   27.00   Deductible sand coinsurance relating to amount on line 24 (for CAH, see instructions)   28.00   27.00				, ,		
23.00   Cost of physicians' services in a teaching hospital (see instructions)   0   23.00		, , , , , , , , , , , , , , , , , , ,	e instructions)			ı
Total prospective payment (sum of lines 3, 4, 8 and 9)		· · · · · · · · · · · · · · · · · · ·				
COMPUTATION OF REIMBURSEMENT SETTLEMENT   Deductibles and coinsurance (for CAH, see instructions)   86,032   25.00   Deductibles and Coinsurance (for CAH, see instructions)   3,031,510   26.00   25.00   Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see   1,772,110   27.00   instructions)   0   28.00   Direct graduate medical education payments (from Wkst. E-4, line 50)   0   29.00   29.00   25.00   Direct graduate medical education costs (from Wkst. E-4, line 36)   0   29.00   29.00   25.00   30.00   Subtotal (sum of lines 27 through 29)   1,772,110   30.00   30.00   Subtotal (sum of lines 27 through 29)   1,772,110   30.00   29.00   25.00   20.00   25.00   2		, , , , , , , , , , , , , , , , , , , ,	ructions)		0	ı
25.00   Deductibles and coinsurance (For CAH, see instructions)   26.00   Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)   3,031,510   26.00   27.00   Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)   1,772,110   27.00   28.00   28.00   29.00   ESRD direct medical education payments (From Wkst. E-4, line 50)   0   28.00   29.00   28.00   29.00   28.00   29.00   28.00   29.00   28.00   29.00	24.00				0	24.00
27.00   Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)   0   28.00   29.00   28.00   29.00   28.00   29.00   28.00   29.00   28.00   29.00   28.00   29.00   28.00   29.00   29.00   28.00   29.00	25. 00				86, 032	25. 00
Instructions   Direct graduate medical education payments (from Wkst. E-4, line 50)   0   28.00   29.00   29.00   28.00   29.00   28.00   29.00   28.00   29.00   28.00   29.00   28.00   29.00   28.00   29		, ·				
28.00   Direct graduate medical education payments (from Wkst. E-4, line 50)   ESRD direct medical education costs (from Wkst. E-4, line 36)   Composite rate costs (from Wkst. E-4, line 36)   Composite rate ESRD (from Wkst. Inc. 15)   Composite rate ESRD (from Wst. Inc. 15)   Composite rate ESRD (from Wst. Inc. 15)   Compo	27. 00		olus the sum of lines 22	and 23] (see	1, 772, 110	27. 00
29.00   ESRD diffect medical education costs (from Wkst. E-4, line 36)   29.00   30.00   Subtotal (sum of lines 27 through 29)   1,772,110   30.00	28 00		ne 50)		0	28 00
30.00   Subtotal (sum of lines 27 through 29)   1,772,110   30.00   2,282   31.00   2,382   32.00   2,382   32.00   32.00   Subtotal (line 30 minus line 31)   1,769,828   32.00   32.00   33.00   33.00   33.00   33.00   33.00   33.00   33.00   33.00   33.00   34.00   Allowable Bad DeBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   498,066   34.00   35.00   34.00   Allowable bad debts (see instructions)   498,066   34.00   33.00   33.30			116 00)		Ö	1
32.00   Subtotal (line 30 minus line 31)   1,769,828   32.00   ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   33.00   Composite rate ESRD (from Wkst. I -5, line 11)   0   33.00   34.00   Allowable bad debts (see instructions)   448,066   34.00   35.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   461,616   36.00   37.00   Subtotal (see instructions)   461,616   36.00   37.00   Subtotal (see instructions)   2,093,571   37.00   38.00   MSP-LCC reconciliation amount from PS&R   0   38.00   39.50   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39.50   39.99   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39.99   39.99   RECOVERY OF ACCELERATED DEPRECIATION   0   39.99   40.00   Subtotal (see instructions)   2,093,571   40.00   40.01					1, 772, 110	ł
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   33. 00   Composite rate ESRD (from Wkst. I - 5, line 11)   0   448,066 34,00   34.00   All lowable bad debts (see instructions)   323,743   35.00   35.00   Adjusted reimbursable bad debts (see instructions)   323,743   35.00   All lowable bad debts for dual eligible beneficiaries (see instructions)   461,616   36.00   37.00   Subtotal (see instructions)   2,093,571   37.00   38.00   MSP-LCC reconciliation amount from PS&R   0   38.00   39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.50   99.90   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.90   99.90   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39.90   99.90   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39.90   99.90   OTHER ADJUSTMENTS (SEE INSTRUCTIONS)   0   39.90   99.90   OTHER ADJUSTMENTS (SEE INSTRUCTIONS)   0   39.90   99.90   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39.90   99.90   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39.90   99.90   00.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS)   0   0   0   0   0   0   0   0   0	31.00	Primary payer payments			2, 282	31. 00
33.00   Composite rate ESRD (from Wkst. I-5, line 11)	32. 00				1, 769, 828	32. 00
34.00	22 00	·	)ES)		0	22 00
35.00		,				
36.00		· · · · · · · · · · · · · · · · · · ·				
38. 00       MSP-LCC reconciliation amount from PS&R       0       38. 00         39. 00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       39. 00         39. 50       Pioneer ACO demonstration payment adjustment (see instructions)       0       39. 90         39. 98       Partial or full credits received from manufacturers for replaced devices (see instructions)       0       39. 98         39. 99       RECOVERY OF ACCELERATED DEPRECIATION       0       39. 99         40. 00       Subtotal (see instructions)       2, 093, 571       40. 00         40. 01       Interim payments       2, 397, 480       41. 00         42. 00       Tentative settlement (for contractors use only)       42. 00       42. 00         43. 00       Balance due provider/program (see instructions)       -345, 780       43. 00         44. 00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,       0       44. 00         90. 00       Oigi inal outlier amount (see instructions)       0       90. 00         91. 00       Outlier reconciliation adjustment amount (see instructions)       0       91. 00         92. 00       The rate used to calculate the Time Value of Money       0. 00       92. 00         93. 00       Time Value of Money (see instructions)			ructions)			
39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39. 50 Pi oneer ACO demonstration payment adjustment (see instructions) 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 98 RECOVERY OF ACCELERATED DEPRECIATION 40. 00 Subtotal (see instructions) 40. 01 Sequestration adjustment (see instructions) 41. 00 Interim payments 42. 00 Tentative settlement (for contractors use only) 43. 00 Balance due provider/program (see instructions) 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 515. 2  TO BE COMPLETED BY CONTRACTOR  90. 00 Outlier reconciliation adjustment amount (see instructions) 79. 00 Untiler reconciliation adjustment amount (see instructions) 79. 00 The rate used to calculate the Time Value of Money 79. 00 Time Value of Money (see instructions)	37.00	Subtotal (see instructions)			2, 093, 571	37. 00
39. 50 Pi oneer ACO demonstration payment adjustment (see instructions) 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 98 RECOVERY OF ACCELERATED DEPRECIATION 39. 99 40. 00 Subtotal (see instructions) 40. 01 Sequestration adjustment (see instructions) 41. 00 Interim payments 41. 00 Interim payments 42. 00 Tentative settlement (for contractors use only) 43. 00 Balance due provider/program (see instructions) 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44. 00  90. 00 Original outlier amount (see instructions) 91. 00 Outlier reconciliation adjustment amount (see instructions) 92. 00 The rate used to calculate the Time Value of Money 93. 00 Time Value of Money (see instructions) 93. 00 Time Value of Money (see instructions) 94. 00 93. 00						
39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions)  39. 98 RECOVERY OF ACCELERATED DEPRECIATION  40. 00 Subtotal (see instructions)  50 Sequestration adjustment (see instructions)  41. 00 Interim payments  42. 00 Tentative settlement (for contractors use only)  43. 00 Balance due provider/program (see instructions)  44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, payments (see instructions)  90. 00 Original outlier amount (see instructions)  91. 00 Outlier reconciliation adjustment amount (see instructions)  92. 00 The rate used to calculate the Time Value of Money  93. 00 Time Value of Money (see instructions)  94. 00 93. 00  95. 00 Time Value of Money (see instructions)  96. 00 97. 00 Og 30. 00  97. 00 Time Value of Money (see instructions)  98. 00 99. 00  99. 00 Time Value of Money (see instructions)  99. 00 Og 30. 00		, , , , ,				
39. 99 40. 00 Subtotal (see instructions) 40. 01 Sequestration adjustment (see instructions) 41. 00 Interim payments 42. 00 Tentative settlement (for contractors use only) 43. 00 Balance due provider/program (see instructions) 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, spits 2  To BE COMPLETED BY CONTRACTOR  90. 00 Original outlier amount (see instructions) 91. 00 Outlier reconciliation adjustment amount (see instructions) 92. 00 The rate used to calculate the Time Value of Money 93. 00 Time Value of Money (see instructions) 94. 00 93. 00 93. 00				+!>	_	
40.00 Subtotal (see instructions) 40.01 Sequestration adjustment (see instructions) 41.00 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Bal ance due provider/program (see instructions) 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 515.2  TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Time Value of Money (see instructions) 96.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions)		· · · · · · · · · · · · · · · · · · ·				
40. 01 Sequestration adjustment (see instructions) 41. 00 Interim payments 42. 00 Tentative settlement (for contractors use only) 43. 00 Balance due provider/program (see instructions) 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  \$\frac{5}{115.2}\$ \tag{0} \text{44.00}  90. 00 Original outlier amount (see instructions) 91. 00 Outlier reconciliation adjustment amount (see instructions) 92. 00 The rate used to calculate the Time Value of Money 93. 00 Time Value of Money (see instructions) 93. 00 Time Value of Money (see instructions) 94. 00 Time Value of Money (see instructions) 95. 00 Time Value of Money (see instructions) 96. 00 Time Value of Money (see instructions) 97. 00 Time Value of Money (see instructions) 98. 00 Time Value of Money (see instructions) 99. 00 Time Value of Money (see instructions) 99. 00 Time Value of Money (see instructions)						
41. 00   Interim payments   2, 397, 480   41. 00   42. 00   Tentative settlement (for contractors use only)   0   42. 00   43. 00   Balance due provider/program (see instructions)   -345, 780   43. 00   44. 00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,   0   44. 00   10   10   10   10   10   10   10		, ,				
43.00 Balance due provider/program (see instructions)  44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00    90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  93.00 Time Value of Money (see instructions)  94.00 Outlier reconciliation adjustment amount (see instructions)  95.00 Outlier reconciliation adjustment amount (see instructions)  96.00 Outlier reconciliation adjustment amount (see instructions)  97.00 Outlier reconciliation adjustment amount (see instructions)  98.00 Outlier reconciliation adjustment amount (see instructions)  99.00 Outlier reconciliation adjustment amount (see instructions)						
44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\frac{1}{5115.2}\$ \frac{10 \text{ BE COMPLETED BY CONTRACTOR}}{\text{70 BE complete amount (see instructions)}} 0 90.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00 Outlier reconciliation adjustment amount (see instructions) 0 92.00 The rate used to calculate the Time Value of Money (see instructions) 0 93.00	42.00	,				
\$115.2 TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 0 Outlier reconciliation adjustment amount (see instructions) 0 Utlier reconciliation adjustment amount (see instructions) 0 P1.00 1 The rate used to calculate the Time Value of Money 1 Time Value of Money (see instructions) 0 P3.00						•
TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  94.00 Time Value of Money (see instructions)  95.00 Time Value of Money (see instructions)	44. 00					44.00
90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 90.00 91.00 92.00 93.00						
91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  0 91.00  92.00  93.00	90. 00				0	90.00
92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0.00 92.00 93.00						
	92. 00	The rate used to calculate the Time Value of Money			0.00	
94.00   lotal (sum of lines 91 and 93)   0   94.00						1
	94.00	Iotal (sum of lines 91 and 93)			0	94.00

Health Financial Systems

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Peri od: | Worksheet E-1 | From 10/01/2015 | Part | To 09/30/2016 | Date/Time Prepared: Provider CCN: 15-1320

Title XVIII   Hospital   Cost					10 09/30/2010	2/27/2017 10: 3	
mm/dd/yyyy			Title	XVIII	Hospi tal		
1.00			Inpatien	t Part A	Par	t B	
1.00							
1.00							
Interrim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "MONE" or enter a zero.		I=	1. 00				
Submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NOME" or enter a zero				2, 665, 44			
Services rendered in the cost reporting period. If none, write "MONE" or netra zero   3.00   3.00   3.00   3.00   3.00   3.00   3.01   3.00	2.00				0	0	2. 00
write "NONE" or enter a zero							
List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider							
amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "MONE" or enter a zero. (1)  Program to Provider  3.01 3.02 3.03 3.04 3.05 Provider to Program  3.50 3.50 ADJUSTMENTS TO PROGRAM 0 0 0 3.05 Provider to Program  3.51 3.52 0 0 0 0 3.55 3.53 3.54 0 0 0 0 3.55 3.53 3.54 0 0 0 0 3.55 3.55 3.54 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.25-3.49) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to West E or West E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "MONE" or enter a zero. (1) Program to Provider  5.00 Tentative To PROGRAM 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3 00						3 00
For the cost reporting period. Also show date of each   Program to Provider   Program to Provider   Program to Provider   DJUSTMENTS TO PROVIDER   0 0 0 3.01 3.01 3.02 3.03 3.04 0 0 0 3.03 3.04 0 0 0 3.03 3.05   0 0 0 3.05 3.05 3.05   0 0 0 3.05 3.05 3.05   0 0 0 3.05 3.05 3.05   0 0 0 0 3.05 3.05 3.05   0 0 0 0 3.05 3.05 3.05   0 0 0 0 3.05 3.05 3.05 3.05   0 0 0 0 3.05 3.05 3.05 3.05 3.05 3.05 3	0.00						0.00
Program to Provider							
ADJUSTMENTS TO PROVIDER							
3.02							
3.03 3.04 3.05 Provider to Program 3.50 3.51 3.51 3.52 3.53 4.00 3.54 3.99 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to West. E or West. E-3, line and column as appropriate) To BE COMPLETED BY CONTRACTOR write "NoNE" or enter a zero. (1) Program to Provider  5.00 FINATIVE TO PROGRAM 5.50 TENTATIVE TO PROGRAM 6.00 Program to Provider 5.50 EINTATIVE TO PROGRAM 7.50 Social Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.55-5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 6.00 the central report of		ADJUSTMENTS TO PROVIDER			-		
3.04					-		
3.05   Provider to Program					*		
Provider to Program							
ADJUSTMENTS TO PROGRAM	3.05	Durani dan da Durangan			0	0	3.05
3.51	2 50					0	2 50
3.52   3.53   3.54   3.60   3.52   3.50		ADJUSTIMENTS TO PROGRAM			*		
3.53   3.54   0   0   0   3.53   3.54   0   0   0   3.53   3.54   0   0   0   3.53   3.54   0   0   0   3.54   3.54   3.59   3.50-3, 98)   Total interim payments (sum of lines 1, 2, and 3.99)							
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   Contractor Number (Mo/Day/Yrr)					-		
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   2,665,449   2,397,480   4.00   Total interim payments (sum of lines 1, 2, and 3.99)   2,665,449   2,397,480   4.00   Total interim payments (sum of lines 1, 2, and 3.99)   2,665,449   2,397,480   4.00   Total interim payments (sum of lines 1, 2, and 3.99)   2,665,449   2,397,480   4.0					0	l ol	
Total interim payments (sum of lines 1, 2, and 3.99)   2,665,449   2,397,480   4.00		Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 99
Contractor		3. 50-3. 98)					
appropriate)   TO BE COMPLETED BY CONTRACTOR	4.00			2, 665, 44	.9	2, 397, 480	4.00
TO BE COMPLÉTED BY CONTRACTOR   List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider   TENTATIVE TO PROVIDER   0 0 0 0 5.02 5.03							
5.00							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider	Г 00						г оо
Write "NONE" or enter a zero. (1)   Program to Provider   TENTATI VE TO PROVI DER   0   0   0   5.01	5.00						5.00
Program to Provider							
TENTATI VE TO PROVIDER							
5.03   Provider to Program   5.50   TENTATIVE TO PROGRAM   0   0   5.50     5.51   0   0   0   5.51     5.52   0   0   0   5.51     5.52   5.99   Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)   0   0   5.52     5.99   Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)   0   0   0     6.00   Determined net settlement amount (balance due) based on the cost report. (1)   0   0     6.01   SETTLEMENT TO PROVIDER   0   0   0     6.02   SETTLEMENT TO PROGRAM   60,885   345,780   6.02     7.00   Total Medicare program liability (see instructions)   2,604,564   2,051,700   7.00     Contractor Number (Mo/Day/Yr)   0   1.00   2.00	5. 01				0	0	5. 01
Provider to Program	5.02				0	0	5. 02
TENTATI VE TO PROGRAM	5.03				0	0	5.03
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)   6.00   Determined net settlement amount (balance due) based on the cost report. (1)   6.01   SETTLEMENT TO PROVIDER   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		TENTATI VE TO PROGRAM					
5. 99 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 0 0 6. 01 6. 02 SETTLEMENT TO PROGRAM 60, 885 7. 00 Total Medicare program liability (see instructions) 2, 604, 564 2, 051, 700 7. 00  Contractor NPR Date (Mo/Day/Yr) 0 1. 00 2. 00					-		
5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  Contractor Number (Mo/Day/Yr)  Number (Mo/Day/Yr)  0 1.00 2.00							
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 0 0 0 0 6.01 6.02 SETTLEMENT TO PROGRAM 60,885 345,780 6.02 7.00 Total Medicare program liability (see instructions) 2,604,564 2,051,700 7.00  Contractor NUMber (Mo/Day/Yr) 0 1.00 2.00	5. 99				0	0	5. 99
the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  Contractor NPR Date (Mo/Day/Yr)  Number (Mo/Day/Yr)  0 1.00 2.00	4 00						4 00
6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  Contractor Number (Mo/Day/Yr) 0 1.00 2.00	6.00						6.00
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  Contractor Number (Mo/Day/Yr) 0 1.00 2.00	6. 01				0	n	6. 01
7.00 Total Medicare program liability (see instructions)  2,604,564  2,051,700  7.00  Contractor NPR Date (Mo/Day/Yr)  0 1.00 2.00					-	1	
Contractor NPR Date (Mo/Day/Yr)  0 1.00 2.00	7. 00						
0 1.00 2.00							
			(	)	1. 00	2. 00	
8.00 Name or Contractor   8.00	8. 00	Name of Contractor					8. 00

Provider CCN: 15-1320 Component CCN: 15-M320 Subprovi der -Title XVIII

		litie	XVIII	Subprovi der - I PF	PPS	
		Innatien	t Part A		t B	
		'				
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
1 00	T <del>-</del>	1.00	2.00	3. 00	4. 00	4 00
1.00	Total interim payments paid to provider		756, 059		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for		0		0	2. 00
	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			<b>'</b>		
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3.02			0		0	3. 02
3. 03			0		0	3. 03
3. 04 3. 05			0		0 0	3. 04 3. 05
3.03	Provider to Program				0	3.00
3. 50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51	7.5555 TIMENTO TO TROOTS III		Ö		Ö	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)		756, 059		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
0.00	desk review. Also show date of each payment. If none,					0.00
	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
г го	Provi der to Program	ı				
5. 50 5. 51	TENTATI VE TO PROGRAM		0 0		0	5. 50 5. 51
5. 51						5. 51
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
0. 77	5. 50-5. 98)					0. //
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		6		0	6. 01
6. 02	SETTLEMENT TO PROGRAM				0	6. 02
7. 00	Total Medicare program liability (see instructions)		756, 065		0	7. 00
				Contractor	NPR Date	
		-	)	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor		,	1.00	2.00	8. 00
5. 55	1	I		I .	1	. 5. 55

JAY COUNTY HOSPITAL Health Financial Systems In Lieu of Form CMS-2552-10 ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-1320 Peri od: Worksheet E-1 From 10/01/2015 To 09/30/2016 Part I Component CCN: 15-Z320 Date/Time Prepared: 2/27/2017 10:37 am Title XVIII Swing Beds - SNF Cost Part B Inpatient Part A mm/dd/yyyy mm/dd/yyyy Amount Amount 1.00 2.00 3.00 4.00 1.00 Total interim payments paid to provider 1, 077, 514 1. 00 0 2.00 Interim payments payable on individual bills, either 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 0 3.01 0 3.02 0 3.02 3.03 0 3.03 0 3.04 0 0 3.04 3.05 0 0 3.05

8.00

8.00 Name of Contractor

Health Financial Systems	JAY COUNTY HOSPITAL		In Lie	u of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS		Provi der CCN: 15-1320	Peri od: From 10/01/2015	Worksheet E-2
			Component CCN: 15-Z320		

	Comp	oonent CCN: 15-Z320	To 09/30/2016	Date/Time Pre 2/27/2017 10:	
		Title XVIII	Swing Beds - SNF	Cost	
			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)		788, 746	0	1. 00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A,		258, 793	0	3. 00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instruc				
4.00	Per diem cost for interns and residents not in approved teaching p	rogram (see		0.00	4. 00
	instructions)				
5.00	Program days		560	0	5. 00
6.00	Interns and residents not in approved teaching program (see instru			0	6. 00
7. 00	Utilization review - physician compensation - SNF optional method	onl y	0		7. 00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		1, 047, 539	0	
9.00	Primary payer payments (see instructions)		0	0	,
10. 00	Subtotal (line 8 minus line 9)		1, 047, 539	0	10.00
11. 00	Deductibles billed to program patients (exclude amounts applicable	to physician	0	0	11. 00
	professional services)				
	Subtotal (line 10 minus line 11)		1, 047, 539	0	1
13. 00	Coinsurance billed to program patients (from provider records) (ex	cl ude coi nsurance	3, 374	0	13. 00
	for physician professional services)				
	80% of Part B costs (line 12 x 80%)			0	1
	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		1, 044, 165	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
	Pioneer ACO demonstration payment adjustment (see instructions)		0	0	1
	410A RURAL DEMONSTRATION PROJECT		0	_	16. 55
	Allowable bad debts (see instructions)		0	0	
	Adjusted reimbursable bad debts (see instructions)		0	0	
	Allowable bad debts for dual eligible beneficiaries (see instructi	ons)	0	0	
	Total (see instructions)		1, 044, 165	0	1 . ,
19. 01	Sequestration adjustment (see instructions)		20, 883	0	
	Interim payments		1, 077, 514	0	
	Tentative settlement (for contractor use only)		0	0	
	Balance due provider/program (line 19 minus lines 19.01, 20, and 2		-54, 232	0	
23. 00	Protested amounts (nonallowable cost report items) in accordance w chapter 1, $\S 115.2$	ith CMS Pub. 15-2,	0	0	23. 00

Health Financial Systems		JAY COUNTY HOS	SPI TAL				In Lie	u of Form CMS-2552	-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS		Provi der	CCN: 1	15-1320	Peri o	od: 10/01/2015	Worksheet E-2	
			Component	CCN:	15-Z320	То	09/30/2016	Date/Time Prepare	

	Component	1. 13 2320	10 077 307 2010	2/27/2017 10:	
	Title	XIX	Swing Beds - SNF	Cost	
			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, col. 3, line 200, for Part A, and sum o	f Wkst. D,	0		3. 00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)				
4.00	Per diem cost for interns and residents not in approved teaching program (so	ee	0.00		4. 00
	instructions)				
5.00	Program days		0		5. 00
6.00	Interns and residents not in approved teaching program (see instructions)		0		6. 00
7.00	Utilization review - physician compensation - SNF optional method 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
10.00	Subtotal (line 8 minus line 9)		0		10.00
11. 00	Deductibles billed to program patients (exclude amounts applicable to physic	ci an	0		11. 00
	professional services)				
12.00	Subtotal (line 10 minus line 11)		0		12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coin	nsurance	0		13. 00
	for physician professional services)				
	80% of Part B costs (line 12 x 80%)		0		14. 00
15. 00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		0		15. 00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		16. 00
	Pioneer ACO demonstration payment adjustment (see instructions)		0		16. 50
16. 55	410A RURAL DEMONSTRATION PROJECT		0		16. 55
	Allowable bad debts (see instructions)		0		17. 00
17. 01	Adjusted reimbursable bad debts (see instructions)		0		17. 01
18. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		18. 00
19. 00	Total (see instructions)		0		19. 00
19. 01	Sequestration adjustment (see instructions)		0		19. 01
20.00	Interim payments		0		20. 00
21. 00	Tentative settlement (for contractor use only)		0		21. 00
22. 00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)		0		22. 00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Protested amounts (nonallowable cost report items)	ub. 15-2,	0		23. 00
	chapter 1, §115.2				

Health Financial Systems	JAY COUNTY HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Peri od: From 10/01/2015 To 09/30/2016	Worksheet E-3 Part V Date/Time Prepared: 2/27/2017 10:37 am
	Ti +1 a Y\/111	Hospi tal	Cost

			10 09/30/2010	2/27/2017 10:	
		Title XVIII	Hospi tal	Cost	
				1. 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE F	PART A SERVICES - COST	RELMBURSEMENT		
1.00	Inpatient services			2, 962, 184	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction	ns)		0	2. 00
3.00	Organ acquisition			0	3. 00
4. 00	Subtotal (sum of lines 1 through 3)			2, 962, 184	4. 00
5. 00	Primary payer payments			2, 702, 101	5. 00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			2, 971, 959	6.00
0.00	COMPUTATION OF LESSER OF COST OR CHARGES			2, 7, 1, 7, 0, 7	0.00
	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			U	10.00
11. 00	Aggregate amount actually collected from patients liable for particular and patients are particular and particu	avment for services on	a charge basis	0	11. 00
12. 00	Amounts that would have been realized from patients liable for			0	12.00
12.00	had such payment been made in accordance with 42 CFR 413.13(e)	payment for services o	ii a charge basi's	O	12.00
13. 00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000	13. 00
	Total customary charges (see instructions)			0.000000	14.00
15. 00	Excess of customary charges over reasonable cost (complete only	v if line 14 evceeds li	na 6) (saa	0	15. 00
13.00	instructions)	y II IIIle 14 exceeds II	(366	O	13.00
16. 00	Excess of reasonable cost over customary charges (complete only	vifline 6 exceeds lin	e 14) (see	0	16, 00
	instructions)	ye e exceede	0 1.17 (000	· ·	10.00
17. 00	Cost of physicians' services in a teaching hospital (see instru	uctions)		0	17. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			-	
18. 00	Direct graduate medical education payments (from Worksheet E-4,	. line 49)		0	18. 00
	Cost of covered services (sum of lines 6, 17 and 18)			2, 971, 959	19. 00
	Deductibles (exclude professional component)			342, 160	
	Excess reasonable cost (from line 16)			0	21. 00
	Subtotal (line 19 minus line 20 and 21)			2, 629, 799	22. 00
23. 00	Coinsurance			0	23. 00
	Subtotal (line 22 minus line 23)			2, 629, 799	
	Allowable bad debts (exclude bad debts for professional service	es) (see instructions)		42, 953	
	Adjusted reimbursable bad debts (see instructions)	, (,		27, 919	
	Allowable bad debts for dual eligible beneficiaries (see instru	uctions)		29, 643	
	Subtotal (sum of lines 24 and 25, or line 26)	401.01.07		2, 657, 718	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			2,007,710	29. 00
	Pioneer ACO demonstration payment adjustment (see instructions)	)		0	29. 50
29. 99					29. 99
	Subtotal (see instructions)				
	Interim payments			53, 154 2, 665, 449	
	Tentative settlement (for contractor use only)			2, 005, 449	32.00
33. 00	Balance due provider/program (line 30 minus lines 30.01, 31, a	nd 32)		-60, 885	
34. 00	Protested amounts (nonallowable cost report items) in accordance		chanter 1	-60, 665	34.00
34.00	\$115. 2	CC WITH OWS TUD. 19-2,	chapter I,	U	34.00
	13119. 4		l	l l	ı

PART		II tie will	I PF	PPS				
PART II - MEDICARE PART A SERVICES - IPP PPS   Page   Page   Sext cuil of goutlier, ECT, and medical education payments)   807,553   1.00				1 00				
1,00   Ret Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)		PART II - MEDICARE PART A SERVICES - IPE PPS		1.00				
2.00   Not 1FF PPS Outhlier Payments   40, 144   2.00	1.00			807, 553	1. 00			
3.00   Net IPF PPS ECT Payments   0.3 0.00								
Unwellighted Intern and resident FIE count in the most recent cost report filled on or before November   15, 2004. (see instructions)   2		,						
4.01   Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42   CFR \$412.42(d)(1)(iii)(F)(1) or (2) (see instructions)	4.00		fore November	0.00	4. 00			
program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CRF \$412.424(a)(1)(111)(5)(1) or (2) (see instructions)   New Teaching program adjustment. (see instructions)   New Teaching program adjustment. (see instructions)   New Teaching program (see instruction)   New Teaching program (see instructions)   New Teaching pro		15, 2004. (see instructions)						
CFR \$412.42(d)(1)(iii)(F)(1) or (2) (see instructions)	4.01	Cap increases for the unweighted intern and resident FTE count for residents that were	di spl aced by	0.00	4. 01			
5.00         New Teaching program adjustment. (see instructions)         0.00         6.00           6.00         Current year's unwelghted FTE count of IAR excluding FTEs in the new program growth period of a "new teaching program" (see instructions)         0.00         6.00           7.00         Current year's unwelghted IAR FTE count for residents within the new program growth period of a "new teaching program" (see instructions)         0.00         7.00           8.00         Internand resident count for IFP PSP Bedical education adjustment (see instructions)         4.084699         9.00           9.00         Average Dail y Census (see instructions)         4.084699         9.00           11.00         Teaching Adjustment (line 1 multiplied by line 10).         0.000000         1.00           12.00         Teaching Adjustment (line 1 multiplied by line 10).         0.000000         1.00           13.00         Nursing and Allied Heal th Managed Care payment (see instructions)         0.11.00         1.00           14.00         Organ acquisi tin on (DN NOT USF THIS LINE)         1.4.00         1.5.00           15.00         Cost of physici ans' services in a teaching hospital (see instructions)         874,697 16.00         1.5.00           16.00         Subtotal (see instructions)         874,697 16.00         1.5.00           17.00         Primary payer payments         874,697 18.00		program or hospital closure, that would not be counted without a temporary cap adjustme	ent under 42					
Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)   Current year's unweighted IAR FTE count for residents within the new program growth period of a "new teaching program" (see instructions)   0.00   7.00								
teaching program" (see instructions)  1.00 current year's unweighted IAR FTE count for residents within the new program growth period of a "new teaching program" (see instructions)  1.00 leaching program" (see instructions)  1.00 Average Daily Census (see instructions)  1.00 Teaching Adjustment Factor ((i.f. (line 9)) raised to the power of .5150 -1).  1.00 Teaching Adjustment (line 1 multiplied by line 10).  1.01 Teaching Adjustment (line 1 multiplied by line 10).  1.02 Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)  1.03 Teaching Adjustment (line 1 multiplied by line 10).  1.04 Organ acquisition (DO NOT USE THIS LINE)  1.05 Octoor of physicians' services in a teaching hospital (see instructions)  1.06 Organ acquisition (DO NOT USE THIS LINE)  1.07 Teaching Adjustment (line 1 multiplied by line 10).  1.09 Organ acquisition (DO NOT USE THIS LINE)  1.00 Subtotal (see instructions)  1.01 Teaching Adjustment (line 1 multiplied by line 10).  1.02 Organ acquisition (DO NOT USE THIS LINE)  1.03 Subtotal (line 16 less line 17).  1.04 Organ acquisition (line 16 less line 17).  1.05 Subtotal (line 16 less line 17).  1.06 Subtotal (line 16 less line 17).  1.07 Open Deductible see of the s				l e				
2.00   Current year's unweighted I&R FIE count for residents within the new program growth period of a "new teaching program" (see instructions)   0.00   1.00	6. 00		riod of a "new	0.00	6. 00			
teaching program" (see instructions)  8. 00  9. 00  Average Dally Census (see instructions)  10. 00  9. 00  Average Dally Census (see instructions)  11. 00  12. 00  Teaching Adjustment (ine 1 multiplied by line 10).  12. 00  13. 00  14. 00  15. 00  16. 00  17. 00  18. 00  18. 00  18. 00  18. 00  19. 0	7 00	,		0.00	7 00			
8.00	7.00		riod of a "new	0.00	7.00			
9.00   Average Daily Census (see instructions)   4.084699   9.00   Teaching Adjustment Factor ((1 + (line 8/line 9)) raised to the power of .5150 -1).   0.000000   10.00	9 00			0.00	9 00			
10.00   Teaching Adjustment Factor { ((1 + (line 8/line 9)) raised to the power of .5150 -1).								
11.00   Teaching Adjustment (line 1 multiplied by line 10).   11.00   Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)   847,697   12.00   13.00   Nursing and Allied Heal th Managed Care payment (see instruction)   14.00   15								
12.00				l				
13. 00   Nursing and Allied Heal th Managed Care payment (see instruction)   13. 00   14. 00   0rgan acquisition (D0 NOT USE THIS LINE)   14. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   16. 00								
14. 00								
15.00   Cost of physicians' services in a teaching hospital (see instructions)   15.00   16.00   Subtotal (see instructions)   847,697   16.00   17.00   Primary payer payments   0.17.00   17.00   18.00   Subtotal (line 16 less line 17).   847,697   18.00   Subtotal (line 18 minus line 19)   848,697   18.00   Coinsurance   784,949   20.00   21.00   Coinsurance   784,949   22.00   22.00   Subtotal (line 20 minus line 21)   771,495   22.00   23.00   Allowable bad debts (exclude bad debts for professional services) (see instructions)   0.24.00   23.00   Allowable bad debts (exclude bad debts for professional services) (see instructions)   0.24.00   23.00   Allowable bad debts (exclude bad debts for professional services) (see instructions)   0.25.00   Allowable bad debts (see instructions)   0.26.00   Subtotal (sum of lines 22 and 24)   771,495   26.00   27.00   Direct graduate medical education payments (from Wkst. E-4, line 49)   0.27.00   28.00   29.00   Outlier payments reconciliation   0.27.00   29.00   0								
16. 00       Subtotal (see instructions)       847,697       16. 00         17. 00       Primary payer payments       0 17. 00         18. 00       Subtotal (line 16 less line 17).       887,697       18. 00         19. 00       Deductibles       62,748       19. 00         20. 00       Subtotal (line 18 minus line 19)       784,949       20. 00         21. 00       Coinsurance       13,454       21. 00         22. 00       Subtotal (line 20 minus line 21)       771,495       22. 00         23. 00       All lowable bad debts (exclude bad debts for professional services) (see instructions)       0 23. 00         24. 00       Adjusted reimbursable bad debts (see instructions)       0 24. 00         25. 00       All lowable bad debts for dual eligible beneficiaries (see instructions)       0 25. 00         26. 00       Subtotal (sum of lines 22 and 24)       771,495       26. 00         27. 00       Direct graduate medical education payments (from Wkst. E-4, line 49)       0 27. 00         28. 00       Other pass through costs (see instructions)       0 28. 00         30. 00       Other pass through costs (see instructions)       0 29. 00         30. 00       Other pass through costs (see instructions)       0 29. 00         30. 00       Other pass through costs (se				0				
17. 00		3						
18. 00   Subtotal (line 16 less line 17).   847, 697   18. 00   19. 00   Deductibles   784, 949   20. 00   Subtotal (line 18 minus line 19)   784, 949   20. 00   771, 495   22. 00   77								
20.00   Subtotal (line 18 minus line 19)   784, 949   20.00   21.00   Coinsurance   13, 454   21.00   22.00   Subtotal (line 20 minus line 21)   771, 495   22.00   23.00   Allowable bad debts (exclude bad debts for professional services) (see instructions)   0   24.00   24.00   Adjusted reimbursable bad debts (see instructions)   0   24.00   25.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   0   25.00   26.00   Subtotal (sum of lines 22 and 24)   771, 495   26.00   27.00   Direct graduate medical education payments (from Wkst. E-4, line 49)   0   27.00   Other pass through costs (see instructions)   0   28.00   29.00   Other pass through costs (see instructions)   0   28.00   29.00   Other pass through costs (see instructions)   0   29.00   29.00   Other pass through costs (see instructions)   0   29.00	18. 00			847, 697	18. 00			
21.00   Coinsurance   13,454   21.00   22.00   Subtotal (line 20 minus line 21)   771,495   22.00   23.00   All lowable bad debts (exclude bad debts for professional services) (see instructions)   0 23.00   24.00   Adjusted reimbursable bad debts (see instructions)   0 24.00   25.00   All lowable bad debts for dual eligible beneficiaries (see instructions)   0 25.00   26.00   Subtotal (sum of lines 22 and 24)   771,495   26.00   27.00   Direct graduate medical education payments (from Wkst. E-4, line 49)   0 27.00   28.00   Other pass through costs (see instructions)   0 28.00   29.00   Outlier payments reconciliation   0 29.00   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	19. 00	· · · · · · · · · · · · · · · · · · ·		62, 748	19. 00			
22. 00       Subtotal (line 20 minus line 21)       771, 495       22. 00         23. 00       Al I lowable bad debts (exclude bad debts for professional services) (see instructions)       0 23. 00         24. 00       Adjusted reimbursable bad debts (see instructions)       0 24. 00         25. 00       Al I lowable bad debts for dual eligible beneficiaries (see instructions)       0 25. 00         26. 00       Subtotal (sum of lines 22 and 24)       771, 495       26. 00         27. 00       Direct graduate medical education payments (from Wkst. E-4, line 49)       0 27. 00         28. 00       Other pass through costs (see instructions)       0 28. 00         29. 00       Outlier payments reconciliation       0 29. 00         30. 00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0 30. 00         30. 50       Pioneer ACO demonstration payment adjustment (see instructions)       0 30. 50         31. 00       Recovery of Accelerated Depreciation       0 30. 99         31. 01       Sequestration adjustment (see instructions)       771, 495       31. 00         31. 02       Interim payments       756, 059       32. 00         32. 00       Tentative settlement (for contractor use only)       33. 00         33. 00       Balance due provider/program (line 31 minus lines 31. 01, 32 and 33)       6 34. 00 <td>20.00</td> <td>Subtotal (line 18 minus line 19)</td> <td></td> <td>784, 949</td> <td>20. 00</td>	20.00	Subtotal (line 18 minus line 19)		784, 949	20. 00			
23. 00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 24. 00 Adjusted reimbursable bad debts (see instructions) 25. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 26. 00 Subtotal (sum of lines 22 and 24) 27. 00 Direct graduate medical education payments (from Wkst. E-4, line 49) 28. 00 Other pass through costs (see instructions) 29. 00 Outlier payments reconciliation 30. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 30. 99 Foneer ACO demonstration payment adjustment (see instructions) 30. 99 Recovery of Accelerated Depreciation 31. 00 Total amount payable to the provider (see instructions) 31. 01 Sequestration adjustment (see instructions) 32. 00 Interim payments 33. 00 Tentative settlement (for contractor use only) 34. 00 Balance due provider/program (line 31 minus lines 31.01, 32 and 33) 35. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 515.00 36. 00 Original outlier amount from Worksheet E-3, Part II, line 2 37. 00 Outlier reconciliation adjustment amount (see instructions) 37. 00 Outlier reconciliation adjustment amount (see instructions) 38. 00 Outlier reconciliation adjustment amount (see instructions) 39. 00 Outlier reconciliation adjustment amount (see instruct	21. 00	Coi nsurance		13, 454	21. 00			
24. 00       Adj usted reimbursable bad debts (see instructions)       0       24. 00         25. 00       All lowable bad debts for dual eligible beneficiaries (see instructions)       0       25. 00         26. 00       Subtotal (sum of lines 22 and 24)       771, 495       26. 00         27. 00       Direct graduate medical education payments (from Wkst. E-4, line 49)       0       27. 00         28. 00       Other pass through costs (see instructions)       0       28. 00         29. 00       Outlier payments reconciliation       0       29. 00         30. 00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       30. 00         30. 00       Pioneer ACO demonstration payment adjustment (see instructions)       0       30. 00         30. 99       Recovery of Accelerated Depreciation       0       30. 99         31. 01       Sequestration adjustment (see instructions)       771, 495       31. 00         31. 01       Interim payments       756, 059       32. 00         32. 00       Tentative settlement (for contractor use only)       0       33. 00         34. 00       Bal ance due provider/program (line 31 minus lines 31. 01, 32 and 33)       6       34. 00         35. 00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0	22. 00	Subtotal (line 20 minus line 21)		771, 495	22. 00			
25. 00 Allowable bad debts for dual eligible beneficiaries (see instructions)  26. 00 Subtotal (sum of lines 22 and 24)  27. 00 Direct graduate medical education payments (from Wkst. E-4, line 49)  28. 00 Other pass through costs (see instructions)  29. 00 Outlier payments reconciliation  30. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  30. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  30. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS)  30. 09 Pioneer ACO demonstration payment adjustment (see instructions)  30. 09 Total amount payable to the provider (see instructions)  31. 01 Sequestration adjustment (see instructions)  32. 00 Interim payments  33. 00 Interim payments  34. 00 Bal ance due provider/program (line 31 minus lines 31.01, 32 and 33)  35. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  35. 00 Other add debts for dual eligible beneficiaries (see instructions)  40, 144  50. 00 Ottlier reconciliation adjustment amount (see instructions)  50. 00 Ottlier reconciliation adjustment amount (see instructions)  50. 00 The rate used to calculate the Time Value of Money  50. 00 The rate used to calculate the Time Value of Money	23. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		0	23. 00			
26. 00 Subtotal (sum of lines 22 and 24)  27. 00 Direct graduate medical education payments (from Wkst. E-4, line 49)  28. 00 Other pass through costs (see instructions)  29. 00 Outlier payments reconciliation  30. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  30. 50 Pioneer ACO demonstration payment adjustment (see instructions)  30. 99 Recovery of Accelerated Depreciation  30. 99 Total amount payable to the provider (see instructions)  31. 01 Sequestration adjustment (see instructions)  32. 00 Interim payments  33. 00 Interim payments  34. 00 Balance due provider/program (line 31 minus lines 31.01, 32 and 33)  35. 00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 15.00  50. 00 Original outlier amount from Worksheet E-3, Part II, line 2  0 Outlier reconciliation adjustment amount (see instructions)  10 Other pass through costs (see instructions)  26. 00 Other pass through costs (see instructions)  27. 00 Other pass through costs (see instructions)  28. 00 Other pass through costs (see instructions)  29. 00 Other pass through costs (see instructions)  30. 00 Other pass through costs (see instructions)  30. 00 Other pass through costs (see instructions)  31. 01 Sequestration adjustment (see instructions)  32. 00 Interim payments  33. 00 Other pass through costs (see instructions)  34. 00 Other pass through costs (see instructions)  35. 00 Other pass through costs (see instructions)  36. 00 Original outlier amount from Worksheet E-3, Part II, line 2  37. 00 Outlier reconciliation adjustment amount (see instructions)  38. 00 Other pass through costs (see instructions)  39. 00 Other pass through costs (see instructions)  30. 00 Other pass through costs (see instructions)  30. 00 Other pass through cost (see instructions)  30. 00 Other pass through cost (see instructions)  30. 00 Other pass through cost (see instructions)  30. 00 Other pass (see in	24.00	Adjusted reimbursable bad debts (see instructions)			24. 00			
27.00       Direct graduate medical education payments (from Wkst. E-4, line 49)       0       27.00         28.00       Other pass through costs (see instructions)       0       28.00         29.00       Outlier payments reconciliation       0       29.00         30.00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       30.00         30.50       Pioneer ACO demonstration payment adjustment (see instructions)       0       30.50         30.99       Recovery of Accelerated Depreciation       0       30.99         31.00       Total amount payable to the provider (see instructions)       771,495       31.00         31.01       Sequestration adjustment (see instructions)       15,430       31.01         32.00       Interim payments       756,059       32.00         33.00       Tentative settlement (for contractor use only)       33.00         34.00       Balance due provider/program (line 31 minus lines 31.01, 32 and 33)       6       34.00         35.00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 91.00       35.00         50.00       Original outlier amount from Worksheet E-3, Part II, line 2       40,144       50.00         50.00       The rate used to calculate the Time Value of Money       0.00       52.00    <	25. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)			25. 00			
28. 00 Other pass through costs (see instructions) 0 28. 00 29. 00 Outlier payments reconciliation 0 29. 00 30. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 30. 00 30. 50 Pi oneer ACO demonstration payment adjustment (see instructions) 0 30. 50 30. 90 Recovery of Accelerated Depreciation 0 30. 99 31. 00 Total amount payable to the provider (see instructions) 771, 495 31. 00 31. 01 Sequestration adjustment (see instructions) 771, 495 31. 00 31. 01 Interim payments 756, 059 32. 00 33. 00 Interim payments 756, 059 32. 00 34. 00 Balance due provider/program (line 31 minus lines 31. 01, 32 and 33) 6 34. 00 35. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 35. 00 35. 00 Original outlier amount from Worksheet E-3, Part II, line 2 40, 144 50. 00 50. 00 The rate used to calculate the Time Value of Money 0. 00 52. 00								
29. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 50 Pi oneer ACO demonstration payment adjustment (see instructions) 30. 99 Recovery of Accelerated Depreciation 30. 09 31. 00 31. 00 31. 01 Sequestration adjustment (see instructions) 30. 90 31. 01 32. 00 Interim payments 32. 00 Interim payments 33. 00 Tentative settlement (for contractor use only) 33. 00 Balance due provider/program (line 31 minus lines 31. 01, 32 and 33) 35. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 35. 00 To BE COMPLETED BY CONTRACTOR 50. 00 Original outlier amount from Worksheet E-3, Part II, line 2 50. 00 The rate used to calculate the Time Value of Money 50. 00 The rate used to calculate the Time Value of Money 50. 00 The rate used to calculate the Time Value of Money 50. 00 The rate used to calculate the Time Value of Money 50. 00 The rate used to calculate the Time Value of Money 50. 00 The rate used to calculate the Time Value of Money 50. 00 The rate used to calculate the Time Value of Money 50. 00 The rate used to calculate the Time Value of Money 50. 00 The rate used to calculate the Time Value of Money 50. 00 The rate used to calculate the Time Value of Money 50. 00 The rate used to calculate the Time Value of Money 50. 00 The rate used to calculate the Time Value of Money 50. 00 The rate used to calculate the Time Value of Money 50. 00 The rate used to calculate the Time Value of Money								
30.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   30.00   30.50   30.50   Pi oneer ACO demonstration payment adjustment (see instructions)   0   30.50   30.99   Recovery of Accelerated Depreciation   0   30.99   31.00   Total amount payable to the provider (see instructions)   771,495   31.00   32.00   Interim payments   15,430   31.01   32.00   Interim payments   756,059   32.00   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)   6   34.00   35.00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0   35.00   S115.2   To BE COMPLETED BY CONTRACTOR   40,144   50.00   51.00   Outlier reconciliation adjustment amount (see instructions)   0   51.00   52.00   The rate used to calculate the Time Value of Money   0.00   52.00								
30. 50 Pi oneer ACO demonstration payment adjustment (see instructions)  30. 99 Recovery of Accelerated Depreciation  30. 99 31. 00 Total amount payable to the provider (see instructions)  31. 01 Sequestration adjustment (see instructions)  32. 00 Interim payments  33. 00 Tentative settlement (for contractor use only)  34. 00 Balance due provider/program (line 31 minus lines 31. 01, 32 and 33)  35. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 35. 00  36. 00 Original outlier amount from Worksheet E-3, Part II, line 2  37. 00 Outlier reconciliation adjustment amount (see instructions)  38. 00 Tentative settlement (for contractor use only)  39. 00 Outlier reconciliation adjustment amount (see instructions)  30. 50 Outlier reconciliation adjustment amount (see instructions)								
30.99 Recovery of Accelerated Depreciation 0 30.99 31.00 Total amount payable to the provider (see instructions) 771, 495 31.00 31.01 Sequestration adjustment (see instructions) 15, 430 31.01 32.00 Interim payments 756, 059 32.00 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) 6 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 35.00 TO BE COMPLETED BY CONTRACTOR  Original outlier amount from Worksheet E-3, Part II, line 2 40, 144 50.00 51.00 The rate used to calculate the Time Value of Money 0.00 52.00								
31.00   Total amount payable to the provider (see instructions)   771, 495   31.00   31.01   Sequestration adjustment (see instructions)   15, 430   31.01   32.00   Interim payments   756, 059   32.00   33.00   Tentative settlement (for contractor use only)   0   33.00   34.00   Bal ance due provider/program (line 31 minus lines 31.01, 32 and 33)   6   34.00   Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,   0   35.00		1						
31.01 Sequestration adjustment (see instructions)  32.00 Interim payments  33.00 Tentative settlement (for contractor use only)  34.00 Balance due provider/program (line 31 minus lines 31.01, 32 and 33)  35.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  TO BE COMPLETED BY CONTRACTOR  50.00 Original outlier amount from Worksheet E-3, Part II, line 2  Outlier reconciliation adjustment amount (see instructions)  52.00 The rate used to calculate the Time Value of Money  15, 430 31.01  756,059 32.00  33.00  35.00  50.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
32.00   Interim payments   756,059   32.00   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)   6   34.00   70 protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,   0   35.00   70 BE COMPLETED BY CONTRACTOR   70 BE COMPLETED BY CONTRACTOR   70 BE COMPLETED BY CONTRACTOR   70 Utilier reconciliation adjustment amount (see instructions)   0   51.00   52.00   71 The rate used to calculate the Time Value of Money   0.00   52.00   75 Contractor   75 Co		1						
33.00 Tentative settlement (for contractor use only)  34.00 Balance due provider/program (line 31 minus lines 31.01, 32 and 33)  35.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  35.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  36.00 Original outlier amount from Worksheet E-3, Part II, line 2  37.00 Outlier reconciliation adjustment amount (see instructions)  38.00 Add 30  39.00 Add 30  30.00 Add								
34.00 Balance due provider/program (line 31 minus lines 31.01, 32 and 33)  Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 35.00  TO BE COMPLETED BY CONTRACTOR  Original outlier amount from Worksheet E-3, Part II, line 2  Outlier reconciliation adjustment amount (see instructions)  The rate used to calculate the Time Value of Money  34.00  40,144  50.00  51.00								
35.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 §115.2  TO BE COMPLETED BY CONTRACTOR  50.00 Original outlier amount from Worksheet E-3, Part II, line 2 40,144 50.00 Outlier reconciliation adjustment amount (see instructions) 0 51.00 The rate used to calculate the Time Value of Money 0.00 52.00		3/						
\$115.2 TO BE COMPLETED BY CONTRACTOR  50.00 Original outlier amount from Worksheet E-3, Part II, line 2 51.00 Outlier reconciliation adjustment amount (see instructions) 52.00 The rate used to calculate the Time Value of Money  \$115.2  40, 144  50.00  51.00  52.00			hantor 1					
TO BE COMPLETED BY CONTRACTOR  50.00 Original outlier amount from Worksheet E-3, Part II, line 2 51.00 Outlier reconciliation adjustment amount (see instructions) 52.00 The rate used to calculate the Time Value of Money  50.00 The rate used to calculate the Time Value of Money  50.00 The rate used to calculate the Time Value of Money	33.00		партег т,	٥	33.00			
50.00 Original outlier amount from Worksheet E-3, Part II, line 2 51.00 Outlier reconciliation adjustment amount (see instructions) 52.00 The rate used to calculate the Time Value of Money  40, 144 50.00 51.00 52.00								
51.00 Outlier reconciliation adjustment amount (see instructions)  0 51.00  The rate used to calculate the Time Value of Money  0.00 52.00	50.00			40, 144	50.00			
52.00 The rate used to calculate the Time Value of Money 0.00 52.00								
		· · · · · · · · · · · · · · · · · · ·						
	53. 00			0	53.00			

Health Financial Systems	JAY COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1320	Period: Worksheet E-3

To 09/30/2016 Date/Time Prepared: 2/27/2017 10:37 am Title XIX Hospi tal Cost Inpati ent Outpati 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 1.00 0 2.00 Medical and other services Λ 2.00 3.00 Organ acquisition (certified transplant centers only) 0 3.00 Subtotal (sum of lines 1, 2 and 3) 0 4.00 4.00 5.00 Inpatient primary payer payments 5.00 Outpatient primary payer payments 6.00 Λ 6.00 7.00 Subtotal (line 4 less sum of lines 5 and 6) 0 7.00 COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges 8.00 Routine service charges 0 8.00 9.00 Ancillary service charges 0 0 9.00 10.00 Organ acquisition charges, net of revenue 0 10.00 0 11 00 Incentive from target amount computation 11 00 12.00 Total reasonable charges (sum of lines 8 through 11) 0 0 12.00 CUSTOMARY CHARGES Amount actually collected from patients liable for payment for services on a charge 13.00 0 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) 16.00 o 17.00 17.00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 0 line 4) (see instructions) 18.00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 0 0 18.00 (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 0 20.00 21.00 Cost of covered services (enter the lesser of line 4 or line 16) 0 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 0 23.00 Outlier payments 23.00 Λ 24.00 Program capital payments 24.00 25.00 Capital exception payments (see instructions) 0 25.00 26.00 26 00 Routine and Ancillary service other pass through costs 0 Subtotal (sum of lines 22 through 26) 27.00 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) 0 0 29.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 30.00 Excess of reasonable cost (from line 18) 0 0 30.00 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 0 0 31.00 32.00 Deducti bl es 0 0 0 0 0 0 0 0 0 32.00 0 33 00 33 00 Coi nsurance 0 34.00 Allowable bad debts (see instructions) Λ 34.00 35.00 35.00 Utilization review Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 36, 00 0 36, 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 37.00 0 37.00 38.00 Subtotal (line 36 ± line 37) 0 38.00 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 41.00 Interim payments 0 41.00 Balance due provider/program (line 40 minus line 41) 42.00 0 42.00

Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,

0

0 43.00

43.00

chapter 1, §115.2

Health Financial Systems	JAY COUNTY HOSPITAL	In Lieu of Form CMS-2552-1			
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1320	Peri od: From 10/01/2015	Worksheet E-3		
	Component CCN: 15-M320				
	Title XIX	Subprovi der -	Cost		

		II tie xix	I PF	COST		
		I	Inpatient	Outpati ent		
			1, 00	2. 00		
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVI	CES FOR TITLES V OR XIX		2.00		
	COMPUTATION OF NET COST OF COVERED SERVICES	SES TON TITLES V ON ALL	OLIVI OLO		1	
1.00	Inpatient hospital/SNF/NF services		44, 103		1.00	
2. 00	Medical and other services		11, 100	0		
3. 00	Organ acquisition (certified transplant centers only)		0	Ü	3. 00	
4. 00	Subtotal (sum of lines 1, 2 and 3)		44, 103	0	1	
5. 00	Inpatient primary payer payments		0	ŭ	5. 00	
6. 00	Outpatient primary payer payments			0		
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		44, 103	0		
	COMPUTATION OF LESSER OF COST OR CHARGES		,		1	
	Reasonable Charges					
8.00	Routine service charges		0		8.00	
9. 00	Ancillary service charges		17, 321	0	1	
10.00	Organ acquisition charges, net of revenue		0	_	10.00	
11. 00	Incentive from target amount computation		0		11. 00	
12. 00	Total reasonable charges (sum of lines 8 through 11)		17, 321	0	1	
	CUSTOMARY CHARGES		,		1	
13.00	Amount actually collected from patients liable for payment for s	ervices on a charge	0	0	13. 00	
	basis	g-				
14.00	Amounts that would have been realized from patients liable for p	ayment for services on	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)		17, 321	0	16.00	
17.00	Excess of customary charges over reasonable cost (complete only	if line 16 exceeds	0	0	17. 00	
	line 4) (see instructions)					
18.00	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds line	26, 782	0	18. 00	
	16) (see instructions)					
19. 00	Interns and Residents (see instructions)		0	0	19. 00	
20.00	Cost of physicians' services in a teaching hospital (see instruc	tions)	0	0		
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)		17, 321	0	21.00	
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be con	mpleted for PPS provide				
22. 00	Other than outlier payments		0	0		
23.00	Outlier payments		0	0		
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		
27. 00	Subtotal (sum of lines 22 through 26)		0	0		
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0		
29. 00	Titles V or XIX (sum of lines 21 and 27)		17, 321	0	29. 00	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30. 00	Excess of reasonable cost (from line 18)		26, 782	0		
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		17, 321	0		
32. 00	Deducti bl es		0	0		
33. 00	Coinsurance		0	0		
34. 00	Allowable bad debts (see instructions)		0	0		
35. 00	Utilization review		0	_	35. 00	
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 3	3)	17, 321	0		
37. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0		
	Subtotal (line 36 ± line 37)		17, 321	0		
39. 00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00	
	Total amount payable to the provider (sum of lines 38 and 39)		17, 321	0		
41.00	Interim payments		20, 153	0		
42.00	Balance due provider/program (line 40 minus line 41)	' II ONG D I 4E 3	-2, 832	0		
43. 00	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub 15-2,	0	0	43. 00	
	chapter 1, §115.2		1		I	

lealth Financial Systems JAY COUNTY HOSPITAL In Lieu of Form CMS-2552-10

Health Financial Systems

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

Provider CCN: 15-1320 Pe

Peri od: Worksheet G From 10/01/2015 To 09/30/2016 Date/Ti me Prepared: 2/27/2017 10: 37 am

		General Fund	Speci fi c	Endowment Fund	2/27/2017 10: Plant Fund	3/ am
			Purpose Fund			
	CURRENT ASSETS	1.00	2. 00	3. 00	4. 00	
1.00	Cash on hand in banks	2, 988, 608	T c	ol ol	0	1.00
2.00	Temporary investments	-9, 624, 424	•	-	0	
3.00	Notes recei vabl e	0	C	o	0	
4.00	Accounts receivable	25, 494, 955		0	0	
5.00	Other recei vable	304, 455	C	0	0	
6.00	Allowances for uncollectible notes and accounts receivable	0 721 770			0	6. 00 7. 00
7. 00 8. 00	Inventory Prepai d expenses	2, 731, 770			0	8.00
9. 00	Other current assets	0			0	9. 00
10.00	Due from other funds	0	d	o o	0	10.00
11. 00	Total current assets (sum of lines 1-10)	21, 895, 364	C	0	0	11. 00
	FIXED ASSETS					
12. 00	Land	347, 733			0	
13.00	Land improvements	952, 332			0	13.00
14. 00 15. 00	Accumulated depreciation Buildings	0 25 114 042	C		0	14. 00 15. 00
16. 00	Accumulated depreciation	25, 114, 962			0	16. 00
17. 00	Leasehold improvements	0			0	17. 00
18. 00	Accumulated depreciation	Ö	d	o o	0	18. 00
19.00	Fi xed equipment	2, 426, 508	C	o	0	19. 00
20. 00	Accumulated depreciation	-28, 882, 882	C	0	0	20. 00
21. 00	Automobiles and trucks	0	C	0	0	21. 00
22. 00	Accumulated depreciation	0	C	0	0	22. 00
23. 00	Maj or movable equipment	13, 931, 159		0	0	23. 00
24. 00 25. 00	Accumulated depreciation Minor equipment depreciable	0			0	24. 00 25. 00
26. 00	Accumulated depreciation	0			0	26.00
27. 00	HIT designated Assets			o o	0	27. 00
28. 00	Accumul ated depreciation	0	d	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	C	o	0	29. 00
30. 00	Total fixed assets (sum of lines 12-29)	13, 889, 812	C	0	0	30.00
	OTHER ASSETS	_	_			
31.00	Investments	0	C		0	31.00
32. 00 33. 00	Deposits on leases Due from owners/officers	0	C		0	32. 00 33. 00
34. 00	Other assets	11, 341, 395			0	34. 00
35. 00	Total other assets (sum of lines 31-34)	11, 341, 395			0	35. 00
36.00	Total assets (sum of lines 11, 30, and 35)	47, 126, 571	d	0	0	
	CURRENT LIABILITIES					
37. 00	Accounts payable	767, 852	1	- 1	0	37. 00
38. 00	Salaries, wages, and fees payable	1, 563, 097	C	0	0	38. 00
39. 00 40. 00	Payroll taxes payable (chart tarm)	0		0	0	39.00
41. 00	Notes and Loans payable (short term) Deferred income	0			0	40. 00 41. 00
42. 00	Accel erated payments	0			O	42.00
43. 00	Due to other funds	Ö	l c	o	0	
44.00	Other current liabilities	4, 890, 201	c	o	0	44. 00
45.00	Total current liabilities (sum of lines 37 thru 44)	7, 221, 150	C	0	0	45. 00
	LONG TERM LIABILITIES	1				
46. 00	Mortgage payable	0	C	0	0	46. 00
47. 00 48. 00	Notes payable Unsecured Loans	0	C	=	0	1
49. 00	Other long term liabilities			=	0	1
50.00	Total long term liabilities (sum of lines 46 thru 49)	0		-	0	
51. 00	Total liabilities (sum of lines 45 and 50)	7, 221, 150	d	o o	0	
	CAPITAL ACCOUNTS					
52.00	General fund balance	39, 905, 421				52. 00
53. 00	Specific purpose fund		C			53. 00
54. 00	Donor created - endowment fund balance - restricted			0		54.00
55. 00 56. 00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance Plant fund balance - invested in plant			١	0	56. 00 57. 00
58. 00	Plant fund balance - reserve for plant improvement,				0	
55. 55	replacement, and expansion				O	55. 55
59. 00	Total fund balances (sum of lines 52 thru 58)	39, 905, 421	c	o	0	59. 00
60. 00	Total liabilities and fund balances (sum of lines 51 and	47, 126, 571	C	0	0	60.00
	[59]	I	I			I

| Peri od: | Worksheet G-1 | To .09/30/2015 | To .09/30/2 JAY COUNTY HOSPITAL

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES Provider CCN: 15-1320

					Γο 09/30/2016	Date/Time Pre 2/27/2017 10:	pared: 37 am
		General	Fund	Special P	urpose 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 13. 00 14. 00 15. 00 17. 00 18. 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) Deductions (debit adjustments) (specify)  Total deductions (sum of lines 12-17)	1.00 0 0 0 0 0 0	2. 00 44, 117, 089 -4, 211, 668 39, 905, 421 0 39, 905, 421		4. 00 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)		39, 905, 421		0		19. 00
		Endowment Fund	PI ant	Fund			
		6. 00	7. 00	8. 00			
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	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		o o		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	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0	0 0 0 0 0	(			9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0			) )		18. 00 19. 00

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

			To 09/30/2016	Date/Time Pre 2/27/2017 10:	
	Cost Center Description	Inpatient	Outpati ent	Total	, d
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	6, 266, 04		6, 266, 043	1. 00
2.00	SUBPROVI DER - I PF	1, 213, 68		1, 213, 680	2. 00
3.00	SUBPROVI DER - I RF		0	0	3. 00
4.00	SUBPROVI DER		0	0	4. 00
5.00	Swing bed - SNF		0	0	5. 00
6.00	Swing bed - NF		0	0	6.00
7.00	SKILLED NURSING FACILITY				7. 00
8.00	NURSING FACILITY				8. 00
9.00	OTHER LONG TERM CARE	7 470 70		7 470 702	9.00
10. 00	Total general inpatient care services (sum of lines 1-9) Intensive Care Type Inpatient Hospital Services	7, 479, 72	.3	7, 479, 723	10.00
11. 00	INTENSIVE CARE UNIT	1	0	0	11. 00
12. 00	CORONARY CARE UNIT			O	12.00
13. 00	BURN INTENSIVE CARE UNIT				13. 00
14. 00	SURGI CAL INTENSIVE CARE UNIT				14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15.00
16. 00	Total intensive care type inpatient hospital services (sum of lines		0	0	16.00
	11-15)			Ü	10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	7, 479, 72	3	7, 479, 723	17. 00
18.00	Ancillary services	12, 349, 31	7 61, 639, 867	73, 989, 184	18. 00
19.00	Outpati ent servi ces	867, 52	1 17, 967, 540	18, 835, 061	19. 00
20.00	RURAL HEALTH CLINIC		0 0	0	20. 00
21.00	FEDERALLY QUALIFIED HEALTH CENTER		0 0	0	21. 00
22.00	HOME HEALTH AGENCY				22. 00
23.00	AMBULANCE SERVICES				23. 00
24.00	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	PHYSICIANS'S PRIVATE OFFICES		0 2, 509, 478	2, 509, 478	
27. 01	WEST JAY CLINIC	2, 21		77, 196	
27. 02	TRI COUNTY	844, 63		3, 578, 187	27. 02
27. 03	HOSPI TALI ST	290, 27		407, 308	27. 03
27. 04	FAMILY FIRST HEALTH	1, 52		120, 550	27. 04
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	21, 835, 20	85, 161, 485	106, 996, 687	28. 00
	G-3, line 1) PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)	1	41, 218, 166		29. 00
30. 00	ADD (SPECIFY)		0		30.00
31. 00	(SECTITY)		0		31.00
32. 00			0		32. 00
33. 00			0		33. 00
34. 00			0		34. 00
35. 00			0		35. 00
36. 00	Total additions (sum of lines 30-35)		0		36. 00
37. 00	DEDUCT (SPECIFY)		0		37. 00
38. 00			0		38. 00
39. 00			0		39. 00
40.00			0		40.00
41.00			0		41.00
42.00	Total deductions (sum of lines 37-41)		0		42. 00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer	-	41, 218, 166		43. 00
	to Wkst. G-3, line 4)				

		UNTY HOSPITAL		u of Form CMS-2	
SIAIEN	IENT OF REVENUES AND EXPENSES	Provider CCN: 15-1320	Peri od: From 10/01/2015	Worksheet G-3	
			To 09/30/2016	Date/Time Pre	nared:
			10 077 007 2010	2/27/2017 10: 3	
				1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column			106, 996, 687	1.00
2. 00	Less contractual allowances and discounts on patients'	accounts		71, 423, 138	
3. 00	Net patient revenues (line 1 minus line 2)			35, 573, 549	
4. 00	Less total operating expenses (from Wkst. G-2, Part II,			41, 218, 166	
5. 00	Net income from service to patients (line 3 minus line	4)		-5, 644, 617	5.00
	OTHER INCOME				
6. 00	Contributions, donations, bequests, etc			0	
7. 00	Income from investments			0	
3. 00	Revenues from telephone and other miscellaneous communi	cation services		0	
9. 00	Revenue from television and radio service			0	9.00
10. 00	Purchase di scounts			0	10.00
11. 00	Rebates and refunds of expenses			0	
12. 00	Parking Lot receipts			0	
13. 00	Revenue from Laundry and Linen service			0	13.00
14. 00	Revenue from meals sold to employees and guests			0	14.00
15. 00	Revenue from rental of living quarters			0	15.00
16. 00	Revenue from sale of medical and surgical supplies to d	other than patients		0	16.00
17. 00	Revenue from sale of drugs to other than patients			0	17.00
18. 00	Revenue from sale of medical records and abstracts			0	18.00
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20. 00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21. 00	Rental of vending machines			0	21.00
22. 00	Rental of hospital space			0	22.00
23. 00	Governmental appropriations			0	23.00
24. 00	OTHER OPERATING INCOME			1, 264, 019	24.00
24. 01	NON-OPERATING INCOME			168, 930	
25. 00	Total other income (sum of lines 6-24)			1, 432, 949	
26. 00	Total (line 5 plus line 25)			-4, 211, 668	26.00
27. 00	OTHER EXPENSES (SPECIFY)			0	1
28. 00	Total other expenses (sum of line 27 and subscripts)			0	
	Net income (or loss) for the period (line 26 minus line	e 28)		-4, 211, 668	