This report is required by law (42 USC 1395g, 42 CFR 413.20(b)). Fail ure to report can result in all inter.in FORM APPROVED payments makes since the beginning of the cost report ing port oble ing deemed overpayments (42 USC 1395g). OBB ND. 0733-0500 FXPIRES 05-31-2019 MOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-1320 Form 10/0/12018 Period: From 10/0/12018	Health Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS-2552-10
AND SETTLEMENT SUMMARY From 10/01/2016 Parts 1-111 PART 1 - COST REPORT STATUS Date: 2/26/2018 2/05 pm Provider 1. [X] Electronically filed cost report Date: 2/26/2018 2/05 pm Second Provider 1. [X] Electronically filed cost report Date: 2/26/2018 2/05 pm Second Provider 1. [X] Electronically filed cost report Date: 2/26/2018 2/05 pm Second Provider 1. [X] Electronically filed cost report Date: 2/26/2018 2/05 pm Second Provider 5. [1] Cost Report Status 6. Date Received In ONR Date: (2) Settled without Audit 9. [N Initial Report for this Provider CCN] [1] Contractor's Vendor Code: 4 (3) Sectled without Audit 9. [N Initial Report for this Provider CCN] [2] Olif line S. Column 11: Second Telepont In ONR Date: (3) Sectled without Audit 9. [N Inftal Report for this Provider CCN] [2] Olif line S. Column 11: Electronically filed cost report In ONR Date: (3) Sectled without Audit 9. [N Inftal Report for this Provider CCN] [2] Olif line S. Column 11: Electronically filed cost report (4) Repened (5) Amended Provider CN] [2] Olif line S. Column 11: Electronically filed cost report (4) Repened (5) Amended Provider CN] [2] Olif line S.						OMB NO. 0938-0050
PART 11 - COST REPORT STATUS Provider 1. [X] Electronically filed cost report 2. [] Manually submitted cost report Date: 2/26/2018 Time: 2:05 pm 3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report 10. NPR Date: 1. [X] Electronically filed cost report 10. NPR Date: 11. Contractor: S Vendor Code: 4 (Contractor 7. Contractor No. 10. NPR Date: 11. Contractor: S Vendor Code: 4 (2) Settled without Audit 8 [. N] Initial Report for this Provider CCN 12. O If Times 7. contractor No. 11. Contractor: S Vendor Code: 4 (3) Settled with Nout Audit 9 [N] Initial Report for this Provider CCN 12. O If Times 7. contractor No. 11. Contractor: S Vendor Code: 4 (3) Settled with Nout Kudit 9 [N] Initial Report for this Provider CCN 12. O If Times 7. contractor No. 11. Contractor: S Vendor Code: 4 (3) Settled with Nout Xudit 8 [N] Initial Report for this Provider CCN 12. O If Times 7. contractor No. 11. Contractor: S Vendor Code: 4 (4) Repened 1. Sommeter 1. Settled with Nout Xudit 8 [N] Initial Report S Vendor CCN 12. O If Time: Z = Settled N] NoutNet Not Net Net Net Net Net Net Net Net Net Ne		ORT CERTIFICATIO	N Provider C	CN: 15-1320	From 10/01/2016	Parts I-III Date/Time Prepared:
use only 2. [] Manual Ly submitted cost report 3. [0] If this is an amended proprime the number of times the provider resubmitted this cost report 4. [F] Wedicare Utilization. Enter "F" for full or "L" for low. Contractor use only 5. [1] Cost Report Status 6. Date Received: (1) As Submitted 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for this Provider CCN (3) Settled without Audit 8. [N] Initial Report for this Provider CCN (6) Reported (5) Amended PART 11 - CERTIFICATION MISSERPESTATION OF RAJSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE NAD/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THE AVAILENT OR INCILLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES NAD/OR IMPRISONMENT WAY RESULT. CERTIFICATION BY CHIEF FINANCIAL 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 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 healt care services, and that the services identified in this cost 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 of mothas and	PART I - COST REPORT STATUS				1	
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report 4. [f] Wedicare Utilization. Enter 'F" for Ill or 'L" for Iow. Contractor (1) Submitted (2) Settled without Audit 8. [N] Initial Report for this Provider CCN (3) Settled without Audit 9. [N] Final Report for this Provider CCN (3) Repended (4) Reopened (5) Amended (5) Amended (6) Reopened (7) Assumitted in the Audit 9. [N] Final Report for this Provider CCN (1) Reopened (3) Amended (4) Reopened (5) Amended (7) BETHIS AND/OR INFERSIONENT UNCER REPORT LAW. PENPT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AM/OR INPRISONENT UNCER REPORTAL LAW. PURIFIERDIN THE ID IN THIS REPORT WEE PROVIDED OR PROCURED THROUGH THE PAYMENT DI RECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE SAND/OR IMPRISONMENT MAY RESULT. CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S) I HEREBY CERTIFY that 1 have read the above certification statement and Statement of Revenue and Expenses prepared by JAY COUNTY MOSPITAL (15-1320) for the cost reporting period beginning 10/01/2016 and ending 09/30/2017 and to the best of my knowledge and belief, this report and Statement and Statement of Revenue and expenses prepared by JAY COUNTY MOSPITAL (15-1320) for the cost re		port			Date: 2/26/20	018 Time: 2:05 pm
4. [F] Medicare Utilization. Enter "F" for full or "L" for low. Contractor Use only 5. [1] Cost Report Status 6. Date Received: 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for this Provider CON (3) Settled without Audit 8. [N] Initial Report for this Provider CON (4) Reopened (5) Amended [1] Initial Report for this Provider CON (5) Amended PART 11 - CERTIFICATION MISREPRESENTATION OR FALSFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AMD/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AMD/OR IMPRISONMENT WAY RESULT. CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMIN INSTRATOR 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 ending 09/30/2017 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 majoricable instructions, except as noted. I further certify that I an familiar with the laws and regulations regarding the provision of heal th care services, and that the services Identified in this cost report were provided in complicate with such laws and regulations. [] have read and agree with the above certification statement, I certify that I intend my electronic signature on this certification statement to be the legally binding						
use only (1) & Submitted 7. Contractor No. 11. Contractor's Vendor Code: 4 (2) Settled with out Audit B [N] linitial Report for this Provider CCN (2) If fines, column 1:s 4: Enter number of times reopened = 0-9. (3) Settled with Audit 9. [N] Final Report for this Provider CCN (2) If fines, column 1:s 4: Enter number of times reopened = 0-9. (4) Reopened (5) Amended 9. [N] Final Report for this Provider CCN (2) If fines, column 1:s 4: Enter number of times reopened = 0-9. (5) Amended 9. [N] Final Report for this Provider CCN (2) If fines, column 1:s 4: Enter number of times reopened = 0-9. (6) MI STRATIVE ACTION Missepretstration or RatSiFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT WAY RESULT. CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S) ILEREBY CERTIFY that 1 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 report were provided in compliance with such laws and regulations. [] I have read and agree with the above certification statement. I certify that 1 intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature. [] I have read and agree with the above certification statement. I certify that 1 intend	3. [0] If this is an amended report 4. [F] Medicare Utilization. Enter	enter the numbe "F" for full or	er of times th "L" for low.	e provider r	esubmitted this	cost report
INISERRESENTATION 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 CHIEF FINANCIAL 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 (5-1320) for the cost 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. []] I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature. (Signed)	use only (1) As Submitted 7. Contr (2) Settled without Audit 8. [N] (3) Settled with Audit 9. [N] (4) Reopened	actor No. Initial Report	for this Prov r this Provid	11.C ider CCN12.[contractor's Vend 0]Ifline 5, co	olumn 1 is 4: Enter
ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT. CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S) I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronic cally filed or manually submit the 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 10/01/2016 and ending 09/30/2017 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 heal th care services, and that the services identified in this cost report were provided in compliance with such laws and regulations. []] have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature. (Signed)	PART II - CERTIFICATION			I		
PROVURED 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 CHIEF FINANCIAL 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 Bal ance Sheet and Statement of Revenue and Expenses prepared by JAY COUNTY HOSPITAL (15-1320) for the cost 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 regulation sregarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations. []] have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of Provider(s) Image: Cost Center Description If the V Part A Part B HIT Title XIX 1.00 2.00 3.00 PART 111 - SETTLEMENT SUMMARY	MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATI	ON CONTAINED IN	I THIS COST RE	PORT MAY BE	PUNI SHABLE BY CRI	MINAL, CIVIL AND
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 Bal ance Sheet and Statement of Revenue and Expenses prepared by JAY COUNTY HOSPITAL (15-1320) for the cost reporting period beginning 10/01/2016 and ending 09/30/2017 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. []] I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature. (Signed)	PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY (OR INDIRECTLY OF				
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signature on this certification statement to be the legally binding equivalent of my original signature. (Signed) Officer or Administrator of Provider(s) Title Date Cost Center Description Title V Title V Part A 1.00 2.00 3.00 4.00 5.00	electronically filed or manually submitted Expenses prepared by JAY COUNTY HOSPITAL (ending 09/30/2017 and to the best of my kn complete and prepared from the books and r except as noted. I further certify that I health care services, and that the service	cost report and 15-1320) for owledge and beli ecords of the pu am familiar wit	the Balance he cost repor ef, this repo ovider in acc th the laws an	Sheet and St ting period rt and state ordance with d regulation	atement of Reven beginning 10/01/ ment are true, c applicable inst s regarding the	ue and 2016 and prrect, ructions, provision of
Officer or Administrator of Provider(s) Title Date Cost Center Description Title XVIII Title XVIII Date PART III - SETTLEMENT SUMMARY						
Title Date Cost Center Description Title XVIII Title XVIII PART III - SETTLEMENT SUMMARY		(Si gne	ed)			
Date Cost Center Description Title V Part A Part B HIT Title XIX 1.00 2.00 3.00 4.00 5.00		-	Offi c	er or Adminis	strator of Provid	ler(s)
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1.00 2.00 3.00 4.00 5.00 PART III - SETTLEMENT SUMMARY	Cost Conter Description	TitloV				TITIONYLY
PART III - SETTLEMENT SUMMARY	cost center bescription					
	PART III - SETTLEMENT SUMMARY					

1.00	Hospi tal	0	-771	-158, 841	0	12, 940	1.00
2.00	Subprovider - IPF	0	0	0		13, 773	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	12, 292	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	11, 521	-158, 841	0	26, 713	200.00

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

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX		COUNTY HO		er CCN	: 15-1320	Peri od:	n Lieu	u of For Worksh	m CMS-1 eet S-2	
nosri	AL AND HUSFITAL HEALTH CARE COMPLEX	DENTITICATION DA		FIOVIO		. 15-1520	From 10/01	/2016 /2017	Part I		
	1.00	2	00		3.00			4.00	2/26/2		
	Hospital and Hospital Health Care Co		00		5.00			4.00			
1.00 2.00	Street: 500 W. VOTAW City: PORTLAND	PO Box: State: I	N	Zip Cod	- 1727	1 Cou	nty: JAY				1.00 2.00
2.00	CITY. FORTLAND	Component Na		CCN	CBSA			Payme	ent Syst	tem (P,	2.00
			1	Number	Numbe	er Type	Certi fi ed		, 0, or XVIII		
		1.00		2.00	3.00	0 4.00	5.00	6.00	_	8.00	
2 00	Hospital and Hospital-Based Componer	it Identification JAY COUNTY HOSPI		151000	0001	F 1	01 (01 (000	4 N	0		2.00
3.00 4.00	Hospital Subprovider - IPF	JAY COUNTY HUSPT		151320 15M320	9991 9991		01/01/200		0 P	0	3.00 4.00
F 00		HOSPI TAL-PSYCH UI	NIT								5 00
5.00 6.00	Subprovider - IRF Subprovider - (Other)										5.00
7.00	Swing Beds - SNF	JAY COUNTY HOSPI	TAL ⁷	15Z320	9991	5	01/01/200	4 N	0	0	7.00
8.00 9.00	Swing Beds - NF Hospital-Based SNF										8.00 9.00
10.00	Hospital - Based NF										10.00
11. 00	Hospital-Based OLTC										11.00
12.00	Hospital -Based HHA										12.00
13.00	Separately Certified ASC Hospital-Based Hospice										13.00
15.00	Hospital-Based Health Clinic - RHC										15.00
16.00	Hospital - Based Health Clinic - FQHC										16.00
17.00 17.10	Hospital-Based (CMHC) Hospital-Based (CORF)										17.00
18.00	Renal Dialysis										18.00
19.00	Other										19.00
							From 1.0		Tc 2.		
20.00	Cost Reporting Period (mm/dd/yyyy)						10/01/2	2016	09/30	/2017	20.00
21.00	Type of Control (see instructions) Inpatient PPS Information						9				21.00
22.00	Does this facility qualify and is it	currently receiv	ving payme	ents fo	r di spr	roporti ona	te N				22.00
	share hospital adjustment, in accord										
	for yes or "N" for no. Is this facil amendment hospital?) In column 2, en				12.106((c)(2)(Pi c	kle				
22. 01	Did this hospital receive interim un				is cost	t reportin	a N		Ν	J	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)	opor tring porrou t	securring								
22. 02	Is this a newly merged hospital that								Ν	1	22.02
	determined at cost report settlement or "N" for no, for the portion of th										
	in column 2, "Y" for yes or "N" for										
<u></u>	or after October 1.	le real cool fi coti	on from	urbon t			ult N		Ν		
22.03	Did this hospital receive a geograph of the OMB standards for delineating								ľ	4	22.03
	in column 1, "Y" for yes or "N" for	no for the portio	on of the	cost r	eportir	ng period					
	prior to October 1. Enter in column cost reporting period occurring on c						the				
	hospital contain at least 100 but no						i th				
	42 CFR 412.105)? Enter in column 3,	"Y" for yes or "N	N" for no.					_			
23.00	Which method is used to determine Me 1, enter 1 if date of admission, 2 i							3	Ν	1	23.00
	method of identifying the days in th										
	used in the prior cost reporting per	iod? In column 2						Madiaa			
			In-State Medicaid			Out-of State		Medica HMO da		ther di cai d	
			paid days			Medi cai d	Medi cai d	inite da		days	
				unp		paid days	el i gi bl e				
			1.00	da 2.	-	3.00	unpai d 4.00	5.00		5. 00	
24.00	If this provider is an IPPS hospital			0	0	0	0		0		24.00
	in-state Medicaid paid days in colum Medicaid eligible unpaid days in col										
	out-of-state Medicaid paid days in co										
	out-of-state Medicaid eligible unpai	d days in column									
	4, Medicaid HMO paid and eligible bu										
25.00	column 5, and other Medicaid days in If this provider is an IRF, enter th			0	0	0	o		0		25.00
	Medicaid paid days in column 1, the	in-state			-		-				
	Medicaid eligible unpaid days in col										
	out-of-state Medicaid days in column Medicaid eligible unpaid days in col										
	HMO paid and eligible but unpaid day										
		- 1			'	I	1				

	Financial Systems JAY (AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		HOSPI TAL Provi der CC		eriod: rom 10/01/	2016	u of Forn Workshe Part I Date/Ti 2/26/20	et S-2 me Pre	pared:
					Urban/Rur	al S			
	Enter your standard geographic classification (not wa cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa	rural age) st	atus at the en	d of the cost	1.00	2	2.0	0	26.00 27.00
35.00	reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	cation	in column 2.			0			35.00
					Begi nni r	ng:	Endi		
	Enter applicable beginning and ending dates of SCH st of periods in excess of one and enter subsequent date		Subscript line	36 for number	1.00		2.0	00	36.00
37.01	If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo	ne MDH	transitional p	ayment in	N	0			37.00 37.01
38.00	instructions) If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of	s of MD	H status. If I	ine 37 is					38.00
	enter subsequent dates.				Y/N 1.00		Y/I 2. C		
	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) for yes or "N" for no. Does the facility meet the mil with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column instructions)) or (i eage r	i)? Enter in c equirements in	olumn 1 "Y" accordance	N		N		39.00
	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	per 1.	Enter "Y" for		N		N		40.00
						V 1.00	XVIII 2.00	XI X 3. 00	-
	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymer	nt for	di sproporti ona	te share in ac	cordance	N	N	N	45.00
46.00	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wks1 Pt. III.					Ν	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS of Is the facility electing full federal capital payment Teaching Hospitals					N N	N N	N N	47.00 48.00
	Is this a hospital involved in training residents in or "N" for no.	approv	ed GME program	s? Enter "Y"	for yes	Ν			56.00
57.00	If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is "\ "N", complete Wkst. D, Parts III & IV and D-2, Pt. II	ryeso thoft (", com	r "N" for no i his cost repor plete Workshee	n column 1. lf ting period?	column 1 Enter "Y"				57.00
	If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	compl e	te Wkst. D-5.		as	Ν			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes	s <u>, comp</u>	lete Wkst. D-2	, Pt. I. NAHE 413.85 Y/N	Workshee Line #		Pass-Th Qualific Criter Coo	cation rion	59.00
				1.00	2.00		3. 0		
	Are you claiming nursing and allied health education any programs that meet the criteria under §413.85?	(see in	structions)	N Direct CME	IME		Direct	CME	60.00
		Y/N	I ME	Direct GME	I ME		Direct		-
	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in	1.00 N	2.00	3.00	4.00	0.00	5. C		61.00
51. 01	column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see		0.00	0.00					61.01
51. 02	instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		O. OC	0.00					61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00					61.03

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider CC		In Lie Period:	Worksheet S-2	
				From 10/01/2016 To 09/30/2017	Part I Date/Time Pre 2/26/2018 1:5	
	Y/N	IME	Direct GME	I ME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
 61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary and on general the current cost reporting. 		0.00				61. 04 61. 05
and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0. OC	0. (DC		61.06
	Pro	ogram Name	Program Code	IME FTE Count	Unweighted Direct GME FTE Count	
(1 10 Of the FTFe in line (1 OF erreify each new		1.00	2.00	3.00	4.00	(1 10
61.10 Of the FTEs in line 61.05, specify each new program special ty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61. 10
61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			-	0.00	0. 00	61.20
					1.00	
ACA Provisions Affecting the Health Resources and Ser 62.00 Enter the number of FTE residents that your hospital				riad for which	0.00	62.00
your hospital received HRSA PCRE funding (see instruct 52.01 Enter the number of FTE residents that rotated from a	tions)					62.00
during in this cost reporting period of HRSA THC proc Teaching Hospitals that Claim Residents in Nonprovide			ns)			
63.00 Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ettings	during this c			N	63.00
			Unweighted FTEs Nonprovider	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col. 2))	
			Site 1.00	2.00	2.00	
Section 5504 of the ACA Base Year FTE Residents in No	onprovi	der Settings			3.00 reporting	
period that begins on or after July 1, 2009 and befor	re June	9 30, 2010.	-	-		44.00
64.00 Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted nor resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see	all noi all noi non-p n colum	ry care nprovider rimary care n 3 the ratio	O. C	0.00	0. 000000	64.00
Program Name		ogram Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	

SPITAL AND HOSPITAL HEALTH CARE COMPI	LEX IDENTIFICATION D	ATA Provider C		eriod: rom 10/01/2016 o 09/30/2017		
	Program Name	Program Code	Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital	2/26/2018 1:5 Ratio (col. 3/ (col. 3 + col. 4))	56 pm
-	1 00	2.00	Si te	4.00	F 00	-
.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in	1.00	2.00	3.00	4.00	5.00 0.000000	0 65.1
your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			Unweighted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 +	
			Nonprovi der	Hospi tal	col. 2))	
			Si te 1.00	2.00	3.00	-
Section 5504 of the ACA Current	Year FTE Residents i	n Nonprovider Settin				
beginning on or after July 1, 20		•		·		
	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column	ry care resident rovider settings. ry care resident 3 the ratio of	0.00 Unweighted FTEs Nonprovider		0.000000 Ratio (col. 3/ (col. 3 + col. 4))	
00 Enter in column 1 the number of FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column column 2)). (see ir	ry care resident rovider settings. ry care resident 3 the ratio of structions)	0.00 Unweighted FTEs	0.00 Unweighted FTEs in	Ratio (col. 3/ (col. 3 +	
 O0 Enter in column 1 the number of FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 + (column 1 column 1, the program) O0 Enter in column 1, the program 	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column column 2)). (see ir	ry care resident rovider settings. ry care resident 3 the ratio of structions)	0.00 Unweighted FTEs Nonprovider	0.00 Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00	
.00 Enter in column 1 the number of FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column <u>column 2)). (see ir</u> Program Name	ry care resident rovider settings. ry care resident 3 the ratio of structions) Program Code	0.00 Unweighted FTEs Nonprovider Site 3.00	0.00 Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00	
 00 Enter in column 1 the number of FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 + (column 1 divided by (column 1 + column 2)) 00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 3 divided by (column 3 divided by (column 3 + column 	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column <u>column 2)). (see ir</u> Program Name	ry care resident rovider settings. ry care resident 3 the ratio of structions) Program Code	0.00 Unweighted FTEs Nonprovider Site 3.00	0.00 Unweighted FTEs in Hospital 4.00 0.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00 0.000000	
 O0 Enter in column 1 the number of FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 + (column 1 divided by (column 1 +)). (see instructions) O0 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care FTEs that trained in your hospital. Enter in column 3 divided by (column 3 + column 4)). (see instructions) 	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column <u>column 2)). (see ir</u> Program Name <u>1.00</u>	ry care resident rovider settings. ry care resident 3 the ratio of structions) Program Code	0.00 Unweighted FTEs Nonprovider Site 3.00	0.00 Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00 0.000000	
 O0 Enter in column 1 the number of FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 + O0 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 3 divided by (column 4 divided by (column 5 divided	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column <u>column 2)). (see ir</u> Program Name <u>1.00</u>	ry care resident rovider settings. ry care resident 3 the ratio of structions) Program Code 2.00	0.00 Unweighted FTEs Nonprovider Site 3.00 0.00	0.00 Unwei ghted FTEs in Hospi tal 4.00 0.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00 0.000000	
 .00 Enter in column 1 the number of FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 + (column 2 divided by (column 3 divided by column 3, the program code. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 3, the resident FTEs that trained in your hospital. Enter in column 4)). (see instructions) .00 Inpatient Psychiatric Facility P for yes or "N" for no 	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column <u>column 2)). (see ir</u> Program Name <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u>	<pre>inv care resident rovider settings. ry care resident 3 the ratio of structions) Program Code 2.00 2.00 1PF), or does it con n approved GME teach 004? Enter "Y" for ility train resident)(D)? Enter "Y" for</pre>	0.00 Unweighted FTEs Nonprovider Site 3.00 0.00 0.00 tain an IPF sub ing program in yes or "N" for s in a new teac yes or "N" for	Unweighted FTEs in Hospital 4.00 0.00 0.00 1.00 provider? Y the most no. (see hing no.	Ratio (col. 3/ (col. 3 + col. 4)) 5.00 0.000000	0 67.0
 .00 Enter in column 1 the number of FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 + (column 1 divided by (column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 3, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) .00 Is this facility an Inpatient Ps Enter "Y" for yes or "N" for no 1f line 70 is yes: Column 1: Did recent cost report filed on or b 42 CFR 412. 424(d)(1)(iii)(c)) Co program in accordance with 42 CF column 3: If column 2 is Y, indi 	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column <u>column 2)). (see ir</u> Program Name <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u>	ry care resident rovider settings. ry care resident 3 the ratio of structions) Program Code 2.00 2.00	0.00 Unweighted FTEs Nonprovider Site 3.00 0.00 0.00 tain an IPF sub ing program in yes or "N" for s in a new teac yes or "N" for s cost reportin	Unweighted FTEs in Hospital 4.00 0.00 0.00 1.00 provider? Y the most no. (see hing no.	Rati o (col . 3/ (col . 3 + col . 4)) 5.00 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.00000000	70.0

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	ovider CCN: 15-1320	Period: From 10/01/2016 To 09/30/2017	Worksheet S- Part I Date/Time Pr 2/26/2018 1:	epared:
		1.0	0 2.00 3.00	-
6.00 If line 75 is yes: Column 1: Did the facility have an approved G recent cost reporting period ending on or before November 15, 20 no. Column 2: Did this facility train residents in a new teachin CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Col indicate which program year began during this cost reporting per	04? Enter "Y" for yes g program in accordan umn 3: If column 2 is	n the most or "N" for ce with 42 Y,		76.00
			1.00	
Long Term Care Hospital PPS 0.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and 1.00 Is this a LTCH co-located within another hospital for part or al "Y" for yes and "N" for no. TEEDA Decidence		ng period? Enter	- N N	80. 00 81. 00
TEFRA Providers 5.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEF 6.00 Did this facility establish a new Other subprovider (excluded un §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			N	85.00 86.00
7.00 Is this hospital a "subclause (II)" LTCH classified under sectio for yes or "N" for no.	n 1886(d)(1)(B)(iv)(I	I)? Enter "Y"	Ν	87.00
		V 1.00	XI X 2.00	-
Title V and XIX Services 0.00 Does this facility have title V and/or XIX inpatient hospital se	rvices? Enter "Y" for	N	Y	90.00
yes or "N" for no in the applicable column. 1.00 [s this hospital reimbursed for title V and/or XIX through the c		N	Y	91.00
full or in part? Enter "Y" for yes or "N" for no in the applicab 2.00 Are title XIX NF patients occupying title XVIII SNF beds (dual c	le column.		N	92.00
instructions) Enter "Y" for yes or "N" for no in the applicable 3.00 Does this facility operate an ICF/IID facility for purposes of t	column.	N	N	93.00
"Y" for yes or "N" for no in the applicable column. 4.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and		N	N	94.00
applicable column. 5.00 If line 94 is "Y", enter the reduction percentage in the applica 6.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or	ble column.	0. 00 N	0. 00 N	95.00 96.00
applicable column. 7.00 If line 96 is "Y", enter the reduction percentage in the applica 8.00 Does title V or XIX follow Medicare (title XVIII) for the intern stepdown adjustments on Wkst. B, Pt. 1, col. 25? Enter "Y" for y	s and residents post	0. 00 Y	0. 00 Y	97.00 98.00
 column 1 for title V, and in column 2 for title XIX. 8.01 Does title V or XIX follow Medicare (title XVIII) for the report C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title 			Y	98.0
title XIX. 8.02 Does title V or XIX follow Medicare (title XVIII) for the calcul bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N for title V or dia column 2 for title XVIV		Y	Y	98.0
<pre>for title V, and in column 2 for title XIX. 8.03 Does title V or XIX follow Medicare (title XVIII) for a critical reimbursed 101% of inpatient services cost? Enter "Y" for yes or for title V, and in column 2 for title XIX.</pre>			N	98.0
 8.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reim outpatient services cost? Enter "Y" for yes or "N" for no in col in col unn 2 for title XIX. 		N	N	98.0
8.05 Does title V or XIX follow Medicare (title XVIII) and add back t Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in colum			Y	98.0
 column 2 for title XIX. 8.06 Does title V or XIX follow Medicare (title XVIII) when cost reim Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 f column 2 for title XIX. Rural Providers 		Y	Y	98.0
05.00Does this hospital qualify as a CAH?		Y		105.00
06.00 f this facility qualifies as a CAH, has it elected the all-incl for outpatient services? (see instructions)				106.00
07.00 If this facility qualifies as a CAH, is it eligible for cost rei training programs? Enter "Y" for yes or "N" for no in column 1. yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 reimbursed. If yes complete Wkst. D-2, Pt. II.	(see instructions) If			107.00
08.00 Is this a rural hospital qualifying for an exception to the CRNA (CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	fee schedule? See 4	2 N		108.00

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C		eriod: rom 10/01/		Workshe Part I		
		То	09/30/		Date/Ti 2/26/20	me Pre	epareo
	Physi cal	Occupati onal	Speec	h	Respi r	atory	
09.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	1.00 Y	2.00 Y	3.00 Y		4. (Y		109.
		1	I		1. (00	-
10.00 Did this hospital participate in the Rural Community Hospita Demonstration) for the current cost reporting period? Enter ' complete Worksheet E, Part A, lines 200 through 218, and Wor applicable.	"Y" for yes or	"N" for no. I	f yes,	;	Ν		110.
			1.00		2.0	00	+
11.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this construction for yes or "N" for no in column 1. If the response to construct on prong of the FCHIP demo in which this CAH is participate all that apply: "A" for Ambulance services; "B" for act for tele-health services.	ost reporting olumn 1 is Y, rticipating ir	period? Enter enter the column 2.	N				111.
				1.00	2.00	3.00	1
 Miscellaneous Cost Reporting Information 5.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percer psychiatric, rehabilitation and long term hospitals provider Pub. 15-1, chapter 22, §2208.1. 6.00 Is this facility classified as a referral center? Enter "Y" 7.00 Is this facility legally-required to carry malpractice insur 	. If column 2 nt for long te rs) based on 1 for yes or "N	is "E", enter erm care (inclu the definition W for no.	in column des in CMS	N		0	115. 116. 117.
no. 8.00 s the malpractice insurance a claims-made or occurrence pol		5		1			118.
claim-made. Enter 2 if the policy is occurrence.		Premi ums	Losses		Insur	ance	110.
			200000		, nou	unoo	
		1.00	2.00		3. (1
8.01 List amounts of malpractice premiums and paid losses:		334, 527		0		C)118.
			1.00		2. (00	1
8.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scheme			N				118.
and amounts contained therein. 9 OODO NOT USE THIS LINE	5						119
9.00 DO NOT USE THIS LINE 0.00 DO NOT USE THIS LINE 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualified Hold Harmless provision in ACA §3121 and applicable amendment	d Harmless pro n column 1, "\ ualifies for 1	(" for yes or the Outpatient	Ν		N		119. 120.
9.00D0 NOT USE THIS LINE D.00Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu	d Harmless pro n column 1, "\ ualifies for 1 nts? (see ins1	(" for yes or the Outpatient tructions)	N Y		N		
 0.00 D0 NOT USE THIS LINE 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendmere Enter in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost implations? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain heal thcare related taxes as defact? Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included. 	d Harmless pro n column 1, "\ ualifies for t nts? (see inst antable device fined in §1903	<pre>(" for yes or the Outpatient tructions) es charged to 3(w)(3) of the</pre>			N		120.
 0.00 D0 NOT USE THIS LINE 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendmenter Enter in column 2, "Y" for yes or "N" for no. 0.00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no. 0.00 Does the cost report contain healthcare related taxes as defact? Enter "Y" for yes or "N" for no in column 1. If column 7 the Worksheet A Line number where these taxes are included. Transplant Center Information 0.00 Does this facility operate a transplant center? Enter "Y" for 	d Harmless pro n column 1, "Y ualifies for t nts? (see inst antable device fined in §1903 1 is "Y", ente	(" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2	Y		N		120. 121. 122.
 0.00 D0 NOT USE THIS LINE 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendmer Enter in column 2, "Y" for yes or "N" for no. 0.00 Did this facility incur and report costs for high cost implate patients? Enter "Y" for yes or "N" for no. 0.00 Does the cost report contain healthcare related taxes as defact?Enter "Y" for yes or "N" for no in column 1. If column 7 the Worksheet A line number where these taxes are included. Transplant Center Information 0.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 0.00 If this is a Medicare certified kidney transplant center, enter enter for the set as a formation of the set as a formation of	d Harmless pro n column 1, "Y ualifies for t nts? (see inst antable device fined in §1903 1 is "Y", ente or yes and "N" nter the certi	<pre>(" for yes or the Outpatient tructions) es charged to 8(w)(3) of the er in column 2</pre>	YN		N		120. 121. 122. 125.
 0.00 D0 NOT USE THIS LINE 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendmere Enter in column 2, "Y" for yes or "N" for no. 0.00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no. 0.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included. Transplant Center Information 0.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 0.00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 2 	d Harmless pro n column 1, "Y ualifies for t nts? (see inst antable device fined in §1903 1 is "Y", ente or yes and "N" nter the certi 2. ter the certif	<pre>(" for yes or the Outpatient tructions) es charged to 8(w)(3) of the er in column 2 / for no. If fication date</pre>	YN		N		120. 121. 122. 125. 126.
 00 DO NOT USE THIS LINE 00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no. 00 Did this facility incur and report costs for high cost implate patients? Enter "Y" for yes or "N" for no. 00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1. Transplant Center Information 00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 00 If this is a Medicare certified kidney transplant center, entin column 1 and termination date, if applicable, in column 2. 	d Harmless pro n column 1, "Y ualifies for t nts? (see inst antable device fined in §1903 1 is "Y", ente or yes and "N" nter the certif 2. ter the certif 2. ter the certif	(" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2 ' for no. If fication date fication date	YN		N		120. 121. 122. 125. 126. 127. 128.
 0.00 DO NOT USE THIS LINE 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA \$3121 and applicable amendments? (see instructions) Enter in cnum 2, "Y" for yes or "N" for no. 0.00 Did this facility incur and report costs for high cost implate patients? Enter "Y" for yes or "N" for no. 0.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included. Transplant Center Information 0.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 0.01 If this is a Medicare certified heart transplant center, entin column 1 and termination date, if applicable, in column 2. 0.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2. 0.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2. 0.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2. 	d Harmless pro n column 1, "Y ualifies for t nts? (see inst antable device fined in §1903 1 is "Y", ente or yes and "N" nter the certi 2. ter the certif 2. er the certifi	(" for yes or the Outpatient tructions) es charged to B(w)(3) of the er in column 2 for no. If fication date fication date cation date in	Y N		N		120. 121. 122. 125. 126. 127. 128. 129.
 00 DO NOT USE THIS LINE 00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA \$3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no. 00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no. 00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 00 If this is a Medicare certified heart transplant center, entin column 1 and termination date, if applicable, in column 2. 00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2. 00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2. 00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2. 00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2. 00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2. 00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2. 00 If this is a Medicare certified pancreas transplant center, entin column 1 and termination date, if applicable, in column 2. 	d Harmless pro n column 1, "Y ualifies for t nts? (see inst antable device fined in §1903 1 is "Y", ente or yes and "N" nter the certif 2. ter the certif 2. er the certifi enter the certifi enter the certifi	<pre>(" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2 f for no. If fication date fication date fication date cation date in rtification</pre>	Y N		N		120. 121. 122. 125. 126. 127. 128. 129. 130.
 0.00 D0 NOT USE THIS LINE 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no. 0.00 Did this facility incur and report costs for high cost implate patients? Enter "Y" for yes or "N" for no. 0.00 Does the cost report contain heal thcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included. Transplant Center Information 0.00 Dif this is a Medicare certified kidney transplant center, entin column 1 and termination date, if applicable, in column 2. 0.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2. 0.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2. 0.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2. 0.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2. 0.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2. 0.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2. 0.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2. 0.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2. 0.00 If this is a Medicare certified pancreas transplant center, entin column 1 and termination date, if	d Harmless pro n column 1, ") ualifies for t nts? (see inst antable device fined in §1903 1 is "Y", ente or yes and "N" nter the certi 2. ter the certif 2. ter the certif 2. er the certif 2. er the certif 1. umn 2. r, enter the certif 1.umn 2.	(" for yes or the Outpatient tructions) es charged to 8(w)(3) of the er in column 2 f for no. If fication date fication date fication date in cation date in trification certification	Y N		N		120. 121. 122. 125. 126. 127. 128. 129. 130. 131.
 9.00 D0 NOT USE THIS LINE 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost implate patients? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain heal thcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included. Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 5.00 If this is a Medicare certified kidney transplant center, end in column 1 and termination date, if applicable, in column 2 7.00 If this is a Medicare certified liver transplant center, end in column 1 and termination date, if applicable, in column 2 9.00 If this is a Medicare certified liver transplant center, end in column 1 and termination date, if applicable, in column 2 9.00 If this is a Medicare certified liver transplant center, end in column 1 and termination date, if applicable, in column 2 9.00 If this is a Medicare certified liver transplant center, end in column 1 and termination date, if applicable, in column 2 9.00 If this is a Medicare certified liver transplant center, end in column 1 and termination date, if applicable, in column 2 9.00 If this is a Medicare certified liver transplant center, end in column 1 and termination date, if applicable, in column 2 9.00 If this is a Medicare certified liver transplant center, end in column 1 and termination date, if applicable, in column 2 9.00 If this is a Medicare certified pancreas transplant center, end in column 1 and termination date, if applic	d Harmless pro n column 1, "Y ualifies for t nts? (see inst antable device fined in §1903 1 is "Y", ente or yes and "N" nter the certif 2. ter the certif 2. er the certifi enter the certifi enter the certifi lumn 2. r, enter the certif 1umn 2. ter the certif 2.	(" for yes or the Outpatient tructions) es charged to B(w)(3) of the er in column 2 for no. If fication date fication date cation date in rtification certification fication date	Y N		N		120. 121.

Health Financial Systems	JAY COUNTY	HOSPI TAL			In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provider CC	CN: 15-1320		od: 10/01/2016 09/30/2017		epared:
					1.00	2.00	-
140.00 Are there any related organization chapter 10? Enter "Y" for yes or ' are claimed, enter in column 2 the 1.00	'N" for no in column 1. I	f yes, and home r. (see instruc	office c		Y 3.00	2.00	140.00
If this facility is part of a cha	n organization, enter or	lines 141 thro	ough 143 t	the name		of the home	
office and enter the home office of 141.00Name:	<u>contractor name and contr</u> Contractor's Name:	actor number.	Contr	actor's	Numbors		141.00
142. 00 Street: 143. 00 Ci ty:	PO Box: State:		Zip C				142.00 143.00
						1.00	-
144.00 Are provider based physicians' cos	sts included in Worksheet	Α?				Y	144.00
				-	1.00	2.00	-
145.00 If costs for renal services are cl inpatient services only? Enter "Y" no, does the dialysis facility inc period? Enter "Y" for yes or "N"	' for yes or "N" for no i clude Medicare utilizatio for no in column 2.	n column 1. If n for this cost	column 1 reportin	g		2.00	145.00
146.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/d	n column 1. (See CMS Pub.	ously filed cos 15-2, chapter	t report? 40, §4020)) f	N		146.00
						1.00	+
147.00 Was there a change in the statisti						N	147.00
148.00 Was there a change in the order of 149.00 Was there a change to the simplifi				for no		N N	148.00 149.00
149. Johnas there a change to the shipitin	eu cost friturny methou?	Part A	Part		Title V	Title XIX	149.00
		1.00	2.00)	3.00	4.00	
Does this facility contain a provi or charges? Enter "Y" for yes or '							
155.00Hospi tal		N	N		N	N	155.00
156.00 Subprovi der – IPF		N	N		N	N	156.00
157. 00 Subprovi der – IRF 158. 00 SUBPROVI DER		N	N		Ν	N	157.00 158.00
159. 00 SNF		N	N		Ν	N	159.00
160.00 HOME HEALTH AGENCY		N	N		N	N	160.00
161. 00 CMHC 161. 10 CORF			N N		N N	N N	161.00 161.10
						1.00	
Multicampus 165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that has o		uses in d	li fferent	CBSAs?	Ν	165.00
	Name O	<u>County</u> 1.00	State 2.00	Zip Coo 3.00	4.00	FTE/Campus 5.00	-
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)		1.00	2.00	3.00	4.00		0166.00
						1.00	1
Health Information Technology (HI					ct		
167.00 Is this provider a meaningful user 168.00 If this provider is a CAH (line 10 reasonable cost incurred for the H	D5 is "Y") and is a meani	ngful user (lin			ter the	Y	167.00 168.00
168.01 If this provider is a CAH and is a					ardshi p		168.01
exception under §413.70(a)(6)(ii)' 169.00 If this provider is a meaningful of transition factor. (see instruction	user (line 167 is "Y") an			is "N")			169.00
					Begi nni ng	Endi ng	-
170.00 Enter in columns 1 and 2 the EHR I period respectively (mm/dd/yyyy)	beginning date and ending	date for the r	eporting	1	<u>1.00</u> 10/01/2016	2.00 09/30/2017	170.00

Health Financial Systems	JAY COUNTY HO	SPI TAL	In Lie	eu of Form CMS	6-2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DATA	Provider CCN: 15-1320	Period: From 10/01/2016	Worksheet S	-2	
			To 09/30/2017			
			1.00	2.00		
171.00 If line 167 is "Y", does this provide	er have any days for indiv	viduals enrolled in	N		0171.00	
	section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter					
	"Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section					
1876 Medicare days in column 2. (see	instructions)					

10SPI T	Financial Systems JAY COUNTY AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNALRE	HOSPITAL Provider C	CN: 15-1320	Peri od:	u of Form CMS Worksheet S-	
100111			UN. 13 1320	From 10/01/2016 To 09/30/2017	Part II Date/Time Pr 2/26/2018 1:	repared
		1		Y/N	Date	
				1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter M mm/dd/yyyy format.	N for all NO r	esponses. En	ter all dates in	the	
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation					_
I. 00	Has the provider changed ownership immediately prior to the	e beainnina of	the cost	N		1.0
	reporting period? If yes, enter the date of the change in a					
			Y/N	Date	<u>V/I</u>	
2.00	Has the provider terminated participation in the Medicare F	Program? If	1.00 N	2.00	3.00	2.0
3. 00	yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary. Is the provider involved in business transactions, includir	mn 3, "V" for	N			3.0
5. 00	contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provid Officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug der or its of the board	IN IN			5.
			Y/N	Туре	Date	
			1.00	2.00	3.00	
	Financial Data and Reports		N		04/04/0010	
1.00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	For Compiled,	N	A	04/01/2018	4.0
5.00	Are the cost report total expenses and total revenues diffe		N			5.0
	those on the filed financial statements? If yes, submit rec	conciliation.		V /N	Logal Open	_
				Y/N 1.00	Legal Oper. 2.00	
	Approved Educational Activities		-		2.00	
o. 00	Column 1: Are costs claimed for nursing school? Column 2:	lfyes, is t	he provider i	s N		6.0
7.00 3.00	the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved		d duri na tho	N N		7. (
	cost reporting period? If yes, see instructions.		0			
9.00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction	ns.				9.
10.00	Was an approved Intern and Resident GME program initiated of cost reporting period? If yes, see instructions.			N		10.
1.00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	l & R in an Ap	proved	N		11.
					Y/N 1.00	
	Bad Debts		-		1.00	
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			cost reporting	Y N	12. 13.
4.00		ents waived? I	fyes, see in	nstructions.	N	14.
F 00	Bed Complement	ng nori od 2 Lf		atruationa	N	1.5
5.00	Did total beds available change from the prior cost reporti		<u>yes, see m</u>	Par	<u>N</u>	15.
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
6.00	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	N		N		16.0
7.00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Y	01/05/2018	Y	01/05/2018	17.
8.00	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	Ν		Ν		18.
9. 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	Ν		Ν		19.

HOSPI T	Financial Systems JAY COUNTY AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNALRE		CCN: 15-1320	Period: From 10/01/2016 To 09/30/2017	Worksheet S Part II	repared:
		Descr	iption	Y/N	Y/N	
			0	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
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EDT CHILDRENS			1.00	
	Capital Related Cost		HUSH TALS)			
22.00	Have assets been relifed for Medicare purposes? If yes, see	e instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense			ing the cost	N	23.00
23.00	reporting period? If yes, see instructions.		Sal S liade dui	The cost	IN IN	23.00
24.00	Were new leases and/or amendments to existing leases entero If yes, see instructions	ed into during	this cost re	eporting period?	Ν	24.00
25.00	Have there been new capitalized leases entered into during	the cost rend	rting period?	lfves see	Y	25.00
_0.00	instructions.	003t i ept	. the period:	. , ,00, 300	,	20.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during th	he cost report	ing period?	f yes, see	Ν	26.00
	instructions.		3 1	J * * . * *		
27.00	Has the provider's capitalization policy changed during the	e cost reporti	ng period? If	yes, submit	Ν	27.00
	сору.					
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit en	ntered into du	iring the cost	reporting	N	28.00
	period? If yes, see instructions.					
29.00	Did the provider have a funded depreciation account and/or		ebt Service H	Reserve Fund)	Y	29.00
20.00	treated as a funded depreciation account? If yes, see inst				N	20.00
30.00	Has existing debt been replaced prior to its scheduled matu	urity with new	debt? IT yes	s, see	N	30.00
31.00	instructions. Has debt been recalled before scheduled maturity without is	ssuance of now	dobt2 If you	500	Ν	31.00
31.00	instructions.	SSUALICE OF THEM	debt? IT yes	s, see	IN	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care se	rvices furnish	ed through co	ontractual	N	32.00
	arrangements with suppliers of services? If yes, see instru					
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 ap		ng to competi	tive bidding? If	N	33.00
	no, see instructions.		0 1	0		
	Provi der-Based Physi ci ans					
34.00	Are services furnished at the provider facility under an a	rrangement wit	h provider-ba	ised physicians?	Y	34.00
	lf yes, see instructions.					
35.00	If line 34 is yes, were there new agreements or amended exi		ents with the	provi der-based	N	35.00
	physicians during the cost reporting period? If yes, see in	nstructions.				
				Y/N	Date	_
				1.00	2.00	
26 00	Home Office Costs Were home office costs claimed on the cost report?			N		36.00
	If line 36 is yes, has a home office cost statement been p	ronarod by the	home office?			36.00
57.00	If yes, see instructions.	iepareu by the		IN		37.00
38.00	If line 36 is yes, was the fiscal year end of the home of	fice different	from that of	- N		38.00
	the provider? If yes, enter in column 2 the fiscal year end					
39.00	If line 36 is yes, did the provider render services to othe			5, N		39.00
	see instructions.		J = -			
40.00	If line 36 is yes, did the provider render services to the	home office?	lf yes, see	Ν		40.00
	instructions.					
		1.	00	2.	00	
11 00	Cost Report Preparer Contact Information	TINA		CEVEDO		41.00
		TINA		SEVERS		41.00
41.00	held by the cost report preparer in columns 1, 2, and 3,					
41.00						11
	respectively. Enter the employer/company name of the cost report	BILIF&CO II	C			42 00
	Enter the employer/company name of the cost report	BLUE & CO., LI	_C			42.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LI 317-713-7946	_C	TSEVERS@BLUEAN	DCO. COM	42.00

Health Financial Systems JAY CO	INTY HOSPI TAL	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIR	Provider CCN: 15-1320	Period: From 10/01/2016	Worksheet S-2 Part II	
		To 09/30/2017		pared: 6 pm
	3.00			
Cost Report Preparer Contact Information				
41.00 Enter the first name, last name and the title/position	MANAGER			41.00
held by the cost report preparer in columns 1, 2, and	3,			
respectively.				
42.00 Enter the employer/company name of the cost report				42.00
preparer.				
43.00 Enter the telephone number and email address of the co	st			43.00
report preparer in columns 1 and 2, respectively.				

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	JAY COUNTY	Provi der C	CN: 15-1320	Peri od:	u of Form CMS-2 Worksheet S-3	
105111	ALE AND HOST THE HEALTH OAKE COMPLEX STATISTIC			CN. 15 1520	From 10/01/2016		
					To 09/30/2017	Date/Time Pre	
						2/26/2018 1:5	6 pm
						I/P Days / O/P Visits /	
						Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
	component	Line Number	No. of Deus	Avai I abl e	onit fibur 5	intro v	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		25			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)						2.0
. 00	HMO IPF Subprovider						3.0
. 00	HMO IRF Subprovider						4.0
. 00	Hospital Adults & Peds. Swing Bed SNF					0	5.0
. 00	Hospital Adults & Peds. Swing Bed NF					0	6.0
. 00	Total Adults and Peds. (exclude observation		25	9, 12	25 57, 408. 00	0	7.0
	beds) (see instructions)						
. 00	INTENSIVE CARE UNIT	31.00	0		0 0.00	0	8.0
. 00	CORONARY CARE UNIT						9.0
0.00	BURN INTENSIVE CARE UNIT	33.00	0		0 0.00	0	
1.00	SURGICAL INTENSIVE CARE UNIT						11.0
2.00	OTHER SPECIAL CARE (SPECIFY)					_	12.0
3.00	NURSERY	43.00				0	13.0
4.00	Total (see instructions)		25	9, 12	25 57, 408. 00	0	
5.00	CAH visits	10.00	10	2.45		0	
6.00	SUBPROVIDER - IPF	40.00	10			0	
7.00 8.00	SUBPROVIDER - IRF	41.00	0		0	0	17.0 18.0
9.00	SUBPROVIDER SKILLED NURSING FACILITY	42.00	0		0	0	18.0
9.00 0.00	NURSING FACILITY						20. 0
1.00	OTHER LONG TERM CARE						20.0
2.00	HOME HEALTH AGENCY						22.0
3.00	AMBULATORY SURGICAL CENTER (D. P.)						23.0
4.00	HOSPI CE						24.0
4.10	HOSPICE (non-distinct part)	30, 00					24.
5.00	CMHC - CMHC	30.00					25.0
5.10	CMHC - CORF	99. 10				0	
6.00	RURAL HEALTH CLINIC	88.00				0	
6.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.2
7.00	Total (sum of lines 14-26)	0,100	35			Ũ	27.0
8.00	Observation Bed Days					0	
9.00	Ambul ance Trips					-	29.0
0.00	Employee discount days (see instruction)						30.0
1.00	Employee discount days - IRF						31. (
2.00	Labor & delivery days (see instructions)		0		0		32.0
2.01	Total ancillary labor & delivery room						32.0
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33.0
3 01	LTCH site neutral days and discharges						33.0

OSPI TA	L AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC		Period: From 10/01/2016 To 09/30/2017		epare
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2	1, 058	16	2, 39			1.
	for the portion of LDP room available beds)	100					
	HMO and other (see instructions)	102	0				2.
	HMO I PF Subprovi der HMO I RF Subprovi der	33	0				4.
	Hospital Adults & Peds. Swing Bed SNF	249	0	35	1		5
	Hospital Adults & Peds. Swing Bed SM	247	0		5		6
00	Total Adults and Peds. (exclude observation beds) (see instructions)	1, 307	16	2, 75			7
	INTENSIVE CARE UNIT	0	0		0		8
00 00	CORONARY CARE UNIT						9
00	BURN INTENSIVE CARE UNIT	0	0		0		10
. 00	SURGI CAL I NTENSI VE CARE UNI T						11
. 00	OTHER SPECIAL CARE (SPECIFY)						12
	NURSERY		0	18			13
	Total (see instructions)	1, 307	16	2, 94	4 0.00	296.16	
	CAH visits	0	0		0		15
	SUBPROVIDER - IPF	673	21	1,06			
	SUBPROVIDER - IRF	0	0		0.00		
	SUBPROVIDER		0		0 0.00	0.00	
	SKILLED NURSING FACILITY						19
	NURSING FACILITY						20
	OTHER LONG TERM CARE						21
	HOME HEALTH AGENCY						22
	AMBULATORY SURGICAL CENTER (D. P.)						23
	HOSPI CE				~		24
	HOSPICE (non-distinct part)	0	0		0		24
	CMHC - CMHC	0			0 0 00	0.00	25
	CMHC - CORF	0	0		0 0.00 0 0.00		
	RURAL HEALTH CLINIC	0	0				
	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.00 0.00		
	Total (sum of lines 14-26) Observation Bed Days		0	28		310.47	28
	Ambulance Trips	0	0	28	'		28
	Employee discount days (see instruction)	0			0		30
	Employee discount days (see fisting to the fisting the fisting to				0		31
	Labor & delivery days (see instructions)	0	0	3			32
	Total ancillary labor & delivery room	0	0	-	0		32
	outpatient days (see instructions)				Ĭ		52
	LTCH non-covered days	0					33
	LTCH site neutral days and discharges	0					33

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	JAY COUNTY H	Provider CC	CN: 15-1320	Period: From 10/01/2016 To 09/30/2017	u of Form CMS-2 Worksheet S-3 Part I Date/Time Pre 2/26/2018 1:5	pared:
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 21.00 21.00 23.00 24.00 23.00 24.00 25.00 25.00 25.00 25.00 26.00 27.00 28.00 29.00 30.00 21.00 25.00 20.0	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) 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) INTENSI VE CARE UNIT CORONARY CARE UNIT BURN INTENSI VE CARE UNIT SURGICAL INTENSI VE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CORF RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instructions) Total ancillary labor & delivery room	0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	0	3.	14.00 38 8 32 0 0 0 38 8 57 2 0 0 0 0	816 816 148 0 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 14.00
33. 00 33. 01	outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges				0 0		33.00 33.01

Heal th	Financial Systems	JAY COUNTY HOS	PI TAL		In Lie	u of Form CMS	-2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CC	CN: 15-1320	Peri od:	Worksheet S-	10
					From 10/01/2016 To 09/30/2017		
	Uncompensated and indigent care cost compute	ati on				1.00	
1.00	Cost to charge ratio (Worksheet C, Part I Li		vided by Li	ne 202 colum	n 8)	0. 30300	1 1.00
1.00	Medicaid (see instructions for each line)		vided by ii		11 0)	0. 30300	1 1.00
2.00	Net revenue from Medicaid					2, 013, 15	5 2.00
3.00	Did you receive DSH or supplemental payments	s from Medicaid?				_, _, _,	3.00
4.00	If line 3 is yes, does line 2 include all DS		tal payment	s from Medic	ai d?		4.00
5.00	If line 4 is no, then enter DSH and/or suppl	lemental payments f	rom Medicai	d		(5.00
6.00	Medi cai d charges					11, 629, 85	
7.00	Medicaid cost (line 1 times line 6)		(1			3, 523, 85	
8.00	Difference between net revenue and costs for < zero then enter zero)	1 0			nes 2 and 5; if	1, 510, 70	8.00
0 00	Children's Health Insurance Program (CHIP) ((see instructions f	or each lin	ie)			
9.00 10.00	Net revenue from stand-alone CHIP Stand-alone CHIP charges						9.00
11.00	Stand-alone CHIP cost (line 1 times line 10))					11.00
12.00	Difference between net revenue and costs for		(line 11 mi	nus line 9 [.]	if < zero then		12.00
.2.00	enter zero)		(1110 11		2010 11011		.2.00
	Other state or local government indigent car	re program (see ins	tructions f	or each line)		
	Net revenue from state or local indigent car						13.00
14.00	Charges for patients covered under state or	local indigent car	e program (Not included	in lines 6 or		0 14.00
45 00							15 00
15.00 16.00	State or local indigent care program cost (I Difference between net revenue and costs for			program (Li	no 15 minue line		15.00 16.00
10.00	13; if < zero then enter zero)		urgent care	e program (ri		:	10.00
	Grants, donations and total unreimbursed cos	st for Medicaid, CH	IP and stat	e/local indi	gent care progra	ams (see	
	instructions for each line)						
17.00	Private grants, donations, or endowment inco						0 17.00
18.00 19.00	Government grants, appropriations or transfe				o (our of lines) 18.00) 19.00
19.00	Total unreimbursed cost for Medicaid , CHIP 8, 12 and 16)	and state and roca	r rhurgent	care program	s (sum of filles	1, 510, 70	19.00
				Uni nsured	Insured	Total (col. 1	
			-	patients	patients	+ col. 2)	
	Uncomponented Caro (coo instructions for one	sh lino)		1.00	2.00	3.00	-
20.00	Uncompensated Care (see instructions for eac Charity care charges and uninsured discounts		cility	597, 40	01 0	597, 40	1 20.00
20.00	(see instructions)		onney	0,7,10		077,10	20.00
21.00	Cost of patients approved for charity care a	and uninsured disco	unts (see	181, 0 ⁻	3 0	181, 01	3 21.00
	instructions)						
22.00	Payments received from patients for amounts	previously written	off as		0 0	(22.00
22.00	charity care	N N		101 0	3 0	101 01	
23.00	Cost of charity care (line 21 minus line 22))		181, 01	3 0	181, 01	3 23.00
						1.00	
24.00	Does the amount on line 20 column 2, include	e charges for patie	nt days bey	ond a length	of stay limit		24.00
	imposed on patients covered by Medicaid or o	other indigent care	program?	0	3		
25.00	If line 24 is yes, enter the charges for pat stay limit	tient days beyond t	he indigent	care progra	m's length of		25.00
26.00	Total bad debt expense for the entire hospit	tal complex (see in	structions)			1, 699, 86	5 26.00
27.00	Medicare reimbursable bad debts for the enti	ire hospital comple	x (see inst	ructions)		386, 04	27.00
27.01	Medicare allowable bad debts for the entire	hospital complex (see instruc	tions)		593, 90	
28.00	Non-Medicare bad debt expense (line 26 minus					1, 105, 95	1
29.00	Cost of non-Medicare and non-reimbursable Me		pense (see	instructions)	542, 97	
30.00	Cost of uncompensated care (line 23 column 3		ing 20)			723, 98	
31.00	Total unreimbursed and uncompensated care co	ust (Time ta binz t	ine 30)			2, 234, 68	/ 31.00

	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	JAY COUNTY I	HOSPI TAL Provi der Ci	CN: 15-1320 P	In Lie eriod:	u of Form CMS-2 Worksheet A	2552-10
				F	rom 10/01/2016 o 09/30/2017	Date/Time Pre	pared:
	Cost Center Description	Sal ari es	Other	Total (col 1	Recl assi fi cat	2/26/2018 1:5 Recl assi fi ed	
		Sararres	other	+ col . 2)	ions (See	Trial Balance	
					A-6)	(col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
2.00	GENERAL SERVICE COST CENTERS 00200 NEW CAP REL COSTS-MVBLE EQUIP		1, 834, 083	1, 834, 083	0	1, 834, 083	2.00
2.00	00201 NEW CAP REL COSTS-MVBLE EQUIP MOB		8, 689			8, 689	2.00
2.02	00202 NEW CAP REL COSTS-MVBLE EQUIP-POB		101, 949		0	101, 949	2.02
2.03 4.00	00203 NEW CAP REL COSTS-MVBLE EQUIP- WJ 00400 EMPLOYEE BENEFITS DEPARTMENT	o	31, 142 2, 665, 450		0	31, 142 2, 665, 450	2.03 4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	2, 296, 687	5, 492, 795		0	7, 789, 482	5.00
7.00 7.01	00700 OPERATION OF PLANT 00701 OPERATION OF PLANT-MOB	277, 282 0	947, 639 46, 243		-22, 813 12, 575	1, 202, 108 58, 818	7.00 7.01
7.02	00702 OPERATION OF PLANT-POB	0	91, 096				7.02
7.03	00703 OPERATION OF PLANT-WJ	0	0	, s	3, 450	3, 450	7.03
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	56, 001 395, 845	44, 153 60, 551			100, 154 456, 396	8.00 9.00
10.00	01000 DI ETARY	360, 323	282, 220		-269, 407	373, 136	10.00
11.00 13.00	01100 CAFETERIA 01300 NURSI NG ADMI NI STRATI ON	0 1, 033, 328	0 13, 746	-	269, 407 0	269, 407 1, 047, 074	11.00 13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	63, 011	7, 780		0	70, 791	14.00
16.00	01600 MEDICAL RECORDS & LIBRARY	335, 105	60, 922	396, 027	0	396, 027	16.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	1, 424, 263	176, 448	1, 600, 711	-128, 192	1, 472, 519	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	0		0	0	31.00
33.00	03300 BURN I NTENSI VE CARE UNI T	0	175 201	-	0	0	33.00
40.00 41.00	04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF	676, 362 0	175, 381 0	851, 743 0	0	851, 743 0	40.00 41.00
42.00	04200 SUBPROVI DER	0	0		0	0	42.00
43.00	04300 NURSERY ANCI LLARY SERVICE COST CENTERS	0	0	0	103, 605	103, 605	43.00
50.00	05000 OPERATING ROOM	812, 211	595, 221	1, 407, 432	-31, 310	1, 376, 122	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	-	24, 587	24, 587	52.00
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0 785, 205	969, 583 669, 009		0	969, 583 1, 454, 214	53.00 54.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00 59.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0 661, 200	1, 321, 600	1, 982, 800	0	0 1, 982, 800	59.00 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	0	371, 414 689, 144			371, 414 595, 732	65.00 66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0007, 144		74, 188		
68.00	06800 SPEECH PATHOLOGY	0	0	0	19, 224	19, 224	68.00
69.00 71.00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	186, 604 0	164, 190 0			350, 794 0	69.00 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	434, 970	1, 715, 286	2, 150, 256	0	2, 150, 256	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	89.00
90. 00 90. 01	09000 CLINIC 09001 FAMILY PRACTICE OF JAY COUNTY	0 1, 625, 156	164, 046 277, 056			164, 046 1, 902, 212	90.00 90.01
	09002 JAY FAMILY MEDICINE	1, 634, 938	250, 359			1, 885, 297	
91.00	09100 EMERGENCY	2, 098, 925	416, 664	2, 515, 589	0	2, 515, 589	
92.00 93.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) 04040 OTHER OUTPATIENT SERVICE COST CENTER	771	18, 979	19, 750	0	19, 750	92.00 93.00
	OTHER REIMBURSABLE COST CENTERS			1			
99.10	09910 CORF SPECIAL 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	0		109.00
	11000 I NTESTI NAL ACQUI SI TI ON 11100 I SLET ACQUI SI TI ON	0	0	0	0		110.00 111.00
	11300 I NTEREST EXPENSE	0	0	0	0		113.00
118.00		15, 158, 187	19, 662, 838	34, 821, 025	0	34, 821, 025	118.00
190. 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200 PHYSI CI ANS' PRI VATE OFFI CES	o	0	0	-	0	192.00
	19300 NONPAI D WORKERS	0	0	0	0		193.00 194.00
	07950 MOB 07951 POB	0	0	0	0		194.00 194.01
194.02	07952 WEST JAY CLINIC	615, 672	33, 712			649, 384	194.02
	07953 CONVENIENT CARE 07954 OTHER NONREIMBURSABLE COST CENTERS	195, 278 0	13, 595 0		0	208, 873	194.03 194.04
	07955 OTHER NONREIMBURSABLE COST CENTERS	0	0	-	0		194.04 194.05
							·

Health Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (OF EXPENSES	Provider C		eri od:	Worksheet A	
				rom 10/01/2016		
				o 09/30/2017	Date/Time Pre 2/26/2018 1:5	
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cat	Recl assi fi ed	
			+ col. 2)	ions (See	Trial Balance	
				A-6)	(col. 3 +-	
					col. 4)	
	1.00	2.00	3.00	4.00	5.00	
194.0607956 TRI COUNTY	245, 418	1, 228, 124	1, 473, 542	0	1, 473, 542	194.06
194. 07 07957 HOSPI TALI ST	431, 393	95, 834	527, 227	0	527, 227	194.07
194.0807958 FAMILY FIRST HEALTH	799, 007	107, 558	906, 565	0	906, 565	194.08
194.0907959 MERIDIAN HEALTH CONVENIENT CARE	0	0	C	0	0	194.09
200.00 TOTAL (SUM OF LINES 118 through 199)	17, 444, 955	21, 141, 661	38, 586, 616	0	38, 586, 616	200.00

	IFICATION AND ADJUSTMENTS OF TRIAL BALANCE O		Provider CO	 Period: From 10/01/2016 To 09/30/2017		repare
	Cost Center Description	Adjustments	Net Expenses		2/26/2018 1:	
	cost center bescription	(See A-8)	For			
		. ,	Allocation			
0		6.00	7.00			_
	GENERAL SERVICE COST CENTERS	120 240	1 705 725			
	DO200 NEW CAP REL COSTS-MUBLE EQUIP DO201 NEW CAP REL COSTS-MUBLE EQUIP MOB	-128, 348 0	1, 705, 735 8, 689			2.
	DO202 NEW CAP REL COSTS-MVBLE EQUIP-POB	0	101, 949			2.
	DO203 NEW CAP REL COSTS-MVBLE EQUIP- WJ	0	31, 142			2.
	DO400 EMPLOYEE BENEFITS DEPARTMENT	3, 703, 057	6, 368, 507			4.
0 0	DO500 ADMI NI STRATI VE & GENERAL	-1, 824, 966	5, 964, 516			5
	DO700 OPERATION OF PLANT	0	1, 202, 108			7.
	00701 OPERATION OF PLANT-MOB	0	58, 818			7.
	00702 OPERATION OF PLANT-POB	0	97, 884			7.
	DO703 OPERATION OF PLANT-WJ DO800 LAUNDRY & LINEN SERVICE	0	3, 450			7.
	00900 HOUSEKEEPING	0	100, 154 456, 396			9.
	D1000 DI ETARY	0	373, 136			10
	D1100 CAFETERI A	-193, 217	76, 190			11.
. 00 0	D1300 NURSING ADMINISTRATION	-15,834	1, 031, 240			13.
	01400 CENTRAL SERVICES & SUPPLY	0	70, 791			14.
	01600 MEDICAL RECORDS & LIBRARY	-14, 803	381, 224			16.
	NPATIENT ROUTINE SERVICE COST CENTERS	-	4 470 545			
	D3000 ADULTS & PEDIATRICS D3100 INTENSIVE CARE UNIT	0				30.
	D3300 BURN INTENSIVE CARE UNIT	0	0			31
	04000 SUBPROVI DER – I PF	0	851, 743			40.
	04100 SUBPROVI DER – I RF	0	0			41
. 00 0	04200 SUBPROVI DER	0	0			42.
	04300 NURSERY	0	103, 605			43.
	ANCI LLARY SERVICE COST CENTERS	0	4 07(400			
	D5000 OPERATING ROOM D5200 DELIVERY ROOM & LABOR ROOM	0	1, 376, 122 24, 587			50.
	D5300 ANESTHESI OLOGY	-969, 583	24, 587			53.
	05400 RADI OLOGY-DI AGNOSTI C	0,000	1, 454, 214			54.
	D5700 CT SCAN	0	0			57.
	D5800 MAGNETIC RESONANCE IMAGING (MRI)	0	0			58.
	05900 CARDI AC CATHETERI ZATI ON	0	0			59
	06000 LABORATORY	-65,000	1, 917, 800			60
	06001 BLOOD LABORATORY	0	0			60.
	D6500 RESPI RATORY THERAPY D6600 PHYSI CAL THERAPY	0 -29, 881	371, 414 565, 851			65.
	06700 OCCUPATI ONAL THERAPY	-27,001	74, 188			67.
	06800 SPEECH PATHOLOGY	0	19, 224			68.
	06900 ELECTROCARDI OLOGY	-29, 261	321, 533			69.
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			71.
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	31, 310			72
	D7300 DRUGS CHARGED TO PATIENTS	-379, 148	1, 771, 108			73.
	DUTPATIENT SERVICE COST CENTERS	0	0			88
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0			89.
	09000 CLINIC	-115, 970				90
	D9001 FAMILY PRACTICE OF JAY COUNTY	-1, 548, 676				90
	09002 JAY FAMILY MEDICINE	-1, 477, 553				90
	09100 EMERGENCY	-1, 681, 452	834, 137			91
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	~	10 750			92
	D4040 OTHER OUTPATIENT SERVICE COST CENTER DTHER REIMBURSABLE COST CENTERS	0	19, 750			93.
	09910 CORF	0	0			99
	SPECIAL PURPOSE COST CENTERS					
5. 00 1	10600 HEART ACQUI SI TI ON	0	0			106
	10900 PANCREAS ACQUISITION	0	0			109
	11000 INTESTINAL ACQUISITION	0	0			110
	11100 I SLET ACQUI SI TI ON	0	0			111
3.001 3.00	I1300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	0 -4, 770, 635	0 30, 050, 390			113
-	IONREIMBURSABLE COST CENTERS	-4,770,035	30, 030, 390			\dashv
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0			190
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0			192
3. 00 1	19300 NONPAI D WORKERS	0	0			193
	07950 MOB	0	0			194.
	07951 POB	0	0			194
	07952 WEST JAY CLINIC	-649, 384	0			194.
	07953 CONVENIENT CARE	-208, 873	0			194.
	07954 OTHER NONREIMBURSABLE COST CENTERS 07955 OTHER NONREIMBURSABLE COST CENTERS	0	0			194. 194.
	JIJJJJJULIEN NUNNET NUDURJADEL GUJT GENTERJ	0	. 0			1174.

Health Financial Systems	JAY COUNTY	HOSPI TAL		In Lieu	u of Form CMS-	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (E OF EXPENSES Provider CCN: 15			Period:	Worksheet A	
				From 10/01/2016 To 09/30/2017	Date/Time Pre 2/26/2018 1:5	epared: 56 pm
Cost Center Description	Adjustments	Net Expenses				
	(See A-8)	For				
		Allocation				
	6.00	7.00				
194. 07 07957 H0SPI TALI ST	0	527, 227				194.07
194.0807958 FAMILY FIRST HEALTH	0	906, 565				194.08
194.0907959 MERIDIAN HEALTH CONVENIENT CARE	0	0				194.09
200.00 TOTAL (SUM OF LINES 118 through 199)	-5, 628, 892	32, 957, 724				200.00

Heal th	Financial Systems		JAY COUNTY H	IOSPI TAL		In Lieu	J of Form CMS-2552-1
RECLAS	SI FI CATI ONS			Provider C	CCN: 15-1320	Period: From 10/01/2016	Worksheet A-6
						To 09/30/2017	Date/Time Prepared: 2/26/2018 1:56 pm
		Increases					
	Cost Center	Line #	Sal ary	0ther			
	2.00	3.00	4.00	5.00			
	A - NURSERY RECLASS						
1.00	NURSERY	43.00	95, 130	8, 475			1.00
	TOTALS		95, 130	8, 475			
	B - LABOR & DELIVERY						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	22, 660	1, 927			1.00
	TOTALS	T	22, 660	1, 927			
	C – CAFETERIA						
1.00	CAFETERIA	11.00	151, 077	118, 330			1.00
	TOTALS		151,077	118, 330			
	D - MOB, POB, WEST JAY MAINT						
1.00	OPERATION OF PLANT-MOB	7.01	12, 575	0			1.00
2.00	OPERATION OF PLANT-POB	7.02	6, 788	0			2.00
3.00	OPERATION OF PLANT-WJ	7.03	3, 450	0			3.00
	TOTALS		22, 813	0			
	E - OT ST RECLASS	·					
1.00	OCCUPATIONAL THERAPY	67.00	0	74, 188			1.00
2.00	SPEECH PATHOLOGY	68.00	0	19, 224			2.00
	TOTALS	+	0	93, 412			1
	F - IMPLANTABLE DEVICES	· · ·	· · · · ·				
1.00	IMPL. DEV. CHARGED TO	72.00	0	31, 310			1.00
	PATI ENTS			-			
	TOTALS	+	o	31, 310	1		
500 00	Grand Total: Increases		291, 680	253, 454			500.00

Heal th	Financial Systems		JAY COUNTY H	OSPI TAL		In Lieu	u of Form CMS-2552-10
RECLAS	SIFICATIONS			Provi der	CCN: 15-1320	Period:	Worksheet A-6
					_	From 10/01/2016 To 09/30/2017	Date/Time Prepared: 2/26/2018 1:56 pm
		Decreases					
	Cost Center	Line #	Sal ary	0ther	Wkst. A-7 Ref	f.	
	6.00	7.00	8.00	9.00	10.00		
	A - NURSERY RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	95, 130	8, 475	5	0	1.00
	TOTALS		95, 130	8, 475	5		
	B - LABOR & DELIVERY						
1.00	ADULTS & PEDIATRICS	30.00	22, 660	1, 927	7	0	1.00
	TOTALS		22, 660	1, 927	7		
	C – CAFETERIA						
1.00	DI ETARY	10.00	151, 077	118, 330)	0	1.00
	TOTALS		151, 077	118, 330	0		
	D - MOB, POB, WEST JAY MAINT						
1.00	OPERATION OF PLANT	7.00	22, 813	C)	0	1.00
2.00		0.00	0	C	D	0	2.00
3.00		0.00	0	C		0	3.00
	TOTALS		22, 813	C)		
	E - OT ST RECLASS						
1.00	PHYSI CAL THERAPY	66.00	0	93, 412	2	0	1.00
2.00		0.00	0	C		0	2.00
	TOTALS		0	93, 412	2		
	F - IMPLANTABLE DEVICES						
1.00	OPERATING ROOM	50.00	0	31, 310)	0	1.00
	TOTALS		0	31, 310)		
500.00	Grand Total: Decreases		291, 680	253, 454	1		500.00

	Financial Systems	JAY COUNTY				u of Form CMS-2	
RECONCI	LIATION OF CAPITAL COSTS CENTERS		Provider CC		Period: From 10/01/2016 To 09/30/2017		pared:
				Acqui si ti on	S		
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2.00	3.00	4.00	5.00	
P	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	T BALANCES					
1.00 L	Land	347, 733	0		0 0	0	1.00
2.00 L	Land Improvements	952, 332	0		0 0	0	2.00
3.00 E	Buildings and Fixtures	24, 038, 676	3, 081, 069		0 3, 081, 069	0	3.00
1.00 E	Building Improvements	, o	0		0 0	0	4.00
5.00 F	Fixed Equipment	18, 320, 218	2, 205, 013		0 2, 205, 013	1, 019, 492	5.00
5.00 N	Movable Equipment	, o	0		0 0	0	6.00
.00	HIT designated Assets	0	0		0 0	0	7.00
. 00 5	Subtotal (sum of lines 1-7)	43, 658, 959	5, 286, 082		0 5, 286, 082	1, 019, 492	8.00
. OO F	Reconciling Items	0	0		0 0	0	9.00
10.00 1	Total (line 8 minus line 9)	43, 658, 959	5, 286, 082	L .	0 5, 286, 082	1, 019, 492	10.00
		Endi ng	Fully				
		Bal ance	Depreciated				
			Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						l
	Land	347, 733	0				1.00
	Land Improvements	952, 332	0				2.00
	Buildings and Fixtures	27, 119, 745	0				3.00
	Building Improvements	0	0				4.00
	Fixed Equipment	19, 505, 739	0				5.00
	Movable Equipment	0	0				6.00
	HIT designated Assets	0	0				7.00
	Subtotal (sum of lines 1-7)	47, 925, 549	0				8.00
	Reconciling Items	0	0				9.00
10.00 1	Total (line 8 minus line 9)	47, 925, 549	0				10.00

Health Financial Systems		JAY COUNTY	HOSPI TAL		In Lieu of Form CMS-2552-10			
RECONO	CILIATION OF CAPITAL COSTS CENTERS	Provi der CCN: 15-1320			Period: From 10/01/2016 To 09/30/2017		pared:	
			SUMMARY OF CAPITAL					
Cost Center Description		Depreciation	Lease	Interest	I nsurance (see i nstructi ons)	Taxes (see instructions)		
		9.00	10.00	11.00	12.00	13.00		
-	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	/N 2, LINES 1 a	and 2				
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1, 826, 406	0	7,67	77 0	0	2.00	
2.01	NEW CAP REL COSTS-MVBLE EQUIP MOB	8, 689	0		0 0	0	2.01	
2.02	NEW CAP REL COSTS-MVBLE EQUIP-POB	101, 949	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, 968, 186		7,67	77 0	0	3.00	
		SUMMARY O	F CAPITAL					
	Cost Center Description	Other	Total (1)					
		Capi tal -Rel at						
		ed Costs (see	9 through 14)					
		instructions)						
		14.00	15.00					
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN						
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	1, 834, 083				2.00	
2.01	NEW CAP REL COSTS-MVBLE EQUIP MOB	0	8, 689				2.01	
2.02	NEW CAP REL COSTS-MVBLE EQUI P-POB	0	101, 949				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, 975, 863				3.00	

	Heal th	Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10	
Cost Center Description Gross Assets Capital ized Leases Gross Assets Ratio (col. 1 - col. 2) Ratio Instructions) Insurance PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 2.00 3.00 4.00 5.00 2.00 NEW CAP REL COSTS-WBLE FOULP MB 0 0 0 0.000000 0 2.01 2.01 NEW CAP REL COSTS-WBLE FOULP MB 0 0 0 0 0.000000 0 2.02 2.02 NEW CAP REL COSTS-WBLE FOULP-POB 0 0 0 0 0.000000 2.01 2.02 2.03 NEW CAP REL COSTS-MBLE FOULP-NUJ 0 0 0 0.000000 0 2.03 0.000000 0 2.03 0.000000 0 2.03 0 0 0 0.000000 0 2.00 2.01 2.01 2.01 2.02 2.02 2.02 2.01 2.02 2.02 2.02 2.02 2.02 2.02 2.02 2.02 2.02 2.02 2.02 2.02 2.02 <td>RECONO</td> <td>ILIATION OF CAPITAL COSTS CENTERS</td> <td></td> <td></td> <td></td> <td>From 10/01/2016 To 09/30/2017</td> <td>Part III Date/Time Prep 2/26/2018 1:56</td> <td>pared:</td>	RECONO	ILIATION OF CAPITAL COSTS CENTERS				From 10/01/2016 To 09/30/2017	Part III Date/Time Prep 2/26/2018 1:56	pared:	
PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS Instructions Instructions Instructions 2.00 NEW CAP REL COSTS-MUBLE EQUIP MOB 27, 119, 745 0 2.00 3.00 4.00 5.00 2.01 NEW CAP REL COSTS-MUBLE EQUIP MOB 0 0 0.000000 0 2.00 0.01 NEW CAP REL COSTS-MUBLE EQUIP PoB 0 0 0 0.000000 0 2.01 2.03 NEW CAP REL COSTS-MUBLE EQUIP-NDB 0 0 0 0.000000 0 2.03 0 0 0.000000 0 2.03 0 27,119,745 0 27,119,745 1.000000 0 2.03 0.00 0.000000 0 2.03 0.00 10.0000 0 2.03 0.00 0.000000 0 2.03 0.00 0.000000 0 2.03 0.00 0.00 0 0.00 0.00 0 0.00 0.00 0 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 <td< td=""><td></td><td></td><td colspan="3">COMPUTATION OF RATIOS</td><td>ALLOCATION OF</td><td>OTHER CAPITAL</td><td></td></td<>			COMPUTATION OF RATIOS			ALLOCATION OF	OTHER CAPITAL		
PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 0 3.00 4.00 5.00 2.00 NEW CAP REL COSTS-WUBLE EQUIP 27,119,745 0 27,119,745 1.000000 0 2.00 2.01 NEW CAP REL COSTS-WUBLE EQUIP-POB 0 0 0.000000 0 2.01 2.02 NEW CAP REL COSTS-WUBLE EQUIP-POB 0 0 0 0.000000 0 2.02 2.03 NEW CAP REL COSTS-WUBLE EQUIP-WJ 0 0 0 0 0.000000 0 2.03 3.00 Total (sum of lines 1-2) 27,119,745 0 27,119,745 0 27,119,745 0 27,119,745 0 2.01 Cost Center Description Taxes Other Total (sum of cols, 5 Depreciation Lease 2.00 2.01 NEW CAP REL COSTS-WUBLE EQUIP 0 0 0 0 1.698,058 0 2.01 2.01 NEW CAP REL COSTS-WUBLE EQUIP P-0B 0 0 0 0 1.698,058 0 2.01		Cost Center Description	Gross Assets	•	for Ratio		Insurance		
PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS					col . 2)				
2.00 NEW CAP REL COSTS-MVBLE EQUIP 27, 119, 745 0 27, 119, 745 1.000000 0 2.00 2.01 NEW CAP REL COSTS-MVBLE EQUIP-NOB 0 0 0 0 0.000000 0 2.02 NEW CAP REL COSTS-MVBLE EQUIP-NOB 0 0 0 0.000000 0 2.03 2.03 NEW CAP REL COSTS-MVBLE EQUIP-WJ 0 0 0 0 0.000000 0 2.03 3.00 Total (sum of lines 1-2) 27, 119, 745 0 27, 119, 745 1.000000 0 2.03 3.00 Total (sum of lines 1-2) 27, 119, 745 0 27, 119, 745 1.000000 0 2.03 3.00 Total (sum of lines 1-2) 27, 119, 745 0 27, 119, 745 1.000000 0 3.00 2.00 Cost Center Description Taxes Other Capital-Relat ed Costs Total (sum of lines 1-2) 0 0 0 0 0 2.00 2.01 NEW CAP REL COSTS-MVBLE EQUIP P 0 0 0 0 0				2.00	3.00	4.00	5.00		
2.01 NEW CAP REL COSTS-MVBLE EQUIP MOB 0 0 0 0 0 0 0.000000 0 2.02 2.03 NEW CAP REL COSTS-MVBLE EQUIP-WJ 0	2 00			0	07 110 74	1 00000	0	2 00	
2.02 NEW CAP REL COSTS-MVBLE EQUIP-POB NEW CAP REL COSTS-MVBLE EQUIP-WJ 0 <t< td=""><td></td><td></td><td></td><td>0</td><td>27, 119, 74</td><td></td><td></td><td></td></t<>				0	27, 119, 74				
2.03 NEW CAP REL COSTS-MVBLE EQUIP- WJ 0 0 2.03 0			0						
3.00 Total (sum of lines 1-2) 27, 119, 745 0 27, 119, 745 1.000000 0 3.00 ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL Cost Center Description ALLOCATION OF OTHER CAPITAL Taxes Other Capital -Relat ed Costs Total (sum of cols. 5 Depreciation Lease PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS O			0	0					
ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL Cost Center Description Taxes Other Capital -Relat ed Costs Total (sum of cols. 5 through 7) Depreciation Lease 2.00 PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS Total (sum of cols. 5 through 7) Depreciation Lease 2.01 NEW CAP REL COSTS-MVBLE EQUIP MOB 0 0 0 1.698,058 0 2.00 2.02 NEW CAP REL COSTS-MVBLE EQUIP POB 0 0 0 0 2.02 2.03 NEW CAP REL COSTS-MVBLE EQUIP-POB 0 0 0 1.839,838 0 2.02 3.00 Total (sum of lines 1-2) 0 0 0 1.839,838 0 3.00 3.00 Total (sum of lines 1-2) 0 0 11.00 12.00 13.00 14.00 15.00 2.00 NEW CAP REL COSTS-WRUE EQUIP POR 7.677 0 0 1.705,735 2.00 2.01 NEW CAP REL COSTS-WRUE EQUIP POB 0 0 0 11.00 12.00 13.00 14.00			07 110 745						
Cost Center Description Taxes Other Capital -Relat ed Costs Total (sum of class 5 through 7) Depreciation Lease PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 6.00 7.00 8.00 9.00 10.00 NEW CAP REL COSTS-MVBLE EQUIP 0 0 0 1.698,058 0 2.00 NEW CAP REL COSTS-MVBLE EQUIP POB 0 0 0 11.698,058 0 2.00 2.02 NEW CAP REL COSTS-MVBLE EQUIP POB 0 0 0 2.02 8.689 0 2.02 3.00 Total (sum of lines 1-2) 0 0 0 0 11.839,838 0 2.03 3.00 Total (sum of lines 1-2) 0 0 0 1,839,838 0 3.00 Farmers SumMARY OF CAPITAL Cost Center Description Interest Insurance (see instructions) Taxes (see instructions) Other instructions) Total (2) (sum of cols. 9 through 14) instructions) 11.00 12.00 13.00 14.00 15.00 14.00 12.00	3.00	Total (sum of Times 1-2)					3.00		
PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS Capital -Rel at ed Costs col s. 5 through 7) col s. 5 through 7) col s. 5 through 7) 2.00 NEW CAP REL COSTS-MVBLE EQUIP 0 0 0 10.00 2.01 NEW CAP REL COSTS-MVBLE EQUIP MOB 0 0 0 2.01 2.02 NEW CAP REL COSTS-MVBLE EQUIP-POB 0 0 0 2.01 2.03 NEW CAP REL COSTS-MVBLE EQUIP-POB 0 0 0 2.02 3.00 Total (sum of lines 1-2) 0 0 0 1.839,838 0 3.00 OCST Center Description Interest Insurance (see instructions) Taxes (see instructions) 0 0 14.00 15.00 PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 2.00 NEW CAP REL COSTS-MVBLE EQUIP 7, 677 0 0 17.00 15.00 Insurance (see instructions) 1, 705, 735 2.00 NEW CAP REL COSTS-MVBLE EQUIP 0 0 0 0 15.00			ALLUCA	ITON OF OTHER V	JUNIMART				
PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS Capital -Rel at ed Costs col s. 5 through 7) col s. 5 through 7) col s. 5 through 7) 2.00 NEW CAP REL COSTS-MVBLE EQUIP 0 0 0 10.00 2.01 NEW CAP REL COSTS-MVBLE EQUIP MOB 0 0 0 2.01 2.02 NEW CAP REL COSTS-MVBLE EQUIP-POB 0 0 0 2.01 2.03 NEW CAP REL COSTS-MVBLE EQUIP-POB 0 0 0 2.02 3.00 Total (sum of lines 1-2) 0 0 0 1.839,838 0 3.00 Cost Center Description Interest Insurance (see instructions) Taxes (see optical-Rel at ed Costs (see instructions) 0 0 14.00 15.00 PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 2.00 NEW CAP REL COSTS-MVBLE EQUIP 7,677 0 0 17,05,735 2.00 PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS Cost NWBLE EQUIP MOB 0 0 0 0 17,05,735 2.00 <td colsp<="" td=""><td></td><td>Cost Center Description</td><td>Taxes</td><td>0ther</td><td>Total (sum of</td><td>Depreciation</td><td>Lease</td><td></td></td>	<td></td> <td>Cost Center Description</td> <td>Taxes</td> <td>0ther</td> <td>Total (sum of</td> <td>Depreciation</td> <td>Lease</td> <td></td>		Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
6.00 7.00 8.00 9.00 10.00 PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 0 0 0 1,698,058 0 2.00 NEW CAP REL COSTS-MVBLE EQUIP MOB 0 0 0 0 8,689 0 2.01 NEW CAP REL COSTS-MVBLE EQUIP-POB 0 0 0 0 11,698,058 0 2.02 NEW CAP REL COSTS-MVBLE EQUIP-POB 0 0 0 0 2.02 0 2.03 NEW CAP REL COSTS-MVBLE EQUIP- WJ 0 0 0 3.00 3.00 0 3.00 0 0 0 3.00 3.00 0 3.00 0 0 0 3.00 3.00 3.00 3.00 0 0 0 3.00 3.00 3.00 11.00 12.00 13.00 14.00 15.00 Fract II II - RECONCILIATION OF CAPITAL COSTS CENTERS 2.00 NEW CAP REL COSTS-MVBLE EQUIP 7,677 0 0 14.00 15.00 France I Insurance I				Capi tal -Rel at					
PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 0 0 1,698,058 0 2.00 2.00 NEW CAP REL COSTS-MVBLE EQUIP 0 0 0 0 8,689 0 2.01 2.01 NEW CAP REL COSTS-MVBLE EQUIP MOB 0 0 0 0 8,689 0 2.01 2.02 NEW CAP REL COSTS-MVBLE EQUIP-POB 0 0 0 0 11,698,058 0 2.01 2.03 NEW CAP REL COSTS-MVBLE EQUIP-POB 0 0 0 0 31,142 0 2.03 3.00 Total (sum of lines 1-2) 0 0 0 0 1,839,838 0 3.00 SUMMARY OF CAPITAL Cost Center Description Interest Instructions) Taxes (see instructions) O 0 14.00 15.00 2.00 NEW CAP REL COSTS-MVBLE EQUIP 7,677 0 0 1,705,735 2.00 2.01 NEW CAP REL COSTS-MVBLE EQUIP MOB 0 0 0 0				ed Costs	through 7)				
2.00 NEW CAP REL COSTS-MVBLE EQUIP 0 0 0 1,698,058 0 2.00 2.01 NEW CAP REL COSTS-MVBLE EQUIP MOB 0 0 0 0 8,689 0 2.01 2.02 NEW CAP REL COSTS-MVBLE EQUIP-POB 0 0 0 0 101,949 0 2.02 2.03 NEW CAP REL COSTS-MVBLE EQUIP- WJ 0 0 0 0 31,142 0 2.03 3.00 Total (sum of lines 1-2) 0 0 0 1,839,838 0 3.00 Cost Center Description Interest Insurance (see Taxes (see Other Total (2) 11.00 12.00 13.00 14.00 15.00 11.00 13.00 14.00 15.00 PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 2.00 NEW CAP REL COSTS-MVBLE EQUIP 7,677 0 0 1,705,735 2.00 2.01 NEW CAP REL COSTS-MVBLE EQUIP MOB 0 0 0 0 0 0 101,949 2.02 2.02 NEW CAP REL COSTS-MVBLE EQUIP POB				7.00	8.00	9.00	10.00		
2.01 NEW CAP REL COSTS-MVBLE EQUIP MOB 0 0 0 8,689 0 2.01 2.02 NEW CAP REL COSTS-MVBLE EQUIP-POB 0 0 0 0 101,949 0 2.02 2.03 NEW CAP REL COSTS-MVBLE EQUIP- WJ 0 0 0 0 31,142 0 2.03 3.00 Total (sum of lines 1-2) 0 0 0 0 1,839,838 0 3.00 Cost Center Description Interest Insurance (see instructions) Taxes (see instructions) 0 0 0 11.00 12.00 13.00 14.00 15.00 PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 2.00 NEW CAP REL COSTS-MVBLE EQUIP 7,677 0 0 0 1,705,735 2.00 2.01 NEW CAP REL COSTS-MVBLE EQUIP MOB 0 0 0 0 10,949 2.02 2.02 NEW CAP REL COSTS-MVBLE EQUIP MOB 0 0 0 0 1,705,735 2.00 2.02 NEW CAP REL COSTS-MVBLE EQUIP POB 0 0 0 0 0					1	- 1			
2. 02 NEW CAP REL COSTS-MVBLE EQUIP-POB 0 0 0 101,949 0 2.02 2. 03 NEW CAP REL COSTS-MVBLE EQUIP- WJ 0 0 0 0 31,142 0 2.03 3. 00 Total (sum of lines 1-2) 0 0 0 0 1,839,838 0 3.00 SUMMARY OF CAPITAL Cost Center Description Interest Insurance (see instructions) Taxes (see instructions) 0 ther capital -Relat ed Costs (see instructions) Total (2) (sum of cols. 9 through 14) PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 2. 00 NEW CAP REL COSTS-MVBLE EQUIP 7,677 0 0 1,705,735 2.00 2. 01 NEW CAP REL COSTS-MVBLE EQUIP MOB 0 0 0 0 10,949 2.02			-	-					
2.03 NEW CAP REL COSTS-MVBLE EQUIP- WJ 0 0 0 0 31,142 0 2.03 3.00 3.00 Total (sum of lines 1-2) 0 0 0 0 1,839,838 0 3.00 Cost Center Description Interest Insurance (see instructions) Taxes (see instructions) 0 0 0 10 10 12.00 13.00 14.00 15.00 PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 2.00 NEW CAP REL COSTS-MVBLE EQUIP 7,677 0 0 1,705,735 2.00 2.01 NEW CAP REL COSTS-MVBLE EQUIP MOB 0 0 0 0 101,949 2.02			0	0					
3.00 Total (sum of lines 1-2) 0 0 0 1,839,838 0 3.00 SUMMARY OF CAPITAL Cost Center Description Interest Insurance (see instructions) Taxes (see of tal -Relat costs (see instructions) 0 0 100 100 100 11.00 12.00 13.00 14.00 15.00 PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 2.00 NEW CAP REL COSTS-MVBLE EQUIP 7,677 0 0 0 1,705,735 2.00 2.01 NEW CAP REL COSTS-MVBLE EQUIP MOB 0 0 0 0 0 101,949 2.01 2.02 NEW CAP REL COSTS-MVBLE EQUIP-POB 0 0 0 0 101,949 2.02			0	0					
SUMMARY OF CAPITAL Summary of CAPITAL Cost Center Description Interest Insurance (see instructions) Taxes (see Other Capital -Relat ed Costs (see 9 through 14) (sum of cols. ed Costs (see 9 through 14) instructions) 11.00 12.00 Taxes (see Other Capital -Relat ed Costs (see 9 through 14) (sum of cols. ed Costs (see 9 through 14) instructions) 2.00 NEW CAP REL COSTS-MVBLE EQUIP 7, 677 0 0 11.00 13.00 14.00 15.00 2.00 NEW CAP REL COSTS-MVBLE EQUIP 7, 677 0 0 0 0 0 0 0 1, 705, 735 2.00 2.01 NEW CAP REL COSTS-MVBLE EQUIP MOB 0 0 0 0 0 2.01 2.02 NEW CAP REL COSTS-MVBLE EQUIP POB 0			0	0					
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS Taxes (see (see instructions) Taxes (see instructions) Other Capital -Relat ed Costs (see instructions) Total (2) (sum of col s. 9 through 14) 2.00 PART III - RECONCILIATION OF CAPITAL COSTS CENTERS 11.00 12.00 13.00 14.00 15.00 2.01 NEW CAP REL COSTS-MVBLE EQUIP 7,677 0 0 0 1,705,735 2.00 2.02 NEW CAP REL COSTS-MVBLE EQUIP MOB 0 0 0 0 101,949 2.02	3.00	Total (sum of lines 1-2)	0	0			0	3.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS Instructions) Capital -Relat ed Costs (see instructions) (sum of cols. 9 through 14) 2.00 PART III - RECONCILIATION OF CAPITAL COSTS CENTERS 2.01 NEW CAP REL COSTS-MVBLE EQUIP 7,677 0 0 1,705,735 2.00 2.01 NEW CAP REL COSTS-MVBLE EQUIP MOB 0 0 0 8,689 2.01 2.02 NEW CAP REL COSTS-MVBLE EQUIP-POB 0 0 0 101,949 2.02				SL	JMMARY OF CAPI	IAL			
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS Instructions Capital -Rel at ed Costs (see instructions) (sum of cols. 9 through 14) 2.00 NEW CAP REL COSTS-MVBLE EQUIP 7,677 0 14.00 15.00 2.01 NEW CAP REL COSTS-MVBLE EQUIP MOB 0 0 0 1,705,735 2.00 2.02 NEW CAP REL COSTS-MVBLE EQUIP POB 0 0 0 101,949 2.02		Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)		
PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 11.00 12.00 13.00 14.00 15.00 2.00 NEW CAP REL COSTS-MVBLE EQUIP 7,677 0 0 0 1,705,735 2.00 2.01 NEW CAP REL COSTS-MVBLE EQUIP MOB 0 0 0 8,689 2.01 2.02 NEW CAP REL COSTS-MVBLE EQUIP-POB 0 0 0 101,949 2.02		·		(see		Capi tal -Rel at	(sum of cols.		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS 2.00 NEW CAP REL COSTS-MVBLE EQUIP 7, 677 0 0 1, 705, 735 2.00 2.01 NEW CAP REL COSTS-MVBLE EQUIP MOB 0 0 0 8, 689 2.01 2.02 NEW CAP REL COSTS-MVBLE EQUIP POB 0 0 0 101, 949 2.02				instructions)					
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS 2.00 NEW CAP REL COSTS-MVBLE EQUIP 7,677 0 0 1,705,735 2.00 2.01 NEW CAP REL COSTS-MVBLE EQUIP 7,677 0 0 0 8,689 2.01 2.02 NEW CAP REL COSTS-MVBLE EQUIP MOB 0 0 0 0 8,689 2.01 2.02 NEW CAP REL COSTS-MVBLE EQUIP-POB 0 0 0 0 101,949 2.02				,		instructions)	0,		
2. 00 NEW CAP REL COSTS-MVBLE EQUI P 7, 677 0 0 1, 705, 735 2. 00 2. 01 NEW CAP REL COSTS-MVBLE EQUI P MOB 0 0 0 0 8, 689 2. 01 2. 02 NEW CAP REL COSTS-MVBLE EQUI P-POB 0 0 0 0 101, 949 2. 02		1		12.00	13.00	14.00	15.00		
2. 01 NEW CAP REL COSTS-MVBLE EQUI P MOB 0 0 0 0 8, 689 2. 01 2. 02 NEW CAP REL COSTS-MVBLE EQUI P-POB 0 0 0 0 0 101, 949 2. 02					1	- 1			
2. 02 NEW CAP REL COSTS-MVBLE EQUI P-POB 0 0 0 101, 949 2. 02				-					
			0	0		0 0			
2 03 INEW CAP REL COSTS-MURIE FOULD- WI I OI OI OI OI 31 142 2 03	2.02		0	0		0 0			
	2.03	NEW CAP REL COSTS-MVBLE EQUIP- WJ	0	0		0 0	31, 142	2.03	
3. 00 Total (sum of lines 1-2) 7, 677 0 0 1, 847, 515 3. 00	3.00	Total (sum of lines 1-2)	7,677	0	1	0 0	1, 847, 515	3.00	

Heal th Financial	Systems	
AD INCTACATO TO F	VDENCEC	

ADJUST	MENTS TO EXPENSES				eriod: rom 10/01/2016 o 09/30/2017	Worksheet A-8 Date/Time Pre	narod
						2/26/2018 1:5	
				Expense Classification on To/From Which the Amount is			
	Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7	
		(2)	2.00	3.00	4.00	Ref. 5.00	
1.00	Investment income - CAP REL	1.00		*** Cost Center Deleted ***	1.00	0	1.00
2.00	COSTS-BLDG & FIXT (chapter 2) Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter			NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
2. 01	2) Investment income - NEW CAP REL COSTS-MVBLE EQUIP MOB		0	NEW CAP REL COSTS-MVBLE EQUIP MOB	2. 01	0	2.01
2. 02	(chapter 2) Investment income - NEW CAP REL COSTS-MVBLE EQUIP-POB		0	NEW CAP REL COSTS-MVBLE EQUIP-POB	2.02	0	2.02
2. 03	(chapter 2) Investment income - NEW CAP REL COSTS-MVBLE EQUIP- WJ (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP- WJ	2.03	0	2.03
3.00	Investment income - other		0		0.00	0	3.00
4.00	(chapter 2) Trade, quantity, and time		0		0.00	О	4.00
5.00	discounts (chapter 8) Refunds and rebates of		0		0.00	0	5.00
6.00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6.00
7.00	suppliers (chapter 8) Telephone services (pay stations excluded) (chapter		0		0.00	0	7.00
8. 00	21) Tel evi si on and radio service (chapter 21)		0		0.00	0	8.00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician adjustment	A-8-2	0 -4, 843, 584		0.00	0 0	9.00 10.00
11.00	Sale of scrap, waste, etc.		0		0.00	0	11.00
12.00	(chapter 23) Related organization transactions (chapter 10)	A-8-1	-29, 881			0	
13.00 14.00	Laundry and linen service Cafeteria-employees and guests		0		0.00 0.00	0	13.00 14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16. 00			0		0. 00	0	16.00
17.00	Sale of drugs to other than		0		0.00	0	17.00
18.00	patients Sale of medical records and		0		0.00	0	18.00
19. 00	abstracts Nursing and allied health education (tuition, fees,		0		0. 00	0	19.00
20. 00	books, etc.) Vending machines		O		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22. 00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPI RATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSI CAL THERAPY	66.00		24.00
25. 00	Utilization review - physicians' compensation		C	*** Cost Center Deleted ***	114.00		25.00
26.00	(chapter 21) Depreciation - CAP REL COSTS-BLDG & FIXT		O	*** Cost Center Deleted ***	1.00	0	26.00

Health Financial Systems	JAY COUNTY	DSPITAL In Lieu of Form CMS-2552-1			
ADJUSTMENTS TO EXPENSES		Provider CCN: 15-1320	Period: From 10/01/2016	Worksheet A-8	
			To 09/30/2017	Date/Time Prepared: 2/26/2018 1:56 pm	
		Expanse Classification	on Workshoot A		

				Expense Classification on Worksheet A				
				To/From Which the Amount is 1	to be Adjusted			
	Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7		
		(2)				Ref.		
07.00		1.00	2.00		4.00	5.00	07.00	
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		C C	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00	
27.01	Depreciation - NEW CAP REL		0	NEW CAP REL COSTS-MVBLE	2.01	0	27.01	
27.01	COSTS-MVBLE EQUIP MOB			EQUIP MOB	2.01	0	27.01	
27.02			C	NEW CAP REL COSTS-MVBLE	2.02	0	27.02	
	COSTS-MVBLE EQUIP-POB			EQUI P-POB				
27.03	Depreciation - NEW CAP REL		C	NEW CAP REL COSTS-MVBLE	2.03	0	27.03	
	COSTS-MVBLE EQUIP- WJ			EQUIP- WJ				
28.00	Non-physician Anesthetist		C	*** Cost Center Deleted ***	19.00		28.00	
29.00	Physicians' assistant				0.00	0		
30.00	Adjustment for occupational therapy costs in excess of	A-8-3		OCCUPATI ONAL THERAPY	67.00		30.00	
	limitation (chapter 14)							
30.99	Hospice (non-distinct) (see		C	ADULTS & PEDIATRICS	30.00		30.99	
	i nstructi ons)		_					
31.00	Adjustment for speech	A-8-3	C	SPEECH PATHOLOGY	68.00		31.00	
	pathology costs in excess of							
	limitation (chapter 14)		_					
32.00	CAH HIT Adjustment for		C		0.00	0	32.00	
33.00	Depreciation and Interest CAFETERIA SALES	В	105 120	CAFETERI A	11.00	0	33.00	
33.00	MEDICAL RECORDS FEES	B		MEDICAL RECORDS & LIBRARY	16.00	0	33.00	
33.02	SUPPLY REBATES AND DI SCOUNTS	B		ADMI NI STRATI VE & GENERAL	5.00	0		
33.03	OTHER REVENUE	В		ADMI NI STRATI VE & GENERAL	5.00	0	33.03	
33.04	DIABETIC COUNSELING	В	-15, 834	NURSING ADMINISTRATION	13.00	0	33.04	
33.05	CRNA OFFSET	А	-969, 583	ANESTHESI OLOGY	53.00	0	33.05	
33.06	PHYSI CI AN RECRUI TMENT	A		ADMI NI STRATI VE & GENERAL	5.00	0	33.06	
33.07	ADVERTI SI NG EXPENSE	A		ADMI NI STRATI VE & GENERAL	5.00	0	33.07	
33.08	SENI OR PROGRAM	A		ADMI NI STRATI VE & GENERAL	5.00	0	33.08	
33. 09 33. 10	SWI TCHBOARD SALARY	A		ADMINISTRATIVE & GENERAL	5.00	0	33.09 33.10	
33.10	SWI TCHBOARD EH&W PAT TELEPHONE EXPENSE	A A		EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL	4.00 5.00	0	33.10	
33.12	PAT TELEPHONE DEPRECIATION	A		NEW CAP REL COSTS-MVBLE	2.00	9	33.12	
00.12			0, , , , 0	EQUI P	2.00	,	00.12	
33.13	HEALTH EDUCATION	В	-118, 313	ADMI NI STRATI VE & GENERAL	5.00	0	33.13	
33.14	VENDING MACHINE REVENUE	В		CAFETERI A	11.00	0	33.14	
33.15	PHARMACY EMPLOYEE SALES	В		DRUGS CHARGED TO PATIENTS	73.00	0		
33.16	I HA AND AHA DUES	A		ADMI NI STRATI VE & GENERAL	5.00	0		
33.17	LAND RENT	В		ADMI NI STRATI VE & GENERAL	5.00	0	33.17	
33. 18 33. 19	CLINIC RENTAL CONFERENCE ROOM RENTAL	B B		ELECTROCARDI OLOGY ADMI NI STRATI VE & GENERAL	69.00 5.00	0	33. 18 33. 19	
	VENDOR/CONTRACT REV	B		ADMINISTRATIVE & GENERAL	5.00	0		
33.21	OTHER REVENUE	В		MEDICAL RECORDS & LIBRARY	16.00	0		
33.22	EHR DEPRECIATION	A		NEW CAP REL COSTS-MVBLE	2.00	9		
				EQUI P				
33.23	HAF	A		ADMINISTRATIVE & GENERAL	5.00	0		
33.24		В		DRUGS CHARGED TO PATIENTS	73.00	0	33.24	
33.25	JAY COUNTY ER REIMBURSEMENT	B			91.00	0	33.25	
	MERIDIAN HEALTH WEST JAY REIMB			WEST JAY CLINIC	194.02	0	33.26	
33. 27	MERIDIAN HEALTH CONV CARE REIMB	В	-208,8/3	CONVENI ENT CARE	194.03	0	33.27	
33. 28	INTEREST REVENUE	В	-4.348	NEW CAP REL COSTS-MVBLE	2.00	9	33.28	
20		-	., 510	EQUI P	2.00	,		
33. 29	PENSI ON EXPENSE	А	3, 705, 860	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.29	
33.30	OTHER ADJUSTMENTS (SPECIFY)		C		0.00	0	33.30	
F0 00	(3)		F (00 000				F0 00	
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A,		-5, 628, 892				50.00	
	column 6, line 200.)							
(1) De	scription - all chapter referen	ces in this co	lumn nertain t	CMS Pub 15-1				

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(2) Additional content of the determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
 Note: See instructions for column 5 referencing to Worksheet A-7.

Heal th	Financial Systems	JAY COUNT	Y HOSPI TAL	In Lie	eu of Form CMS-	2552-10
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO	ME Provider CCN: 15-1320	Period: From 10/01/2016	Worksheet A-8	8-1
OFFICE				To 09/30/2017		epared: 6 pm
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUST	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED	ORGANI ZATI ONS OR	CLAIMED HOME	
	OFFICE COSTS:					
1.00	66.00	PHYSI CAL THERAPY	RENT/LEASE EXPENSE	30, 119	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).			30, 119	60, 000	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

1105 110	t been posted to worksneet A,	COLUMNIS I ANU/OF Z, L	ne amount arrowable si	iouru be riiurcateu rii cor	unit 4 OF LITS PALL.	
				Related Organization(s)	and/or Home Office	
				5		
	Symbol (1)	Name	Percentage of	Name	Percentage of	
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	Symbol (1) 1.00	Name 2.00		4.00		

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

1 CT IIIDUI					
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	

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

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

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

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

organi zati on.

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

Health Financial Systems JAY C	COUNTY HOS	SPI TAL	In Lieu of Form CMS-2552-10		
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AN	AND HOME	Provider CCN: 15-1320	Period: From 10/01/2016	Worksheet A-8-1	
OFFICE COSTS				Date/Time Prepared:	

	-							2/26/2018	:56 pm
	Net	Wkst. A-7 Ref.							
	Adjustments								
	(col. 4 minus								
	col. 5)*								
	6.00	7.00							
	A. COSTS INCUR	RED AND ADJUST	MENTS REQUIRED AS	A RESULT OF	TRANSACTI ONS	WITH RELATED	ORGANI ZATI ONS	OR CLAIMED HOW	E
	OFFICE COSTS:								
1.00	-29, 881	0							1.00
2.00	0	0							2.00
3.00	0	0							3.00
4.00	0	0							4.00
5.00	-29, 881								5.00

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

nas not	been posted to worksheet A,	COLUMNIS I ANU/C	I Z,	the amount	arrowabre	shourd be	i nui cateu	TH COLUMN 4 0	this part.	
	Related Organization(s)									
	and/or Home Office									
	Type of Business	1								
	6, 00	1								
	0.00									
	B. INTERRELATIONSHIP TO RELATIONSHIP TO RELATIONSHIP TO RELATIONSHIP	TED 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

	Sement under title Aviii.	
6.00		6.00
7.00 8.00		7.00
8.00		8.00
9.00		9.00
9.00 10.00 100.00		10.00
100.00		100.00

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

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

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

 C. Provider has financial interest in corporation, partnership, or other organization.
 D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.

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

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

Heal th	Financial Syst	ems	JAY COUNT	Y HOSPI TAL		In Lie	eu of Form CMS-	2552-10
PROVI DE	ER BASED PHYSIC	I AN ADJUSTMENT		Provider C		Period: From 10/01/2016 To 09/30/2017		epared.
	Wkst. A Line #	I denti fi er	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Prov ider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	60.00	LABORATORY	65,000		C			1.00
2.00	90.00	CLINIC	115, 970	115, 970	0	0	0	2.00
3.00	90. 01	FAMILY PRACTICE OF JAY COUNTY	1, 548, 676	1, 548, 676	C	0	0	3.00
4.00	90. 02	JAY FAMILY MEDICINE	1, 477, 553	1, 477, 553	C	0	0	4.00
5.00	91.00	EMERGENCY	1, 971, 548	1, 636, 385	335, 163	0	0	5.00
6.00	0.00		0	0	C	0	0	6.00
7.00	0.00		0	0	C	0	0	7.00
8.00	0.00		0	0	C	0	0	8.00
9.00	0.00		0	0	(0	0	9.00
10.00	0.00		0	0	(0	0	
200.00	0.00		5, 178, 747	4, 843, 584	335, 163		0	
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	200.00
		I denti fi er	Limit	Unadjusted RCE			of Malpractice	
		raciterrei		Limit	Conti nui ng	Share of col.	Insurance	
					Education	12	Thisurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		LABORATORY	0.00		(1.00
2.00		CLINIC	0	0	C			2.00
3.00		FAMILY PRACTICE OF JAY	0	0				3.00
4.00	90.02	JAY FAMILY MEDICINE	0	0	(0	0	4.00
5.00		EMERGENCY	0	0	0	0	-	
6.00	0.00		0	0	(-	6.00
7.00	0.00		0	0		0	3	7.00
8.00	0.00		0	0	(3	8.00
9.00	0.00			0			0	9.00
10.00	0.00			0		0	0	10.00
200.00	0.00			0			0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	0	200.00
	WKST. A LINE #	Identifier	Component Share of col. 14	Limit	Di sal I owance	Aujustillerit		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00		LABORATORY	0	-				1.00
2.00	90.00	CLINIC	0	0	C	115, 970		2.00
3.00	90. 01	FAMILY PRACTICE OF JAY COUNTY	0	0	C	1, 548, 676		3.00
4.00		JAY FAMILY MEDICINE	0	0	C	1, 477, 553		4.00
5.00	91.00	EMERGENCY	0	0	C	1, 636, 385		5.00
6.00	0.00		0	0	C	0		6.00
7.00	0.00		0	0	C	0		7.00
8.00	0.00		0	0	C	0		8.00
9.00	0.00		0	0	C	0		9.00
10.00	0.00		0	0	(10.00
200.00	0.00		0	0	-	-		200.00
	•	1				, , ,		

	Financial Systems IABLE COST DETERMINATION FOR THERAPY SERVICES DE SUPPLIERS	JAY COUNTY I FURNI SHED BY	Provi der C	CN: 15-1320	Peri od: From 10/01/2016 To 09/30/2017 Physi cal Therapy	Date/Time Pre 2/26/2018 1:5	-3 pared:
						1.00	
	PART I - GENERAL INFORMATION					1.00	
1.00	Total number of weeks worked (excluding aide	s) (see instruc	tions)			52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervi					0	3.00
4.00	Number of unduplicated days in which therapy		on provider si	te but neit	her supervisor	0	4.00
F 00	nor therapist was on provider site (see inst	,	aniata (asa i				E 00
5.00 6.00	Number of unduplicated offsite visits - supe Number of unduplicated offsite visits - ther					0	5.00 6.00
0.00	assistant and on which supervisor and/or the	apy assistants	present during	n the visit(s)) (see	0	0.00
	instructions)			,			
7.00	Standard travel expense rate					0.00	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervi sors	Therapi sts	Assi stants		Trai nees	
9.00	Total hours worked	1.00	2.00	3.00	4.00 00 0.00	5.00	9.00
10.00	AHSEA (see instructions)	92.52	3, 190.00		30 0.00		
11.00	Standard travel allowance (columns 1 and 2,	40.23	40.23		15	0100	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	0		0		12.00
12.01	Number of travel hours (offsite)	0	0		0		12.01
13.00 13.01	Number of miles driven (provider site) Number of miles driven (offsite)	0	0		0		13.00 13.01
13.01		U	0		0		13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1					11, 287	
15.00	Therapists (column 2, line 9 times column 2,					256, 636	
16.00	Assistants (column 3, line 9 times column 3,			1	4 1/ 5	109, 307	16.00
17.00	Subtotal allowance amount (sum of lines 14 a others)	na 15 For respi	ratory therapy	y or tines i	4-16 TOP all	377, 230	17.00
18.00	Aides (column 4, line 9 times column 4, line	10)				0	18.00
19.00	Trainees (column 5, line 9 times column 5, l					0	19.00
20.00	Total allowance amount (sum of lines 17-19 f	or respiratory	therapy or li	nes 17 and 1	8 for all others)	377, 230	20.00
	If the sum of columns 1 and 2 for respiratory						
	occupational therapy, line 9, is greater than		no entries on	lines 21 an	d 22 and enter or	n line 23 the	
21.00	amount from line 20. Otherwise complete line Weighted average rate excluding aides and tr		divided by s	m of column	s 1 and 2 line (0.00	21.00
21.00	for respiratory therapy or columns 1 thru 3,					0.00	21.00
22.00	Weighted allowance excluding aides and train	ees (line 2 tim	es line 21)			0	22.00
23.00	Total salary equivalency (see instructions)					377, 230	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW	VANCE AND TRAVE	_ EXPENSE COMP	PUTATION - F	ROVIDER SITE		
24 00	Standard Travel Allowance Therapists (line 3 times column 2, line 11)					0	24.00
24.00 25.00	Assistants (line 4 times column 3, line 11)					0	
26.00	Subtotal (line 24 for respiratory therapy or	sum of lines 2	4 and 25 for a	all others)		0	
27.00	Standard travel expense (line 7 times line 3				3 and 4 for all	0	
	others)	•	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
28.00	Total standard travel allowance and standard	travel expense	at the provid	der site (su	m of lines 26 and	0	28.00
	27) Onti angl. Traval. All awanga and Onti angl. Traval	Evenence					
29.00	Optional Travel Allowance and Optional Travel 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)		0	30.00
31.00	Subtotal (line 29 for respiratory therapy or		9 and 30 for a	all others)		0	31.00
32.00	Optional travel expense (line 8 times column				py or sum of	0	32.00
	columns 1-3, line 13 for all others)						
33.00	Standard travel allowance and standard trave					0	33.00
34.00 35.00	Optional travel allowance and standard trave Optional travel allowance and optional trave					0	34.00 35.00
35.00	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW				RVICES OUTSIDE PE		35.00
	Standard Travel Expense		En Ende oom o				
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	38.00
39.00	Standard travel expense (line 7 times the su		u o)			0	39.00
40.00	Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.)		2 line 10)			0	40.00
40.00	Assistants (column 3, line 12.01 times column		z, inte 10)			0	
42.00	Subtotal (sum of lines 40 and 41)	,				0	42.00
43.00	Optional travel expense (line 8 times the su	m of columns 1-	3, line 13.01))		0	
	Total Travel Allowance and Travel Expense - (llowing three lir		
	46, as appropriate.		6.11	1.00	1		
44.00	Standard travel allowance and standard trave Optional travel allowance and standard trave						44.00 45.00
45 00							

Heal th	Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
	ABLE COST DETERMINATION FOR THERAPY SERVICES	FURNI SHED BY	Provider C		eriod: rom 10/01/2016	Worksheet A-8 Parts I-VI	-3
UUISIL	E SUPPLIERS				o 09/30/2017	Date/Time Pre	
				P	hysical Therapy	2/26/2018 1:5 Cost	o pm
						1 00	
46.00	Optional travel allowance and optional trave	L expense (sum	of lines 42 a	nd 43 - see in	structions)	1.00	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	0.00	0.00	0.00	0.00	0.00	47.00
	period (if column 5, line 47, is zero or						
	equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each						
	column of line 56)						
48.00	Overtime rate (see instructions)	0.00					48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT			I			
50.00	Percentage of overtime hours by category	0.00	0.00	0.00	0.00	0.00	50.00
	(divide the hours in each column on line 47 by the total overtime worked - column 5,						
	line 47)						
51.00	Allocation of provider's standard work year for one full-time employee times the	0.00	0.00	0.00	0.00	0.00	51.00
	percentages on line 50) (see instructions)						
52.00	DETERMINATION OF OVERTIME ALLOWANCE Adjusted hourly salary equivalency amount	80.45	52.30	0.00	0.00		52.00
52.00	(see instructions)	00.45	52.50	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line	0	0	C	0		53.00
54.00	52) Maximum overtime cost (enter the lesser of	0	0	C	0		54.00
	line 49 or line 53)	-					
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply	0	0	C	0		55.00
	line 47 times line 52)						
56.00	Overtime allowance (line 54 minus line 55 -	0	0	C	0	0	56.00
	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.)						
						1.00	
F7 00	Part VI - COMPUTATION OF THERAPY LIMITATION A	AND EXCESS COST	F ADJUSTMENT			077 000	57.00
57.00 58.00	Salary equivalency amount (from line 23) Travel allowance and expense - provider site	(from lines 3)	3 34 or 35))			377, 230 0	
59.00	Travel allowance and expense - Offsite servi					0	•
60.00	Overtime allowance (from column 5, line 56)					0	
61.00 62.00	Equipment cost (see instructions) Supplies (see instructions)					0	
63.00	Total allowance (sum of lines 57-62)					377, 230	63.00
	Total cost of outside supplier services (from					249, 582	64.00 65.00
05.00	Excess over limitation (line 64 minus line 6) LINE 33 CALCULATION	5 - TT negative	e, enter zero)			0	05.00
	Line 26 = line 24 for respiratory therapy or						100.00
	Line 27 = line 7 times line 3 for respirator Line 33 = line 28 = sum of lines 26 and 27	y therapy or su	um of lines 3 a	and 4 for all	others		100. 01 100. 02
100. 02	LINE 34 CALCULATION						100.02
	Line 27 = line 7 times line 3 for respirator				others		101.00
	Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31	sum of lines 2	29 and 30 for a	all others			101.01 101.02
	LINE 35 CALCULATION						1.01.02
	Line 31 = line 29 for respiratory therapy or				1 2 11		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for all others	13 TOP respira	atory therapy of	or sum of colu	mns I-3, line	0	102.01
102.02	Line 35 = sum of lines 31 and 32					0	102.02

REASON	Financial Systems ABLE COST DETERMINATION FOR THERAPY SERVICES E SUPPLIERS	JAY COUNTY F	IOSPI TAL Provi der CCI	V: 15-1320	In Lie Period: From 10/01/2016 To 09/30/2017 Respiratory Therapy	u of Form CMS-2 Worksheet A-8 Parts I-VI Date/Time Pre 2/26/2018 1:5 Cost	-3 pared:
						1.00	
	PART I - GENERAL INFORMATION						
1.00 2.00	Total number of weeks worked (excluding aide Line 1 multiplied by 15 hours per week	s) (see instruct	tions)			52 780	1.00 2.00
3.00	Number of unduplicated days in which supervi					0	3.00
4.00	Number of unduplicated days in which therapy nor therapist was on provider site (see inst		on provider sit	te but neith	er supervisor	0	4.00
5.00	Number of unduplicated offsite visits - supe		apists (see ins	structions)		0	5.00
6.00	Number of unduplicated offsite visits - ther assistant and on which supervisor and/or the					0	6.00
	instructions)	Tapist was not p	biesent during		(366		
7.00	Standard travel expense rate					0.00	
8.00	Optional travel expense rate per mile	Supervi sors	Therapists	Assi stants	Ai des	0.00 Trai nees	8.00
0.00	Tatal having worked	1.00	2.00	3.00	4.00	5.00	0.00
9.00 10.00	Total hours worked AHSEA (see instructions)	2, 094. 00 72. 73	6, 242. 00 63. 25	0. (0. (0.00 0.00	9.00 10.00
11.00	Standard travel allowance (columns 1 and 2,	31.63	31.63	0. (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	О		0		12.00
12. 01 13. 00	Number of travel hours (offsite) Number of miles driven (provider site)	о	0		0		12.01 13.00
13.00	Number of miles driven (offsite)	0	0		0		13.00
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00 15.00	Supervisors (column 1, line 9 times column 1 Therapists (column 2, line 9 times column 2,					152, 297 394, 807	14.00 15.00
16.00	Assistants (column 3, line 9 times column 3,					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 a others)	nd 15 for respir	ratory therapy	or lines 14	-16 for all	547, 104	17.00
18.00	Aides (column 4, line 9 times column 4, line	10)				93, 437	18.00
19.00	Trainees (column 5, line 9 times column 5, l					0	19.00
20.00	Total allowance amount (sum of lines 17-19 f If the sum of columns 1 and 2 for respirator						20.00
	occupational therapy, line 9, is greater tha	n line 2, make r					
21.00	amount from line 20. Otherwise complete lin Weighted average rate excluding aides and tr		divided by sur	n of columns	1 and 2, line 9	0.00	21.00
22.00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and train					0	22.00
22.00 23.00	Total salary equivalency (see instructions)		es i î î e 21)			640, 541	
	PART III - STANDARD AND OPTIONAL TRAVEL ALLO	WANCE AND TRAVEL	EXPENSE COMPL	JTATION - PR	OVIDER SITE		
24.00	Standard Travel Allowance Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)			1		0	
26.00 27.00	Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3				3 and 4 for all	0	26.00 27.00
	others)		13				
28.00	Total standard travel allowance and standard 27)	travei expense	at the provide	er site (sum	or tines 26 and	0	28.00
20.00	Optional Travel Allowance and Optional Trave Therapists (column 2, line 10 times the sum		12 line 12			0	29.00
29.00 30.00	Assistants (column 3, line 10 times column 3		, interz)			0	30.00
31.00	Subtotal (line 29 for respiratory therapy or					0	31.00
32.00	Optional travel expense (line 8 times column columns 1-3, line 13 for all others)	s I and 2, IIne	13 Tor respira	atory therap	y or sum or	0	32.00
33.00	Standard travel allowance and standard trave		,			0	33.00
34.00 35.00	Optional travel allowance and standard trave Optional travel allowance and optional trave					0	34.00 35.00
00.00	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW				VICES OUTSIDE PR		00.00
36.00	Standard Travel Expense 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 39.00	Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the su	m of lines 5 and	1 6)			0	38.00 39.00
07.00	Optional Travel Allowance and Optional Trave					0	
40.00	Therapists (sum of columns 1 and 2, line 12.		2, line 10)			0	40.00 41.00
41.00 42.00	Assistants (column 3, line 12.01 times colum Subtotal (sum of lines 40 and 41)	n 3, ine 10)				0	41.00
43.00	Optional travel expense (line 8 times the su			of the fit	lowing three l'	0	43.00
	Total Travel Allowance and Travel Expense - 46, as appropriate.	STISTLE SERVICES	s, comprete one	e of the fol	Towing three IIn	185 44, 45, 0r	
44.00		l expense (sum o	of lines 38 and	d 39 - see i	nstructions)	0	44.00

	ABLE COST DETERMINATION FOR THERAPY SERVICES E SUPPLIERS	FURNI SHED BY	Provider CO		Period: From 10/01/2016 To 09/30/2017		pared:
					Respi ratory Therapy	Cost	
						1.00	
5.00	Optional travel allowance and standard travel	expense (sum	of lines 39 ar	nd 42 - see ii	nstructions)	1.00	45.00
6.00	Optional travel allowance and optional travel		of lines 42 ar				46.00
		Therapists 1.00	Assistants 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	5.00	
7.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each	5.00	0.00	7.0	0 0.00	12.00	47.00
3. 00	column of line 56) Overtime rate (see instructions)	94.88	0.00	71. 1	5 0.00		48.00
	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	474.40	0.00				49.00
	CALCULATION OF LIMIT					· · · · · ·	
0. 00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	41.67	0.00	58.3	.3 0.00	100.00	50.00
	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	866. 74	0.00	1, 213. 2	0.00	2, 080. 00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE	(2.25	0.00	47.4	2 0.00		
2.00	Adjusted hourly salary equivalency amount (see instructions)	63. 25	0.00	47.4	.3 0.00		52.00
8. 00	Overtime cost limitation (line 51 times line 52)	54, 821	0	57, 54	5 0		53.00
	Maximum overtime cost (enter the lesser of line 49 or line 53)	474	0	49			54.00
5.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	316	0	33	2 0		55.00
6. 00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for	158	0	16	.6 0	324	56.00
	respiratory therapy and columns 1 through 3 for all others.)						
						1.00	
						1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION A	AND EXCESS COST	ADJUSTMENT				
. 00	Salary equivalency amount (from line 23)					640, 541	
. 00 . 00	Salary equivalency amount (from line 23) Travel allowance and expense - provider site	(from lines 33	3, 34, or 35))	5)		0	58.0
. 00 . 00 . 00	Salary equivalency amount (from line 23) Travel allowance and expense - provider site Travel allowance and expense - Offsite servio	(from lines 33	3, 34, or 35))	5)		0 0	58.0 59.0
. 00 . 00 . 00 . 00	Salary equivalency amount (from line 23) Travel allowance and expense - provider site	(from lines 33	3, 34, or 35))	5)		0 0 324	58.0 59.0 60.0
. 00 . 00 . 00 . 00 . 00	Salary equivalency amount (from line 23) Travel allowance and expense - provider site Travel allowance and expense - Offsite servid Overtime allowance (from column 5, line 56)	(from lines 33	3, 34, or 35))	5)		0 0 324 0	58.0 59.0 60.0 61.0
. 00 . 00 . 00 . 00 . 00 . 00	Salary equivalency amount (from line 23) Travel allowance and expense - provider site Travel allowance and expense - Offsite servic Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) Total allowance (sum of lines 57-62)	(from lines 33 ces (from lines	3, 34, or 35)) s 44, 45, or 46	5)		0 0 324 0 5, 655 646, 520	58.0 59.0 60.0 61.0 62.0 63.0
7.00 3.00 9.00 9.00 1.00 2.00 3.00 4.00 5.00	Salary equivalency amount (from line 23) Travel allowance and expense - provider site Travel allowance and expense - Offsite servid Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63)	(from lines 33 ces (from lines n your records)	3, 34, or 35)) s 44, 45, or 46	5)		0 324 0 5, 655 646, 520 354, 571	58.0 59.0 60.0 61.0 62.0 63.0 64.0
7.00 3.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00	Salary equivalency amount (from line 23) Travel allowance and expense - provider site Travel allowance and expense - Offsite servid Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 65 LINE 33 CALCULATION	(from lines 33 ces (from lines n your records) 3 - if negative	3, 34, or 35)) s 44, 45, or 46) e, enter zero)			0 324 0 5, 655 646, 520 354, 571 0	58.00 59.00 60.00 61.00 62.00 63.00 64.00 65.00
7.00 3.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 00.00 00.01	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) Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 65 LINE 33 CALCULATION Line 26 = line 24 for respiratory therapy or Line 33 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27	(from lines 33 ces (from lines n your records) 3 - if negative sum of lines 2	3, 34, or 35)) s 44, 45, or 46 e, enter zero) 24 and 25 for a	all others	others	0 324 0 5, 655 646, 520 354, 571 0 0 0	58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 100. 00 100. 00
7.00 3.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 00.00 00.01 00.02	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) Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 65 LINE 33 CALCULATION Line 26 = line 24 for respiratory therapy or Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION	(from lines 33 ces (from lines m your records) 3 - if negative sum of lines 2 y therapy or su	3, 34, or 35)) s 44, 45, or 46 e, enter zero) 24 and 25 for a um of lines 3 a	all others and 4 for all		0 0 324 0 5, 655 646, 520 354, 571 0 0 0 0 0	58.00 59.00 60.00 61.00 62.00 63.00 64.00 65.00 100.00 100.00
7.00 3.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 00.00 00.01 00.02 01.00 01.00 01.01	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) Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION Line 26 = line 24 for respiratory therapy or Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or	(from lines 33 ces (from lines m your records) 3 - if negative sum of lines 2 y therapy or su	3, 34, or 35)) 5 44, 45, or 46 9 9, enter zero) 24 and 25 for a um of lines 3 a um of lines 3 a	all others and 4 for all and 4 for all		0 0 324 0 5,655 646,520 354,571 0 0 0 0 0 0 0 0 0	58.00 59.00 60.00 61.00 62.00 63.00 64.00 65.00 100.00 100.00 100.00
7.00 3.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 00.00 00.01 00.02 01.00 01.01 01.01	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) Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 65 LINE 33 CALCULATION Line 26 = line 24 for respiratory therapy or Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION	(from lines 33 ces (from lines a - if negative sum of lines 2 y therapy or su sum of lines 2	3, 34, or 35)) s 44, 45, or 46 e, enter zero) 24 and 25 for a um of lines 3 a 29 and 30 for a	all others and 4 for all and 4 for all all others		0 0 324 0 5,655 646,520 354,571 0 0 0 0 0 0 0 0 0	58. 0 59. 0 60. 0 61. 0 62. 0 63. 0 64. 0 65. 0 100. 0 100. 0 100. 0
7.00 3.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 00.00 00.01 00.02 01.00 01.01 01.01 01.02 01.02	Salary equivalency amount (from line 23) Travel allowance and expense - provider site Travel allowance and expense - Offsite servic Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 65 LINE 33 CALCULATION Line 26 = line 24 for respiratory therapy or Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31	(from lines 33 ces (from lines m your records) 3 - if negative sum of lines 2 y therapy or su y therapy or su sum of lines 2 sum of lines 2	3, 34, or 35)) s 44, 45, or 46) s, enter zero) 24 and 25 for a um of lines 3 a 29 and 30 for a 29 and 30 for a	all others and 4 for all and 4 for all all others all others	others	0 0 324 0 5, 655 646, 520 354, 571 0 0 0 0 0 0 0 0 0 0 0 0 0	58. 0 59. 0 60. 0 61. 0 62. 0 63. 0 64. 0 65. 0 100. 0 100. 0 100. 0 101. 0

REASON	h Financial Systems JAY COUNTY HOSPITAL NABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY Provider DE SUPPLIERS	CCN: 15-1320	In Lie Peri od: From 10/01/2016 To 09/30/2017 Occupati onal Therapy	u of Form CMS- Worksheet A-8 Parts I-VI Date/Time Pre 2/26/2018 1:5 Cost	-3 pared:
				1.00	
1.00 2.00 3.00 4.00	PART I - GENERAL INFORMATION Total number of weeks worked (excluding aides) (see instructions) Line 1 multiplied by 15 hours per week Number of unduplicated days in which supervisor or therapist was on provider Number of unduplicated days in which therapy assistant was on provider			52 780 0 0	
5.00 6.00	nor therapist was on provider site (see instructions) Number of unduplicated offsite visits - supervisors or therapists (see Number of unduplicated offsite visits - therapy assistants (include onl assistant and on which supervisor and/or therapist was not present duri instructions)	y visits made	by therapy	0 0	5.00 6.00
7.00 8.00	Standard travel expense rate Optional travel expense rate per mile			0.00 0.00	
	Supervi sors Therapi sts	Assi stants		Trai nees	
9.00	1.00 2.00 Total hours worked 0.00 1,605.0	<u>3.00</u> 00 0.	4.00 00 0.00	5.00	9.00
10. 00 11. 00			00 0.00	0.00	10. 00 11. 00
12.00 12.01 13.00	Number of travel hours (provider site)0Number of travel hours (offsite)0Number of miles driven (provider site)0	0 0 0	0 0 0		12.00 12.01 13.00
13.01	Number of miles driven (offsite) 0	0	0		13.01
	Part II - SALARY EQUIVALENCY COMPUTATION			1.00	
14. 00 15. 00	Supervisors (column 1, line 9 times column 1, line 10) Therapists (column 2, line 9 times column 2, line 10)			0 122, 413	
16. 00 17. 00		apy or lines 1	4-16 for all	0 122, 413	16.00 17.00
18.00	Aides (column 4, line 9 times column 4, line 10)			0	18.00
19.00 20.00					19.00 20.00
21.00	occupational therapy, line 9, is greater than line 2, make no entries o amount from line 20. Otherwise complete lines 21-23. Weighted average rate excluding aides and trainees (line 17 divided by				21.00
22.00	for respiratory therapy or columns 1 thru 3, line 9 for all others) Weighted allowance excluding aides and trainees (line 2 times line 21)		o i ana <u>2</u> , i i i o i	0	22.00
23.00	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE CO Standard Travel Allowance	MPUTATION - P	ROVIDER SITE	122, 413	23.00
24.00	Therapists (line 3 times column 2, line 11)			0	24.00
25.00 26.00		all others)		0	
27.00			3 and 4 for all	0	27.00
28.00	27)	vider site (su	m of lines 26 and	0	28.00
29.00	Optional Travel Allowance and Optional Travel Expense Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12	2)		0	29.00
30. 00 31. 00		all athors)		0	30.00 31.00
32.00			py or sum of	0	32.00
33.00 34.00		and 31)		0	33.00 34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COM	and 32)	RVICES OUTSIDE PR	0	
36.00	Standard Travel Expense Therapists (line 5 times column 2, line 11)			0	36.00
37.00				0	37.00
38.00 39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)			0	38.00 39.00
40.00	Optional Travel Allowance and Optional Travel Expense Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)			0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)			0	41.00
42.00 43.00)1)		0	
	Total Travel Allowance and Travel Expense - Offsite Services; Complete		llowing three lin		
44.00	46, as appropriate. Standard travel allowance and standard travel expense (sum of lines 38	and 39 - see	instructions)	0	44.00

					From 10/01/2016 To 09/30/2017		
					Occupational Therapy	Cost	
						1.00	
5.00	Optional travel allowance and standard travel	expense (sum	of lines 39 a	nd 42 - see i	nstructions)	0	45.00
6.00	Optional travel allowance and optional travel		of lines 42 a				46.00
	-	Therapists 1.00	Assistants 2.00	Ai des 3.00	Trai nees 4.00	<u>Total</u> 5.00	
	PART V - OVERTIME COMPUTATION	1.00	2.00	3.00	4.00	5.00	
7.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.0	0. 00	0.00	47.0
8.00	Overtime rate (see instructions)	0.00	0.00				48.00
9.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT	0.00	0.00	0.0	0.00		49.00
0. 00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.0	0.00	0.00	50.00
1.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions) DETERMINATION OF OVERTIME ALLOWANCE	0.00	0.00	0.0	00 0.00	0.00	51.00
2.00	Adjusted hourly salary equivalency amount	76.27	0.00	0.0	0.00		52.00
3. 00	(see instructions) Overtime cost limitation (line 51 times line	0	0.00	0.0	0 0		53.0
4. 00	52) Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0		0 0		54.00
5. 00		0	0		0 0		55.00
6. 00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for	0	0		0 0	0	56.00
	respiratory therapy and columns 1 through 3 for all others.)						
					·	1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST	ADJUSTMENT		1		
8.00 9.00 0.00 .00 2.00	Equipment cost (see instructions) Supplies (see instructions)			5)		0	58.0 59.0 60.0 61.0 62.0
	Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION					122, 413 74, 188 0	
0. 01	Line 26 = line 24 for respiratory therapy or Line 27 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION				others	0	100. 0 100. 0 100. 0
01. 01	Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION				others	0	101. 0 101. 0 101. 0
)2.00	LINE 35 CALCULATION Line 31 = line 29 for respiratory therapy or Line 32 = line 8 times columns 1 and 2, line						102. 0 102. 0

REASON	Financial Systems IABLE COST DETERMINATION FOR THERAPY SERVICES DE SUPPLIERS	JAY COUNTY H	DSPITAL Provider CCN:		Period: From 10/01/2016 To 09/30/2017	u of Form CMS-2 Worksheet A-8 Parts I-VI Date/Time Pre 2/26/2018 1:5	-3 pared:
					Speech Pathology	Cost	
	PART I – GENERAL INFORMATION					1.00	
1.00	Total number of weeks worked (excluding aide	s) (see instruct	i ons)			52	1.00
2.00	Line 1 multiplied by 15 hours per week				- ! +	780	2.00
3.00 4.00	Number of unduplicated days in which supervi Number of unduplicated days in which therapy					0	3.00 4.00
5.00	nor therapist was on provider site (see inst Number of unduplicated offsite visits - supe		nists (soo inst	ructions)		0	5.00
6. 00	Number of unduplicated offsite visits - supe assistant and on which supervisor and/or the instructions)	apy assistants (include only vi	sits made		0	6.00
7.00	Standard travel expense rate					0.00	7.00
8.00	Optional travel expense rate per mile	Supervi sors	Therapists /	Assi stants	Ai des	0.00 Trai nees	8.00
		1.00	2.00	3.00	4.00	5.00	
9.00 10.00	Total hours worked AHSEA (see instructions)	0. 00 0. 00	438.00 73.31	0. 0 0. 0		0.00 0.00	9.00 10.00
11.00	Standard travel allowance (columns 1 and 2,	36,66	36.66	0.0		0.00	11.00
	one-half of column 2, line 10; column 3,						
12 00	one-half of column 3, line 10)		0		0		12.00
12.00 12.01	Number of travel hours (provider site) Number of travel hours (offsite)	0	0		0		12.00
13.00	Number of miles driven (provider site)	Ő	0		0		13.00
13.01	Number of miles driven (offsite)	0	0		0		13.01
					-	1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00 15.00	Supervisors (column 1, line 9 times column 1 Therapists (column 2, line 9 times column 2,					0 32, 110	
16.00	Assistants (column 3, line 9 times column 3,					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 a		atory therapy o	r lines 14	-16 for all	32, 110	17.00
10 00	others)	10)				0	10.00
18.00 19.00	Aides (column 4, line 9 times column 4, line Trainees (column 5, line 9 times column 5, l					0	18.00 19.00
20.00	Total allowance amount (sum of lines 17-19 f	or respiratory t				32, 110	
	If the sum of columns 1 and 2 for respiratory						
	occupational therapy, line 9, is greater than amount from line 20. Otherwise complete line		o entries on II	nes 21 and	22 and enter on	line 23 the	
21.00	Weighted average rate excluding aides and tr	ainees (line 17		of columns	1 and 2, line 9	73. 31	21.00
22.00	for respiratory therapy or columns 1 thru 3,					E7 100	22.00
22.00 23.00	Weighted allowance excluding aides and train Total salary equivalency (see instructions)	ees (ITTTTE 2 LITTTTE	s Tine 21)			57, 182 57, 182	
	PART III - STANDARD AND OPTIONAL TRAVEL ALLO	VANCE AND TRAVEL	EXPENSE COMPUT	ATION - PR	OVIDER SITE		
o 4 . o o	Standard Travel Allowance						
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 all	others)		0	
27.00	Standard travel expense (line 7 times line 3	for respiratory	therapy or sum	oflines	3 and 4 for all	0	27.00
28.00	others) Total standard travel allowance and standard	travel expense	at the provider	site (sum	of lines 26 and	0	28.00
20.00	27)			51 10 (301	or trues zo and		20.00
20.00	Optional Travel Allowance and Optional Travel		2 + 1 = 12			0	
29.00 30.00	Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3		2, 11110 12)			0	29.00 30.00
31.00	Subtotal (line 29 for respiratory therapy or	,	and 30 for all	others)		0	31.00
32.00	Optional travel expense (line 8 times column	s 1 and 2, line	13 for respirat	ory therap	y or sum of	0	32.00
33.00	columns 1-3, line 13 for all others) Standard travel allowance and standard trave	evnense (line	28)			0	33.00
34.00	Optional travel allowance and standard trave			31)		0	34.00
35.00	Optional travel allowance and optional trave					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW, Standard Travel Expense	ANCE AND TRAVEL	EXPENSE COMPUTA	TION - SER	VICES OUTSIDE PR	OVIDER 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	38.00
39.00	Standard travel expense (line 7 times the su Optional Travel Allowance and Optional Travel		0)			0	39.00
40.00	Therapists (sum of columns 1 and 2, line 12.		2, line 10)			0	40.00
41.00	Assistants (column 3, line 12.01 times colum					0	41.00
42.00	Subtotal (sum of lines 40 and 41)	n of columno 1 3	line 12 01)			0	42.00 43.00
43.00	Optional travel expense (line 8 times the su Total Travel Allowance and Travel Expense - (of the fol	lowing three line	0 es 44, 45, or	43.00
	46, as appropriate.						
44.00	Standard travel allowance and standard trave						44.00 45.00
45.00	Optional travel allowance and standard trave						

UTSI D	ABLE COST DETERMINATION FOR THERAPY SERVICES E SUPPLIERS	FURNI SHED BY	Provider CC		Period: From 10/01/2016 To 09/30/2017	Date/Time Pre 2/26/2018 1:5	pared:
					Speech Pathology	Cost	
						1.00	
6.00	Optional travel allowance and optional travel	expense (sum c	of lines 42 an	d 43 - see i	nstructions)		46.00
		Therapi sts	Assi stants	Ai des	Trai nees	Total	
		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	0.00	0.00	0.0	0.00	0.00	47.00
	complete lines 48-55 and enter zero in each column of line 56)						
	Overtime rate (see instructions)	0.00	0.00	0.0			48.00
9.00	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						
0.00	Percentage of overtime hours by category	0.00	0.00	0.0	0.00	0.00	50.00
0.00	(divide the hours in each column on line 47	0100	0100	0.10		01.00	00.00
	by the total overtime worked - column 5,						
	line 47)						
1.00	Allocation of provider's standard work year	0.00	0.00	0.0	0. 00	0.00	51.00
	for one full-time employee times the						
	percentages on line 50) (see instructions) DETERMINATION OF OVERTIME ALLOWANCE						
2.00	Adjusted hourly salary equivalency amount	73.31	0,00	0.0	0.00		52.00
	(see instructions)						
3.00	Overtime cost limitation (line 51 times line	0	0		0 0		53.00
	52)						
4.00	Maximum overtime cost (enter the lesser of	0	0		0 0		54.00
5.00	line 49 or line 53) Portion of overtime already included in	0	0		0 0		55.00
0.00	hourly computation at the AHSEA (multiply	0	Ű		0		
	line 47 times line 52)						
6. 00	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	AND EXCESS COST	ADJUSTMENT				
	Salary equivalency amount (from line 23)	(6	24			57, 182	
	Travel allowance and expense - provider site Travel allowance and expense - Offsite servid			`		0	
	Overtime allowance (from column 5, line 56)		44, 43, 01 40)		0	
1.00	Equipment cost (see instructions)					0	
	Supplies (see instructions)					0	
3.00	Total allowance (sum of lines 57-62)					57, 182	63.00
						19, 224	64.00
4.00	Excess over limitation (line 64 minus line 63	3 - if negative,	enter zero)			0	65.00
						0	100.00
5.00	LINE 33 CALCULATION	aum of Lines 04	Fand 25 For a		othors		100. 00 100. 01
5.00 00.00	Line 26 = line 24 for respiratory therapy or				others	0	
5.00 00.00 00.01	Line 26 = line 24 for respiratory therapy or Line 27 = line 7 times line 3 for respiratory					0	1100 02
5.00 00.00 00.01	Line 26 = line 24 for respiratory therapy or Line 27 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27					0	100. 02
5.00 00.00 00.01 00.02	Line 26 = line 24 for respiratory therapy or Line 27 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION	y therapy or sum	n of lines 3 a		others		
5.00 00.00 00.01 00.02 01.00	Line 26 = line 24 for respiratory therapy or Line 27 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27	y therapy or sum y therapy or sum	n of lines 3 a	nd 4 for all	others	0	101. 00
5.00 00.00 00.01 00.02 01.00 01.01	Line 26 = line 24 for respiratory therapy or Line 27 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION Line 27 = line 7 times line 3 for respiratory	y therapy or sum y therapy or sum	n of lines 3 a	nd 4 for all	others	0	100. 02 101. 00 101. 01 101. 02
5.00 00.00 00.01 00.02 01.02 01.01 01.01	Line 26 = line 24 for respiratory therapy or Line 27 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION	y therapy or sum y therapy or sum sum of lines 29	n of lines 3 a n of lines 3 a 9 and 30 for a	nd 4 for all II others	others	0 0 0	101. 00 101. 01 101. 02
5.00 00.00 00.01 00.02 01.00 01.01 01.02 02.00	Line 26 = line 24 for respiratory therapy or Line 27 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION Line 31 = line 29 for respiratory therapy or	y therapy or sum y therapy or sum sum of lines 29 sum of lines 29	n of lines 3 a n of lines 3 a 9 and 30 for a 9 and 30 for a	nd 4 for all II others II others		000000000000000000000000000000000000000	101.00 101.01 101.02 102.00
5.00 00.00 00.01 00.02 01.00 01.01 01.02	Line 26 = line 24 for respiratory therapy or Line 27 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION	y therapy or sum y therapy or sum sum of lines 29 sum of lines 29	n of lines 3 a n of lines 3 a 9 and 30 for a 9 and 30 for a	nd 4 for all II others II others		000000000000000000000000000000000000000	101. 00 101. 01 101. 02

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	JAY COUNTY	HOSPITAL Provider CC		eriod: rom 10/01/2016	u of Form CMS-2 Worksheet B Part I Date/Time Pre	pared:
				CAPI TAL REL	ATED COSTS	2/26/2018 1:5	6 pm
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	NEW MVBLE EQUI P	NEW MVBLE EQUIP MOB	NEW MVBLE EQUI P-POB	NEW MVBLE EQUIP- WJ	
		0	2.00	2.01	2.02	2.03	
2.00 2.01 2.02 2.03 4.00 5.00 7.00 7.01	GENERAL SERVICE COST CENTERS 00200 NEW CAP REL COSTS-MVBLE EQUIP 00201 NEW CAP REL COSTS-MVBLE EQUIP MOB 00202 NEW CAP REL COSTS-MVBLE EQUIP-POB 00203 NEW CAP REL COSTS-MVBLE EQUIP-WJ 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00701 OPERATION OF PLANT-MOB	1, 705, 735 8, 689 101, 949 31, 142 6, 368, 507 5, 964, 516 1, 202, 108 58, 818	1, 705, 735 0 0 0 0 179, 916 122, 878 0	8, 689 0 0 1, 526 1, 276 0	101, 949 0 8, 476 6, 116 0	31, 142 0 0 0 0	2.00 2.01 2.02 2.03 4.00 5.00 7.00 7.01
7.02 7.03 8.00 9.00 10.00 11.00 13.00 14.00	00702 OPERATION OF PLANT-POB 00703 OPERATION OF PLANT-WJ 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	97, 884 3, 450 100, 154 456, 396 373, 136 76, 190 1, 031, 240 70, 791 381, 224	0 9, 766 10, 907 45, 714 45, 100 36, 585 27, 608 31, 164	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	7.02 7.03 8.00 9.00 10.00 11.00 13.00 14.00 16.00
31.00 33.00 40.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03300 BURN INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04200 SUBPROVIDER 04300 NURSERY	1, 472, 519 0 851, 743 0 0 103, 605	261, 557 0 100, 821 0 22, 671	0 0 0 0 0 0 0	0 0 0 0 0 0 0	0 0 0 0 0 0 0	30.00 31.00 33.00 40.00 41.00 42.00 43.00
52. 00 53. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY 05400 RADIOLOGY-DIAGNOSTIC 05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 376, 122 24, 587 0 1, 454, 214 0 0	118, 730 2, 787 0 137, 582 0 0	0 0 0 0 0	45, 843 0 0 0 0 0	0 0 0 0 0 0	50.00 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	05900 CARDIAC CATHETERIZATION 05900 CARDIAC CATHETERIZATION 06000 LABORATORY 06001 BLOOD LABORATORY 06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY 06700 OCCUPATIONAL THERAPY 06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY 06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 0UTPATIENT SERVICE COST CENTERS	0 0 1, 917, 800 0 371, 414 565, 851 74, 188 19, 224 321, 533 0 31, 310 1, 771, 108	0 0 56, 117 0 12, 246 2, 392 0 0 43, 937 0 22, 517	0 0 0 0 0 0 0 0 0 0 0			59.00 60.00 60.01 65.00 66.00 67.00 68.00 69.00 71.00 72.00 73.00
89.00 90.00 90.01 90.02 91.00 92.00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09001 FAMILY PRACTICE OF JAY COUNTY 09002 JAY FAMILY MEDICINE 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) 04040 OTHER OUTPATIENT SERVICE COST CENTER 0THER REIMBURSABLE COST CENTERS	0 0 48, 076 353, 536 407, 744 834, 137 19, 750	0 0 0 189, 616 99, 680 0	0 0 5, 887 0 0 0	0 0 0 0 0 0	0 0 0 0 0 0 0	88.00 89.00 90.01 90.02 91.00 92.00 93.00
99. 10	09910 CORF	0	0	0	0	0	99.10
109. 00 110. 00 111. 00	SPECIAL PURPOSE COST CENTERS 10600 HEART ACQUISITION 10900 PANCREAS ACQUISITION 11000 INTESTINAL ACQUISITION 11100 ISLET ACQUISITION 11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0 0 0 30, 050, 390	0 0 0 1, 580, 291	0 0 0 8, 689	0 0 0 60, 435	0 0 0	106.00 109.00 110.00 111.00 113.00 118.00
192.00 193.00 194.00 194.01	NONKET MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CLANS' PRI VATE OFFI CES 19300 NONPAI D WORKERS 07950 MOB 07951 POB 07952 WEST JAY CLINIC	0 0 0 0 0	19, 883 0 0 0 0 0 0	0 0 0 0 0 0	0 0 0 0 0 0	0 0 0	190.00 192.00 193.00 194.00 194.01 194.02

Health Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 10/01/2016 Fo 09/30/2017	Date/Time Pre	
					2/26/2018 1:5	6 pm
			CAPITAL RE	ELATED COSTS		
Cost Center Description	Net Expenses	NEW MVBLE	NEW MVBLE	NEW MVBLE	NEW MVBLE	
	for Cost	EQUI P	EQUIP MOB	EQUI P-POB	EQUIP- WJ	
	Allocation					
	(from Wkst A					
	col. 7)					
	0	2.00	2.01	2.02	2.03	
194. 03 07953 CONVENI ENT CARE	0	20, 673	(0 0		194.03
194.04079540THER NONREIMBURSABLE COST CENTERS	0	0	(0 0		194.04
194.05079550THER NONREIMBURSABLE COST CENTERS	0	0	(0 0		194.05
194.06 07956 TRI COUNTY	1, 473, 542	0	(0 41, 514	0	194.06
194. 07 07957 HOSPI TALI ST	527, 227	0	(0 0	0	194.07
194.0807958 FAMILY FIRST HEALTH	906, 565	84, 888	(0 0	0	194.08
194.0907959 MERIDIAN HEALTH CONVENIENT CARE	0	0	(0 0	0	194.09
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers		0	(0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	32, 957, 724	1, 705, 735	8, 68	9 101, 949	31, 142	202.00

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	JAY COUNTY	HOSPITAL Provider Co		eriod: rom 10/01/2016	u of Form CMS-2 Worksheet B Part I Date/Time Pre 2/26/2018 1:5	pared:
	Cost Center Description	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	ADMI NI STRATI V E & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT-MOB	
		4.00	4A	5.00	7.00	7.01	
2.00 2.01 2.02 2.03 4.00 5.00 7.00 7.01 7.03 8.00 9.00 10.00 11.00 13.00	GENERAL SERVICE COST CENTERS 00200 NEW CAP REL COSTS-MVBLE EQUIP 00201 NEW CAP REL COSTS-MVBLE EQUIP MOB 00202 NEW CAP REL COSTS-MVBLE EQUIP-OB 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-MOB 00703 OPERATION OF PLANT-WJ 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01100 DIETARY 01300 NURSING ADMINISTRATION	6, 368, 507 838, 437 92, 897 4, 591 2, 478 1, 259 20, 444 144, 508 76, 388 55, 153 377, 230	6, 992, 871 1, 425, 275 63, 409 100, 362 4, 709 130, 364 611, 811 495, 238 176, 443 1, 445, 055	383, 856 17, 077 27, 030 1, 268 35, 110 164, 774 133, 378 47, 520	1, 809, 131 0 0 12, 594 14, 065 58, 950 58, 157 47, 177	80, 486 0 0 0 0 0 0 0 0 0	2.00 2.01 2.02 2.03 4.00 5.00 7.00 7.01 7.01 7.03 8.00 9.00 10.00 11.00 13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	23, 003	121, 402	32, 696	35, 602	0	14.00
16.00	01600 MEDICAL RECORDS & LIBRARY	122, 334	534, 722	144, 012	40, 187	0	16.00
30.00 31.00 33.00 40.00 41.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03300 BURN INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF	476, 945 0 0 246, 915 0	2, 211, 021 0 0 1, 199, 479 0	595, 474 0 0 323, 045 0	337, 285 0 0 130, 012 0	0 0 0 0 0 0	30.00 31.00 33.00 40.00 41.00
42.00	04200 SUBPROVI DER	0	0	0	0	0	42.00
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	34, 728	161, 004	43, 362	29, 234	0	43.00
50.00 52.00 53.00 54.00 57.00 58.00	05000 OPERATI NG ROOM 05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05700 CT SCAN 05800 MAGNETI C RESONANCE I MAGI NG (MRI)	296, 508 8, 272 0 286, 649 0 0	1, 837, 203 35, 646 0 1, 878, 445 0 0	9, 600 0	153, 105 3, 594 0 177, 415 0 0	0 0 0 0 0 0	50.00 52.00 53.00 54.00 57.00 58.00
59.00 60.00 60.01	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 BLOOD LABORATORY	0 241, 380	0 2, 215, 297	0 596, 616 0	0 72, 364 0	0 0 0	59.00 60.00 60.01
65.00 66.00 67.00 68.00 69.00 71.00 72.00	06500 RESPI RATORY THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 IMPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 00TPATI ENT SERVI CE COST CENTERS	0 0 0 68, 122 0 0 158, 791	383, 660 568, 243 74, 188 19, 224 433, 592 0 31, 310 1, 952, 416	103, 328 153, 040 19, 980 5, 177 116, 775 0 8, 432	15, 792 3, 085 0 56, 657 0 29, 036	0 0 0 0 0 0 0	65.00 66.00 67.00 68.00 69.00 71.00 72.00
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00 90.01 90.02 91.00 92.00 93.00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09001 FAMILY PRACTICE OF JAY COUNTY 09002 JAY FAMILY MEDICINE 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) 04040 OTHER OUTPATIENT SERVICE COST CENTER OTHER REIMBURSABLE COST CENTERS	0 0 593, 284 596, 855 766, 240 281	0 48, 076 952, 707 1, 194, 215 1, 700, 057 0 20, 031	12, 948 256, 584 321, 627 457, 861 5, 395	0 0 244, 515 128, 540 0	0 0 80, 486 0 0	92.00 93.00
99.10	09910 CORF SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	99.10
109. 00 110. 00 111. 00	10600 HEART ACQUISITION 10900 PANCREAS ACQUISITION 11000 INTESTINAL ACQUISITION 11100 ISLET ACQUISITION 11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	0 0 0 5, 533, 692	0 0 0 29, 017, 475	0 0 0 5, 931, 678	0 0 0 1, 647, 366	0	106.00 109.00 110.00 111.00 113.00 118.00
192.00 193.00 194.00 194.01 194.02 194.03	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CIANS' PRI VATE OFFI CES 19300 NONPAI D WORKERS 07950 MOB 07951 POB 07952 WEST JAY CLINIC 07953 CONVENIENT CARE 07953 CONVENIENT CARE	0 0 0 0 224, 759 71, 289	19, 883 0 0 0 0 255, 901 91, 962	0 0 0 68, 920	25, 640 0 0 0 0 0 26, 659	0 0 0 0 0 0	190.00 192.00 193.00 194.00 194.01 194.02 194.03
194.05	07954 OTHER NONREIMBURSABLE COST CENTERS 07955 OTHER NONREIMBURSABLE COST CENTERS 07956 TRI COUNTY	0 0 89, 593	0 0 1, 604, 649	0 0 432, 166	0 0 0	0	194. 04 194. 05 194. 06

Health Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		Period:	Worksheet B	
				From 10/01/2016 Fo 09/30/2017		nared
					2/26/2018 1:5	6 pm
Cost Center Description	EMPLOYEE	Subtotal	ADMI NI STRATI V	OPERATION OF	OPERATION OF	
	BENEFI TS		E & GENERAL	PLANT	PLANT-MOB	
	DEPARTMENT					
	4.00	4A	5.00	7.00	7.01	
194. 07 07957 HOSPI TALI ST	157, 486	684, 713	184, 408	3 0	0	194.07
194.0807958 FAMILY FIRST HEALTH	291, 688	1, 283, 141	345, 57	7 109, 466	0	194.08
194.0907959 MERIDIAN HEALTH CONVENIENT CARE	0	0	(0 0	0	194.09
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 through 201)	6, 368, 507	32, 957, 724	6, 992, 87 ⁻	1, 809, 131	80, 486	202.00

Health Financial Systems	JAY COUNTY	HOSPI TAL		In Lieu	ı of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		eriod: rom 10/01/2016	Worksheet B Part I	
			T		Date/Time Pre 2/26/2018 1:5	pared: 6 pm
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	
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01 00200 NEW CAP REL COSTS-MVBLE EQUIP MOB 2.01 00201 NEW CAP REL COSTS-MVBLE EQUIP MOB 2.02 00202 NEW CAP REL COSTS-MVBLE EQUIP-POB 2.03 00203 NEW CAP REL COSTS-MVBLE EQUIP-WJ 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT 7.01 00FRATION OF PLANT-MOB 7.02 00702 OPERATION OF PLANT-POB 7.03 00703 OPERATION OF PLANT-WJ	127, 392 0	5, 977				2.00 2.01 2.02 2.03 4.00 5.00 7.00 7.01 7.02 7.03
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY 16. 00 01600 MEDI CAL RECORDS & LI BRARY		0 0 0 0 0 0 0 0 0 0	178, 068 21, 563 5, 565 0 0 0 0	812, 213 22, 099 21, 801 17, 685 13, 346 15, 065	715, 230 0 0 0 0 0	8.00 9.00 10.00 11.00 13.00 14.00 16.00
INPATIENT ROUTINE SERVICE COST CENTERS			-			
30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT 33.00 03300 BURN INTENSIVE CARE UNIT 40.00 04000 SUBPROVI DER - IPF 41.00 04100 SUBPROVI DER - IRF 42.00 04200 SUBPROVI DER 43.00 04300 NURSERY		0 0 0 0 0 0 0 0	81, 634 0 4, 405 0 0 3, 227	126, 437 0 48, 738 0 0 10, 959	515, 447 0 199, 783 0 0 0	30.00 31.00 33.00 40.00 41.00 42.00 43.00
ANCI LLARY SERVI CE COST CENTERS	((050)	0	10 5 40	107 100		50.00
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	66, 853 0 0 0	0 0 0 0		107, 490 1, 347 0 66, 508 0	0 0 0 0	50.00 52.00 53.00 54.00 57.00
58.00 05800 MAGNETI C RESONANCE MAGI NG (MRI) 59.00 05900 CARDI AC CATHETERI ZATI ON 60.00 06000 LABORATORY 60.01 06001 BLOOD LABORATORY 65.00 06500 RESPI RATORY THERAPY		0		0 0 27, 127 0 5, 920	0 0 0 0	58.00 59.00 60.00 60.01 65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY		0 0 0 0	1, 159 0 0 3, 710	1, 156 0 21, 239	0 0 0 0	66.00 67.00 68.00 69.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 72.00 07200 I MPL. DEV. CHARGED TO PATI ENTS 73.00 07300 DRUGS CHARGED TO PATI ENTS 0UTPATI ENT SERVI CE COST CENTERS	0 0 0	0 0 0	0 0 0	0 0 10, 885	0 0 0	
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 09020 JAY FAMILY MEDICINE 91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 93.00 04040 OTHER OUTPATIENT SERVICE COST CENTER			0 0 0 24, 113 0	0 0 58, 551 91, 662 48, 186 0	0 0 0 0 0 0	88.00 89.00 90.00 90.01 90.02 91.00 92.00 93.00
OTHER REIMBURSABLE COST CENTERS 99. 10 09910 CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS 106. 00 10600 HEART ACQUI SI TI ON 109. 00 10900 PANCREAS ACQUI SI TI ON 110. 00 11000 I NTESTI NAL ACQUI SI TI ON	000000000000000000000000000000000000000	0 0 0	0 0 0	0 0 0	0 0	106. 00 109. 00 110. 00
111.00 11100 I SLET ACQUI SI TI ON 113.00 11300 I NTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0 66, 853	0	0 178, 068	0 716, 201	0	111. 00 113. 00 118. 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 193. 00 19300 NONPAID WORKERS 194. 00 07950 MOB 194. 01 07951 POB 194. 02 07952 WEST JAY CLINIC 194. 03 07953 CONVENIENT CARE		0 0 0 0 5, 977 0		9,612 0 0 0 0 0 0 0	0 0 0 0 0	190.00 192.00 193.00 194.00 194.01 194.02 194.03
194. 04 07954 OTHER NONREI MBURSABLE COST CENTERS 194. 05 07955 OTHER NONREI MBURSABLE COST CENTERS 194. 06 07956 TRI COUNTY 194. 07 07957 HOSPI TALI ST	0 0 60, 539 0	0 0 0 0	0 0 0	0 0 45, 364 0	0 0 0	194. 04 194. 05 194. 06 194. 07

Health Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		Period:	Worksheet B Part I	
				From 10/01/2016 To 09/30/2017	Date/Time Pre 2/26/2018 1:5	
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	
194.0807958 FAMILY FIRST HEALTH	0	0		O 41, 036	0	194.08
194.0907959 MERIDIAN HEALTH CONVENIENT CARE	0	0		0 0	0	194.09
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0		o o	0	201.00
202.00 TOTAL (sum lines 118 through 201)	127, 392	5, 977	178, 06	8 812, 213	715, 230	202.00

	Financial Systems ALLOCATION - GENERAL SERVICE COSTS	JAY COUNTY	HOSPITAL Provider CC	CN: 15-1320 Pe	In Lie	u of Form CMS-: Worksheet B	2552-10
				Fi To	rom 10/01/2016 p 09/30/2017	Part I Date/Time Pre 2/26/2018 1:5	
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI O N	CENTRAL SERVI CES & SUPPLY	MEDI CAL RECORDS & LI BRARY	Subtotal	
		11.00	13.00	14.00	16.00	24.00	
	GENERAL SERVICE COST CENTERS		1				
2. 00 2. 01	00200 NEW CAP REL COSTS-MVBLE EQUIP 00201 NEW CAP REL COSTS-MVBLE EQUIP MOB						2.00
2.01	00202 NEW CAP REL COSTS-MVBLE EQUIP-POB						2.01
2.03	00203 NEW CAP REL COSTS-MVBLE EQUIP- WJ						2.03
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 7.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT						5.00
7.00	00701 OPERATION OF PLANT-MOB						7.00
7.02	00702 OPERATION OF PLANT-POB						7.02
7.03	00703 OPERATION OF PLANT-WJ						7.03
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG						8.00 9.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A	303, 921					11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	31, 312		007 50/			13.00
14.00 16.00	01400 CENTRAL SERVICES & SUPPLY 01600 MEDICAL RECORDS & LIBRARY	4, 550 19, 069		207, 596 281	753, 336		14.00
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	17,007		201	733, 330		10.00
30.00	03000 ADULTS & PEDIATRICS	58, 467	699, 741	12, 695	47, 372	4, 685, 573	30.00
31.00	03100 I NTENSI VE CARE UNI T	C	0	0	0	0	31.00
33.00 40.00	03300 BURN I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF	C 29, 596	Ű	0 790	0 7, 250	0 2, 297, 300	
40.00	04000 SUBPROVIDER - IRF	29, 390		0	7,230	2, 297, 300	
42.00	04200 SUBPROVI DER	C		0	0	0	1
43.00	04300 NURSERY	3, 661	43, 811	0	1, 283	296, 541	43.00
50.00	ANCI LLARY SERVICE COST CENTERS 05000 OPERATING ROOM	30, 092	360, 142	50, 261	115, 061	3, 233, 553	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	745		50, 201	1, 753	3, 233, 553 61, 596	
53.00	05300 ANESTHESI OLOGY	C	0	0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	27, 962	1	20, 612	233, 844	2, 924, 834	
57.00	05700 CT SCAN		-	0	0	0	
58.00 59.00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION		-	0	0	0	
60.00	06000 LABORATORY	32, 884	, i i i i i i i i i i i i i i i i i i i	55, 536	160, 073	3, 159, 897	60.00
60.01	06001 BLOOD LABORATORY	C	0	0	0	0	
65.00		C	0	1, 558	8,009	518, 267	65.00
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY		0	580 0	19, 102 3, 334	746, 365 97, 502	1
68.00	06800 SPEECH PATHOLOGY	C	0	0	697	25, 098	1
69.00	06900 ELECTROCARDI OLOGY	13, 940	0	3, 236	22, 016	671, 165	
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	C	0	0	0	0	
	07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS	12, 906	0	1, 502	722 43, 585	40, 464 2, 576, 157	72.00
	OUTPATIENT SERVICE COST CENTERS	.2,700		17002	107 000	2/0/0/10/	
88.00	08800 RURAL HEALTH CLINIC	C	0	0	0	0	
89.00 90.00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC		0	0 1, 921	0 54	0 62, 999	
90.00 90.01			0	22, 017	9, 161	1, 379, 506	
90.02		C	0	13, 295	6, 491	1, 871, 805	
	09100 EMERGENCY	38, 737	463, 606	10, 390	73, 201	2, 944, 691	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART) 04040 OTHER OUTPATIENT SERVICE COST CENTER	C	0	0	328	25 754	92.00 93.00
93.00	OTHER REIMBURSABLE COST CENTERS		v <u> </u>	0	320	25, 754	93.00
99.10	09910 CORF	C	0	0	0	0	99.10
	SPECIAL PURPOSE COST CENTERS						
	10600 HEART ACQUISITION 10900 PANCREAS ACQUISITION		0	0	0		106.00 109.00
	11000 INTESTINAL ACQUISITION		0	0	0		1109.00
	11100 I SLET ACQUI SI TI ON	C	0 O	0	0		111.00
	11300 INTEREST EXPENSE						113.00
118.00		303, 921	1, 930, 413	194, 674	753, 336	27, 619, 067	118.00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		0	0	60 490	190.00
192.00	19200 PHYSI CLANS' PRI VATE OFFICES		0	0	0		192.00
193.00	19300 NONPAI D WORKERS	C	0	0	0	0	193.00
	07950 MOB	C	0	0	0		194.00
	07951 POB 207952 WEST JAY CLINIC		0	0 443	0	0 331, 241	194.01
	07952 WEST JAY CLINIC 07953 CONVENIENT CARE		0	443 1, 032	0	144, 420	
194.04	07954 OTHER NONREI MBURSABLE COST CENTERS	C	o o	0	0	0	194.04
	07955 OTHER NONREI MBURSABLE COST CENTERS	C	0	0	0		194.05
194.06	07956 TRI COUNTY	C	0	2, 258	0	2, 144, 976	1194.06

Health Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO		Period:	Worksheet B	
				From 10/01/2016 To 09/30/2017		pared: 6 pm
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	MEDI CAL	Subtotal	
		ADMI NI STRATI O	SERVICES &	RECORDS &		
		N	SUPPLY	LI BRARY		
	11.00	13.00	14.00	16.00	24.00	
194. 07 07957 H0SPI TALI ST	0	0		0 0	869, 121	194.07
194.0807958 FAMILY FIRST HEALTH	0	0	9, 18	9 0	1, 788, 409	194.08
194.0907959 MERIDIAN HEALTH CONVENIENT CARE	0	0		o o	0	194.09
200.00 Cross Foot Adjustments					0	200.00
201.00 Negative Cost Centers	0	0		o o	0	201.00
202.00 TOTAL (sum lines 118 through 201)	303, 921	1, 930, 413	207, 59	6 753, 336	32, 957, 724	202.00

Health Financial Systems	JAY COUNTY I			of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-13		Worksheet B Part I
			To 09/30/2017	Date/Time Prepared: 2/26/2018 1:56 pm
Cost Center Description	Intern & Residents	Total		
	Cost & Post			
	Stepdown			
	Adjustments 25.00	26.00		
GENERAL SERVICE COST CENTERS	25.00	20.00		
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. 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 0PERATION OF PLANT-MOB 7.02 00702 0PERATION OF PLANT-POB				7.01
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 11. 00 01100 CAFETERI A				10.00
13. 00 01300 NURSI NG ADMI NI STRATI ON				13.00
14.00 01400 CENTRAL SERVICES & SUPPLY				14.00
16.00 01600 MEDI CAL RECORDS & LI BRARY				16.00
30. 00 03000 ADULTS & PEDIATRICS	0	4, 685, 573		30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	4,000,070		31.00
33. 00 03300 BURN INTENSIVE CARE UNIT	0	0		33.00
40. 00 04000 SUBPROVI DER - I PF	0	2, 297, 300		40.00
41. 00 04100 SUBPROVI DER – I RF 42. 00 04200 SUBPROVI DER	0	0		41.00
43. 00 04300 NURSERY	0	296, 541		43.00
ANCILLARY SERVICE COST CENTERS	1			
50.00 05000 OPERATING ROOM	0	3, 233, 553		50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	0	61, 596 0		52.00 53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	2, 924, 834		54.00
57. 00 05700 CT SCAN	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59. 00 05900 CARDIAC CATHETERIZATION 60. 00 06000 LABORATORY	0	0 3, 159, 897		59.00 60.00
60. 01 06001 BLOOD LABORATORY	0	0		60.01
65. 00 06500 RESPI RATORY THERAPY	0	518, 267		65.00
66. 00 06600 PHYSI CAL THERAPY	0	746, 365		66.00
67. 00 06700 0CCUPATI 0NAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	97, 502 25, 098		67.00 68.00
69. 00 06900 ELECTROCARDI OLOGY	0	671, 165		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	40, 464		72.00
73. 00 07300 DRUGS CHARGED TO PATI ENTS OUTPATI ENT SERVI CE COST CENTERS	0	2, 576, 157		73.00
88. 00 08800 RURAL HEALTH CLINIC	0	0		88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
	0	62,999		90.00
90.01 09001 FAMILY PRACTICE OF JAY COUNTY 90.02 09002 JAY FAMILY MEDICINE	0	1, 379, 506 1, 871, 805		90. 01 90. 02
91. 00 09100 EMERGENCY	0	2, 944, 691		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
93. 00 0400 OTHER OUTPATIENT SERVICE COST CENTER OTHER REIMBURSABLE COST CENTERS	0	25, 754		93.00
99. 10 09910 CORF	0	0		99.10
SPECIAL PURPOSE COST CENTERS				
106.00 10600 HEART ACQUI SI TI ON	0	0		106.00
109. 00 10900 PANCREAS ACQUI SI TI ON	0	0		109.00
110.00 11000 INTESTINAL ACQUISITION 111.00 11100 ISLET ACQUISITION	0	0		110. 00 111. 00
113. 00 11300 I NTEREST EXPENSE	0			113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	27, 619, 067		118.00
NONREI MBURSABLE COST CENTERS	0	(0.400		100.00
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES		60, 490 0		190. 00 192. 00
193. 00 19300 NONPALD WORKERS	o	ő		192.00
194.0007950 MOB	Ō	0		194.00
194. 01 07951 POB	0	0		194.01
194. 02 07952 WEST JAY CLINIC 194. 03 07953 CONVENI ENT CARE	0	331, 241 144, 420		194. 02 194. 03
194. 04 07954 OTHER NONREI MBURSABLE COST CENTERS	o	0		194.03
	51	- 1		

Health Financial Systems	JAY COUNTY HOSPITAL			In Lieu of Form CMS-2552-10		
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	CN: 15-1320	Period: From 10/01/2016 To 09/30/2017	Worksheet B Part I Date/Time Prepared: 2/26/2018 1:56 pm	
Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		1	272072018 1.30 pm	
	25.00	26.00				
194.0507955 OTHER NONREI MBURSABLE COST CENTERS	0	0			194.05	
194. 06 07956 TRI COUNTY	0	2, 144, 976			194.06	
194. 07 07957 HOSPI TALI ST	0	869, 121			194.07	
194.0807958 FAMILY FIRST HEALTH	0	1, 788, 409			194.08	
194.0907959 MERIDIAN HEALTH CONVENIENT CARE	0	0			194.09	
200.00 Cross Foot Adjustments	0	0			200.00	
201.00 Negative Cost Centers	0	0			201.00	
202.00 TOTAL (sum lines 118 through 201)	0	32, 957, 724			202.00	

ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		eriod: com 10/01/2016 o 09/30/2017	Worksheet B Part II Date/Time Pre	
			CAPI TAL REL	ATED COSTS	2/26/2018 1:5	6 pm
Cost Center Description	Directly Assigned New Capital Related Costs	NEW MVBLE EQUIP	NEW MVBLE EQUIP MOB	NEW MVBLE EQUI P-POB	NEW MVBLE EQUIP- WJ	
	0	2.00	2.01	2.02	2.03	
2.00 GENERAL SERVICE COST CENTERS 00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01 00200 New CAP REL COSTS-MVBLE EQUIP 2.01 00201 NEW CAP REL COSTS-MVBLE EQUIP-MOB 2.02 00202 NEW CAP REL COSTS-MVBLE EQUIP-POB 2.03 00203 NEW CAP REL COSTS-MVBLE EQUIP-WJ 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT 7.01 00701 OPERATION OF PLANT-MOB 7.02 00702 OPERATION OF PLANT-POB 7.03 00703 OPERATION OF PLANT-WJ 8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPING 10.00 01000 DI ETARY 11.00 01100 CAFETERIA 13.00 01300 NURSING ADMINISTRATION 14.00 01400 CENTRAL SERVICES & SUPPLY 16.00 01600 MEDICAL RECORDS & LIBRARY		0 179, 916 122, 878 0 0 9, 766 10, 907 45, 714 45, 100 36, 585 27, 608 31, 164	0 1, 526 1, 276 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 8, 476 6, 116 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 0 0 0	2.00 2.01 2.03 4.00 5.00 7.00 7.01 7.03 8.00 9.00 10.00 11.00 13.00 14.00 16.00
INPATIENT ROUTINE SERVICE COST CENTERS				-		
30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT 33.00 03300 BURN INTENSIVE CARE UNIT 40.00 04000 SUBPROVIDER - IPF 41.00 04100 SUBPROVIDER - IRF 42.00 04200 SUBPROVIDER 43.00 04300 NURSERY	0 0 0 0 0 0 0	261, 557 0 100, 821 0 0 22, 671	0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	30. 00 31. 00 33. 00 40. 00 41. 00 42. 00 43. 00
ANCI LLARY SERVICE COST CENTERS 50. 00 05000 OPERATI NG ROOM	0	118, 730	0	45, 843	0	50.00
50. 00 05000 0PERATING ROM 52. 00 05200 DELIVERY 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 MAGING (MRI) 59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 01 06001 LBOORATORY 60. 01 06001 LABORATORY 65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 73. 00 07300 RDIGS CHARGED TO PATI ENTS 0UTPATI ENT SERVICE COST CENTERS 88. 00 08800 RURAL		118, 730 2, 787 0 137, 582 0 0 56, 117 0 12, 246 2, 392 0 0 43, 937 0 0 22, 517		45, 843 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 60.00 60.01 65.00 66.00 67.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90.00 09000 CLINIC 90.01 09001 FAMILY PRACTICE OF JAY COUNTY 90.20 209002 JAY FAMILY MEDICINE 91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 93.00 04040 OTHER OUTPATIENT SERVICE COST CENTER		0 0 189, 616 99, 680 0	0 0 5, 887 0 0	0 0 0 0 0	0 0 0 0 0	89.00 90.00 90.01 90.02 91.00 92.00 93.00
99. 10 09910 CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS 106.00 10600 HEART ACQUI SITI ON 109.00 10900 PANCREAS ACQUI SITI ON 110.00 INTESTI NAL ACQUI SITI ON 111.00 INTESTI NAL ACQUI SITI ON 111.00 ISLET ACQUI SITI ON 113.00 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0 0 0 0	0 0 0 1, 580, 291	0 0 0 8, 689	0 0 0 0 60, 435	0 0 0	106.00 109.00 110.00 111.00 113.00
NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES 193.00 19300 NONPAI D WORKERS 194.00 07950 MOB 194.01 07951 POB 194.02 07952 WEST JAY CLINIC 194.03 07953 CONVENI ENT CARE	0 0 0 0 0 0 0 0	19, 883 0 0 0 0 0 0 20, 673	0 0 0 0 0 0 0 0	0 0 0 0 0 0 0	0 0 0 31, 142	190. 00 192. 00 193. 00 194. 00 194. 01 194. 02 194. 03

Health Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		Period:	Worksheet B	
				From 10/01/2016 To 09/30/2017		nared
				10 07/00/2017	2/26/2018 1:5	
			CAPITAL R	ELATED COSTS		
Cost Center Description	Directly	NEW MVBLE	NEW MVBLE	NEW MVBLE	NEW MVBLE	
	Assigned New	EQUI P	EQUIP MOB	EQUI P-POB	EQUIP- WJ	
	Capi tal					
	Related Costs					
	0	2.00	2.01	2.02	2.03	
194.0407954 OTHER NONREI MBURSABLE COST CENTERS	0	0		0 0	0	194.04
194.0507955 OTHER NONREI MBURSABLE COST CENTERS	0	0		0 0	0	194.05
194.0607956 TRI COUNTY	0	0		0 41, 514	0	194.06
194. 07 07957 HOSPI TALI ST	0	0		0 0	0	194.07
194.0807958 FAMILY FIRST HEALTH	0	84, 888		0 0	0	194.08
194.09 07959 MERIDIAN HEALTH CONVENIENT CARE	0	0		0 0	0	194.09
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers		0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	0	1, 705, 735	8, 68	9 101, 949	31, 142	202.00

Heal th	Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider C	CN: 15-1320 P	eriod: rom 10/01/2016	Worksheet B Part II	
				Ť	o 09/30/2017	Date/Time Pre 2/26/2018 1:5	
	Cost Center Description	Subtotal	EMPLOYEE BENEFITS	ADMI NI STRATI V E & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT-MOB	<u>o pin</u>
		2A	DEPARTMENT 4.00	5.00	7.00	7.01	
0.00	GENERAL SERVICE COST CENTERS						0.00
2.00 2.01	00200 NEW CAP REL COSTS-MVBLE EQUIP 00201 NEW CAP REL COSTS-MVBLE EQUIP MOB						2.00 2.01
2.02	00202 NEW CAP REL COSTS-MVBLE EQUI P-POB						2.02
2.03	00203 NEW CAP REL COSTS-MVBLE EQUIP- WJ		_				2.03
4.00 5.00	00400 EMPLOYEE BENEFI TS DEPARTMENT 00500 ADMI NI STRATI VE & GENERAL	0 189, 918	0	189, 918			4.00 5.00
5.00 7.00	00700 OPERATION OF PLANT	130, 270	0	10, 424	140, 694		5.00 7.00
7.01	00701 OPERATION OF PLANT-MOB	0	0	464	0	464	7.01
7.02	00702 OPERATION OF PLANT-POB	0	0	734	0	0	7.02
7.03 8.00	00703 OPERATION OF PLANT-WJ 00800 LAUNDRY & LINEN SERVICE	0 9, 766	0	34 953	0 979	0	7.03 8.00
8.00 9.00	00900 HOUSEKEEPING	9,788 10,907	0	4,475		0	9.00
10.00	01000 DI ETARY	45, 714	0	3, 622	4, 584	0	10.00
	01100 CAFETERI A	45, 100	0	1, 291	4, 523	0	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	36, 585	0		3,669	0	13.00
	01600 MEDICAL RECORDS & LIBRARY	27, 608 31, 164	0		2, 769 3, 125	0	14.00 16.00
101.00	INPATIENT ROUTINE SERVICE COST CENTERS	017101			0,120		10100
	03000 ADULTS & PEDI ATRI CS	261, 557	0		26, 230	0	30.00
	03100 I NTENSI VE CARE UNI T	0	0	-	0	0	31.00
33.00 40.00	03300 BURN I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF	0 100, 821	0	0 0 8, 773	0 10, 111	0	33.00 40.00
	04100 SUBPROVI DER – I RF	00, 021	0	0,773	0,111	0	40.00
42.00	04200 SUBPROVI DER	0	0	0	0	0	42.00
43.00	04300 NURSERY	22, 671	0	1, 178	2, 274	0	43.00
50.00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	164, 573	0	13, 437	11, 907	0	50.00
	05200 DELIVERY ROOM & LABOR ROOM	2, 787	0		280	0	52.00
	05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C	137, 582	0	13, 739		0	54.00
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	0	57.00 58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59.00
60.00	06000 LABORATORY	56, 117	0	16, 214	5, 628	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	12, 246 2, 392	0	2,806 4,156	1, 228 240	0	65.00 66.00
67.00	06700 OCCUPATI ONAL THERAPY	2, 0,2	0	543	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	141	0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	43, 937	0	3, 171	4, 406	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	71.00 72.00
	07300 DRUGS CHARGED TO PATIENTS	22, 517	0			0	
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	0	0	-	0	0	
	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0	0	0 0 352	0	0	89.00 90.00
	09001 FAMILY PRACTICE OF JAY COUNTY	5, 887	0	6, 968	0	464	
	09002 JAY FAMILY MEDICINE	189, 616	0	8, 734		0	90.02
	09100 EMERGENCY	99, 680	0	12, 434	9, 996	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART) 04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	147	0	0	92.00 93.00
75.00	OTHER REIMBURSABLE COST CENTERS	0	0	1 147		0	75.00
99.10	09910 CORF	0	0	0	0	0	99.10
10/ 00	SPECIAL PURPOSE COST CENTERS						10/ 00
	10600 HEART ACQUI SI TI ON 10900 PANCREAS ACQUI SI TI ON	0	0		0	-	106. 00 109. 00
	11000 INTESTINAL ACQUISITION	0	0	0	0		110.00
	11100 I SLET ACQUI SI TI ON	0	0	0	0		111.00
	11300 INTEREST EXPENSE		_				113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	1, 649, 415	0	161, 099	128, 114	464	118.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	19, 883	0	145	1, 994	0	190.00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192.00
193.00	19300 NONPALD WORKERS	0	0	0	0	0	193.00
	07950 MOB 07951 POB	0	0	0	0		194.00 194.01
	07951 POB 07952 WEST JAY CLINIC	0 31, 142	0	1,872	0		194. 01 194. 02
	07953 CONVENI ENT CARE	20, 673	0	673			194.03
	07954 OTHER NONREI MBURSABLE COST CENTERS	0	0	0	0		194.04
	07955 OTHER NONREIMBURSABLE COST CENTERS 07956 TRI COUNTY	0 11 E1 4	0		0		194. 05 194. 06
174.00		41, 514	0	11, 736	<u> </u>	0	174.00

Health Financial Systems	JAY COUNTY HOSPI TAL			In Lieu of Form CMS-2552-10			
ALLOCATION OF CAPITAL RELATED COSTS	ALLOCATION OF CAPITAL RELATED COSTS			Period:	Worksheet B		
				rom 10/01/2016			
			'	o 09/30/2017	Date/Time Pre 2/26/2018 1:5	pared:	
Cost Center Description	Subtotal	EMPLOYEE	ADMI NI STRATI V	OPERATION OF	OPERATION OF		
	Subtotui	BENEFITS	E & GENERAL	PLANT	PLANT-MOB		
		DEPARTMENT					
	2A	4.00	5.00	7.00	7.01		
194. 07 07957 H0SPI TALI ST	0	0	5, 008	0	0	194.07	
194.0807958 FAMILY FIRST HEALTH	84, 888	0	9, 385	8, 513	0	194.08	
194.0907959 MERIDIAN HEALTH CONVENIENT CARE	0	0	0	0	0	194.09	
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 through 201)	1, 847, 515	0	189, 918	140, 694	464	202.00	

Health F	inancial Systems	JAY COUNTY	HOSPI TAL		In Lieu	u of Form CMS-2	2552-10
	ION OF CAPITAL RELATED COSTS		Provider C		eriod: rom 10/01/2016	Worksheet B Part II	
				Ť		Date/Time Pre 2/26/2018 1:5	
	Cost Center Description	OPERATION OF	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		PLANT-POB 7.02	PLANT-WJ 7.03	LINEN SERVICE 8.00	9.00	10.00	
	ENERAL SERVICE COST CENTERS		7100	0.00		10100	
	0200 NEW CAP REL COSTS-MVBLE EQUIP 0201 NEW CAP REL COSTS-MVBLE EQUIP MOB						2.00 2.01
	0202 NEW CAP REL COSTS-MVBLE EQUIP MOB						2.01
	0203 NEW CAP REL COSTS-MVBLE EQUIP- WJ						2.03
	0400 EMPLOYEE BENEFITS DEPARTMENT 0500 ADMINISTRATIVE & GENERAL						4.00 5.00
	0700 OPERATION OF PLANT						7.00
	0701 OPERATION OF PLANT-MOB						7.01
	0702 OPERATION OF PLANT-POB 0703 OPERATION OF PLANT-WJ	734 0	34				7.02 7.03
	0800 LAUNDRY & LINEN SERVICE	0	0	11, 698			8.00
1	0900 HOUSEKEEPI NG	0	0	1, 417	17, 893		9.00
	1000 DI ETARY 1100 CAFETERI A	0	0	366	487 480	54, 773 0	10.00
	1300 NURSI NG ADMI NI STRATI ON	0	0	0	390	0	13.00
	1400 CENTRAL SERVICES & SUPPLY	0	0	0	294	0	14.00
	1600 MEDICAL RECORDS & LIBRARY NPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	332	0	16.00
	3000 ADULTS & PEDIATRICS	0	0	5, 362	2, 785	39, 473	30.00
	3100 I NTENSI VE CARE UNI T	0	0	0	0	0	31.00
	3300 BURN I NTENSI VE CARE UNI T 4000 SUBPROVI DER – I PF	0	0	0 289	0 1, 074	0 15, 300	33.00 40.00
	4100 SUBPROVI DER – I RF	0	0	0	0	0	41.00
	4200 SUBPROVI DER	0	0	0	0	0	42.00
	4300 NURSERY NCI LLARY SERVI CE COST CENTERS	0	0	212	241	0	43.00
	5000 OPERATING ROOM	385	0	1, 219	2, 368	0	50.00
	5200 DELIVERY ROOM & LABOR ROOM	0	0	0	30	0	52.00
1	5300 ANESTHESI OLOGY 5400 RADI OLOGY-DI AGNOSTI C	0	0	0 929	0 1, 465	0	53.00 54.00
1	5700 CT SCAN	0	0	0	0	0	57.00
	5800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
1	5900 CARDI AC CATHETERI ZATI ON 6000 LABORATORY	0	0	0	0 598	0	59.00 60.00
1	6001 BLOOD LABORATORY	0	0	0	0	0	60.01
	6500 RESPI RATORY THERAPY	0	0	0	130	0	65.00
1	6600 PHYSI CAL THERAPY 6700 OCCUPATI ONAL THERAPY	0	0	76 0	25 0	0	66.00 67.00
1	6800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
	6900 ELECTROCARDI OLOGY 7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0	244	468	0	69.00
	7200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	71.00
	7300 DRUGS CHARGED TO PATIENTS	0	0	0	240	0	73.00
	UTPATIENT SERVICE COST CENTERS 8800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 0	8900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
		0	0	0	0	0	90.00
	9001 FAMILY PRACTICE OF JAY COUNTY 9002 JAY FAMILY MEDICINE	0	0	0	1, 290 2, 019	0	90.01 90.02
91.00 0	9100 EMERGENCY	0	0	1, 584		0	91.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART)		0	0		0	92.00
	4040 OTHER OUTPATIENT SERVICE COST CENTER THER REIMBURSABLE COST CENTERS	0	0	0	0	0	93.00
99.10 0	9910 CORF	0	0	0	0	0	99.10
	PECIAL PURPOSE COST CENTERS 0600 HEART ACQUISITION	0	0	0	0	0	106.00
	0900 PANCREAS ACQUISTION	0	0	0	0		108.00
	1000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
	1100 I SLET ACQUI SI TI ON 1300 I NTEREST EXPENSE	0	0	0	0	0	111.00 113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	385	0	11, 698	15, 778	54, 773	
N	ONREIMBURSABLE COST CENTERS						
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 9200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	212		190.00 192.00
	9300 NONPAID WORKERS	0	0	0	0		192.00
194.000	7950 MOB	0	0	0	0	0	194.00
	7951 POB 7952 WEST JAY CLINIC	0	0 34	0	0		194. 01 194. 02
	7953 CONVENTENT CARE	0	0	0	0		194.02 194.03
194.040	7954 OTHER NONREI MBURSABLE COST CENTERS	0	0	0	0		194.04
	7955 OTHER NONREIMBURSABLE COST CENTERS 7956 TRI COUNTY	0 349	0		0 999		194.05 194.06
	7957 HOSPI TALI ST	0	0	0	0		194.00

Health Financial Systems	JAY COUNTY	HOSPI TAL		In Lieu of Form CMS-2552-10			
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		Period:	Worksheet B		
				From 10/01/2016 To 09/30/2017			
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		
194.0807958 FAMILY FIRST HEALTH	0	0		904	0	194.08	
194.0907959 MERIDIAN HEALTH CONVENIENT CARE	0	0		0 0	0	194.09	
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 through 201)	734	34	11, 69	8 17, 893	54, 773	202.00	

Heal th	Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	TION OF CAPITAL RELATED COSTS		Provider CC		Period: From 10/01/2016	Worksheet B Part II	
					To 09/30/2017	Date/Time Pre 2/26/2018 1:5	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	MEDI CAL	Subtotal	
			ADMI NI STRATI O	SERVICES &	RECORDS &		
		11.00	N 13.00	SUPPLY 14.00	LI BRARY 16.00	24.00	
	GENERAL SERVICE COST CENTERS						
	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
	00201 NEW CAP REL COSTS-MVBLE EQUIP MOB 00202 NEW CAP REL COSTS-MVBLE EQUIP-POB						2.01 2.02
	00203 NEW CAP REL COSTS-MVBLE EQUIP- WJ						2.02
	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT						5.00 7.00
	00700 OPERATION OF PLANT-MOB						7.00
	00702 OPERATION OF PLANT-POB						7.02
	00703 OPERATION OF PLANT-WJ						7.03
	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG						8.00 9.00
	01000 DI ETARY						10.00
	01100 CAFETERI A	51, 394					11.00
	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	5, 295 769		32, 328			13.00 14.00
	01600 MEDICAL RECORDS & LIBRARY	3, 225					16.00
I	INPATIENT ROUTINE SERVICE COST CENTERS		1				1
	03000 ADULTS & PEDIATRICS	9, 887		1, 97		386, 557	30.00 31.00
	03100 I NTENSI VE CARE UNI T 03300 BURN I NTENSI VE CARE UNI T					0	31.00
	04000 SUBPROVI DER – I PF	5,005	10, 368	12:		152, 267	40.00
1	04100 SUBPROVI DER – I RF	C			0 0	0	41.00
	04200 SUBPROVI DER 04300 NURSERY	C 619			0 0 0 71	0 28, 548	42.00
	ANCI LLARY SERVI CE COST CENTERS	017	1,202			20, 340	43.00
50.00	05000 OPERATING ROOM	5, 089		7, 82		223, 737	50.00
	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	126			97	3, 842	52.00
	05400 RADI OLOGY-DI AGNOSTI C	4, 728	, i i i i i i i i i i i i i i i i i i i	3, 210	12,951	0 188, 401	53.00 54.00
	05700 CT SCAN	C		(0	57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	C	-	(0	0	58.00
	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	C 5, 561		8, 648) 0 3 8, 890	0 101, 656	59.00 60.00
	06001 BLOOD LABORATORY	0, 501		(01,000	60.00
	06500 RESPI RATORY THERAPY	C	0	243		17, 098	65.00
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY		0	90		8, 040 728	66.00 67.00
	06800 SPEECH PATHOLOGY		0			180	
	06900 ELECTROCARDI OLOGY	2, 357	0	504		56, 310	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	C	-			0	
72.00	07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS	2, 182	0		40 4 2,420		72.00 73.00
	DUTPATI ENT SERVICE COST CENTERS	2,102		20	2,120	11,101	70.00
	08800 RURAL HEALTH CLINIC	C	0	(0	88.00
	08900 FEDERALLY QUALI FI ED HEALTH CENTER 09000 CLI NI C		0	299		0 654	89.00 90.00
	09001 FAMILY PRACTICE OF JAY COUNTY	C	0	3, 428		18, 546	
	09002 JAY FAMILY MEDICINE	C	0	2, 070		221, 815	
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	6, 551	13, 571	1, 618	4, 065	150, 561	91.00 92.00
	04040 OTHER OUTPATIENT SERVICE COST CENTER	C	0		18	165	
	OTHER REIMBURSABLE COST CENTERS			I			
	09910 CORF SPECI AL PURPOSE COST CENTERS	C	0	(0 0	0	99.10
	10600 HEART ACQUI SI TI ON	C	0	(0	106.00
	10900 PANCREAS ACQUI SI TI ON	C	0		0 0		109.00
	11000 I NTESTI NAL ACQUI SI TI ON	C	0	(0		110.00
	11100 I SLET ACQUI SI TI ON 11300 I NTEREST EXPENSE	C	0		0	0	111.00 113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	51, 394	56, 508	30, 31	5 41, 801	1, 603, 505	
	VONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	0	(0		190.00
	19200 PHYSICIANS' PRIVATE OFFICES 19300 NONPAID WORKERS		0				192.00 193.00
194.00	07950 MOB	C	0			0	194.00
		C	0		0		194.01
	07952 WEST JAY CLINIC 07953 CONVENIENT CARE		0	69 16			194. 02 194. 03
194.04	07954 OTHER NONREI MBURSABLE COST CENTERS		0	(194.03
194.05	07955 OTHER NONREI MBURSABLE COST CENTERS	C	0	(0 0		194.05
194.06	07956 TRI COUNTY	L C	0	352	2 0	54, 950	194.06

Health Financial Systems JAY COUNTY HOSPITAL In Lieu of Provider CCN: 15-1320 ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1320 Period:						2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-1320			Worksheet B Part II	
				From 10/01/2016 To 09/30/2017		pared: 6 pm
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	MEDI CAL	Subtotal	
		ADMI NI STRATI O	SERVICES &	RECORDS &		
		N	SUPPLY	LI BRARY		
	11.00	13.00	14.00	16.00	24.00	
194. 07 07957 HOSPI TALI ST	0	0	(0 0	5, 008	194.07
194.0807958 FAMILY FIRST HEALTH	0	0	1, 43	1 0	105, 121	194.08
194.0907959 MERIDIAN HEALTH CONVENIENT CARE	0	0	(o o	0	194.09
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 through 201)	51, 394	56, 508	32, 32	8 41, 801	1, 847, 515	202.00

	ancial Systems I OF CAPITAL RELATED COSTS	JAY COUNTY I	Provider CCN: 15		of Form CMS- Worksheet B	-2552-10
				/30/2017	Part II Date/Time Pre	
	Cost Center Description	Intern &	Total	 	2/26/2018 1:	56 pm
		Residents Cost & Post				
		Stepdown				
		Adjustments	24.00			
GENE	ERAL SERVICE COST CENTERS	25.00	26.00	 		-
2.00 0020	DO NEW CAP REL COSTS-MVBLE EQUIP					2.00
	DI NEW CAP REL COSTS-MVBLE EQUIP MOB					2.01
	D2 NEW CAP REL COSTS-MVBLE EQUIP-POB D3 NEW CAP REL COSTS-MVBLE EQUIP- WJ					2.02
	DO EMPLOYEE BENEFITS DEPARTMENT					4.00
	DO ADMI NI STRATI VE & GENERAL					5.00
	DO OPERATION OF PLANT DI OPERATION OF PLANT-MOB					7.00
	D2 OPERATION OF PLANT-POB					7.02
7.03 0070	D3 OPERATION OF PLANT-WJ					7.03
	DO LAUNDRY & LINEN SERVICE					8.00
	DO HOUSEKEEPI NG DO DI ETARY					9.00
	DO CAFETERI A					11.00
	DO NURSING ADMINISTRATION					13.00
	DO CENTRAL SERVICES & SUPPLY					14.00
	DO MEDICAL RECORDS & LIBRARY					10.00
30.00 0300	DO ADULTS & PEDIATRICS	0	386, 557			30.00
	DO INTENSIVE CARE UNIT	0	0			31.00
	DO BURN INTENSIVE CARE UNIT DO SUBPROVIDER - IPF	0	0 152, 267			33.00
	DO SUBPROVIDER - IRF	0	0			41.00
	DO SUBPROVI DER	О	0			42.00
	DO NURSERY LLARY SERVICE COST CENTERS	0	28, 548			43.00
	DO OPERATING ROOM	0	223, 737			50.00
	DO DELIVERY ROOM & LABOR ROOM	О	3, 842			52.00
		0	100 101			53.00
	DO RADI OLOGY-DI AGNOSTI C DO CT SCAN	0	188, 401 0			54.00
	DO MAGNETIC RESONANCE IMAGING (MRI)	Ő	Ő			58.00
	DO CARDIAC CATHETERIZATION	0	0			59.00
	DO LABORATORY DI BLOOD LABORATORY	0	101, 656			60.00 60.01
	DO RESPI RATORY THERAPY	0	17, 098			65.00
	DO PHYSI CAL THERAPY	0	8, 040			66.00
	DO OCCUPATI ONAL THERAPY DO SPEECH PATHOLOGY	0	728 180			67.00 68.00
	DO ELECTROCARDI OLOGY	0	56, 310			69.00
71.00 0710	DO MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			71.00
	DO IMPL. DEV. CHARGED TO PATIENTS DO DRUGS CHARGED TO PATIENTS	0	269			72.00
	PATIENT SERVICE COST CENTERS	0	44, 131			73.00
	DO RURAL HEALTH CLINIC	0	0			88.00
	DO FEDERALLY QUALIFIED HEALTH CENTER	0	0			89.00
90.00 0900 90.01 0900	DI FAMILY PRACTICE OF JAY COUNTY	0	654 18, 546			90.00 90.01
	D2 JAY FAMILY MEDICINE	0	221, 815			90.02
	DO EMERGENCY	0	150, 561			91.00
	00 OBSERVATION BEDS (NON-DISTINCT PART) 40 OTHER OUTPATIENT SERVICE COST CENTER	0	165			92.00 93.00
	ER REIMBURSABLE COST CENTERS	UU	105			93.00
99.10 099		0	0			99.10
	CI AL PURPOSE COST CENTERS	0	0			106.00
	DO PANCREAS ACQUISITION	o	0			108.00
110.00 1100	DO INTESTINAL ACQUISITION	Ő	ō			110.00
	DO I SLET ACQUI SI TI ON	0	O			111.00
113.001130	00 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	o	1, 603, 505			113.00 118.00
NONF	REIMBURSABLE COST CENTERS					
	DO GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	22, 234			190.00
	DO PHYSICIANS' PRIVATE OFFICES DO NONPAID WORKERS	0	0			192.00 193.00
193.00 1930		o	o			193.00
						194.01
194. 01 079		0	U			
194.02079	52 WEST JAY CLINIC 53 CONVENIENT CARE	0	33, 117 23, 580			194.02 194.03

Health Financial Systems	JAY COUNTY I	HOSPI TAL		In Lieu of Form CMS-2552-10		
ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-1320		Period: From 10/01/2016	Worksheet B Part II	
				To 09/30/2017	Date/Time Prepared: 2/26/2018 1:56 pm	
Cost Center Description	Intern &	Total				
	Resi dents					
	Cost & Post					
	Stepdown					
	Adjustments					
	25.00	26.00				
194.05 07955 OTHER NONREI MBURSABLE COST CENTERS	0	0			194.05	
194.06 07956 TRI COUNTY	0	54, 950			194.06	
194. 07 07957 HOSPI TALI ST	0	5, 008			194.07	
194.0807958 FAMILY FIRST HEALTH	0	105, 121			194.08	
194.0907959 MERIDIAN HEALTH CONVENIENT CARE	0	0			194.09	
200.00 Cross Foot Adjustments	0	0			200.00	
201.00 Negative Cost Centers	0	0			201.00	
202.00 TOTAL (sum lines 118 through 201)	0	1, 847, 515			202.00	

	Financial Systems ALLOCATION - STATISTICAL BASIS	JAY COUNTY	HOSPI TAL	CN: 15-1320 P	In Lieu eriod:	u of Form CMS-: Worksheet B-1	
				FI To	rom 10/01/2016 o 09/30/2017	Date/Time Pre 2/26/2018 1:5	
			CAPI TAL REL	ATED COSTS			
	Cost Center Description	NEW MVBLE EQUIP (SQUARE FEET)	NEW MVBLE EQUIP MOB (SQUARE FEET)	NEW MVBLE EQUI P-POB (SQUARE FEET)	NEW MVBLE EQUIP- WJ (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
		2.00	2.01	2.02	2.03	4.00	
2.00 2.01 2.02 2.03 4.00 5.00 7.00 7.01	GENERAL SERVICE COST CENTERS 00200 NEW CAP REL COSTS-MVBLE EQUIP 00201 NEW CAP REL COSTS-MVBLE EQUIP MOB 00202 NEW CAP REL COSTS-MVBLE EQUIP-POB 00203 NEW CAP REL COSTS-MVBLE EQUIP-WJ 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00701 OPERATION OF PLANT-MOB	77, 723 0 0 0 8, 198 5, 599	8, 146 0 0 1, 431 1, 196 0	10, 501 0 0 873	3, 300 0 0 0	17, 444, 955 2, 296, 687 254, 469 12, 575	5.00 7.00
7. 02 7. 03 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 16. 00	00702 OPERATION OF PLANT-POB 00703 OPERATION OF PLANT-WJ 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	0 0 445 497 2, 083 2, 055 1, 667 1, 258 1, 420	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	6, 788 6, 788 3, 450 56, 001 395, 845 209, 246 151, 077 1, 033, 328 63, 011 <u>335, 105</u>	7.02 7.03 8.00 9.00 10.00 11.00 13.00 14.00
30.00 31.00 33.00 40.00 41.00 42.00 43.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03300 BURN INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04200 SUBPROVIDER 04300 NURSERY	11,918 0 0 4,594 0 0 1,033	0 0 0 0 0 0 0 0	0 0 0 0	0 0 0 0 0 0	1, 306, 473 0 676, 362 0 95, 130	31.00 33.00 40.00 41.00 42.00
50.00 52.00 53.00 54.00 57.00 58.00 59.00	ANCI LLARY SERVICE COST CENTERS 05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05700 CT SCAN 05800 MAGNETIC RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON	5, 410 127 0 6, 269 0 0 0	0 0 0 0 0 0 0 0	0	0 0 0 0 0 0	812, 211 22, 660 0 785, 205 0 0 0	52.00 53.00
60. 00 60. 01 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00	06000 LABORATORY 06001 BLOOD LABORATORY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS	2, 557 0 558 109 0 2, 002 0 0 0 0 1, 026		0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	661, 200 0 0 0 0 186, 604 0 434, 970	60.00 60.01 65.00 66.00 67.00 68.00 69.00 71.00 72.00
89.00 90.00 90.01 90.02 91.00 92.00	09000 CLI NI C	0 0 0 8, 640 4, 542 0	0 0 5, 519 0 0	0 0 0 0 0 0	0 0 0 0 0 0	0 0 1, 625, 156 1, 634, 938 2, 098, 925 771	89.00 90.00 90.01 90.02 91.00 92.00
99. 10	09910 CORF	0	0	0	0	0	99.10
109.00 110.00 111.00		0 0 0 0 72,007	0 0 0 0 8, 146	0 0 0 0 6, 225	0 0 0 0	0 0	106.00 109.00 110.00 111.00 113.00 118.00
192.00 193.00 194.00 194.01	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CI ANS' PRI VATE OFFI CES 19300 NONPAI D WORKERS 07950 MOB 07951 POB 207952 WEST JAY CLINIC	906 0 0 0 0 0	0 0 0 0 0 0 0	0 0 0	0 0 0 0 3, 300	0 0 0	190.00 192.00 193.00 194.00 194.01 194.02

Heal th Fi	nancial Systems	JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLO	DCATION - STATISTICAL BASIS		Provider CC		Period:	Worksheet B-1	
					From 10/01/2016 To 09/30/2017	Date/Time Pre 2/26/2018 1:5	
			CAPI TAL REL	ATED COSTS			
	Cost Center Description	NEW MVBLE	NEW MVBLE	NEW MVBLE	NEW MVBLE	EMPLOYEE	
		EQUI P	EQUIP MOB	EQUI P-POB	EQUIP- WJ	BENEFI TS	
		(SQUARE	(SQUARE	(SQUARE	(SQUARE	DEPARTMENT	
		FEET)	FEET)	FEET)	FEET)	(GROSS	
						SALARI ES)	
		2.00	2.01	2.02	2.03	4.00	
	953 CONVENI ENT CARE	942	0		0 0	195, 278	194.03
194.0407	954 OTHER NONREI MBURSABLE COST CENTERS	0	0		0 0	0	194.04
194.0507	955 OTHER NONREI MBURSABLE COST CENTERS	0	0		0 0	0	194.05
	956 TRI COUNTY	0	0	4, 27	6 0	245, 418	194.06
194.0707	957 HOSPI TALI ST	0	0		0 0	431, 393	
194.0807	958 FAMILY FIRST HEALTH	3, 868	0		0 0	799, 007	194.08
194.0907	959 MERIDIAN HEALTH CONVENIENT CARE	0	0		0 0	0	194.09
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, 705, 735	8, 689	101, 94	9 31, 142	6, 368, 507	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	21.946335	1.066658	9, 70850	4 9. 436970	0. 365063	203.00
204.00	Cost to be allocated (per Wkst. B,						204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part					0.000000	205.00
	11)						

Health Financial Systems	JAY COUNTY				u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CC		eriod: rom 10/01/2016	Worksheet B-1	
			Т	09/30/2017	Date/Time Pre 2/26/2018 1:5	
Cost Center Description	Reconci I i ati o		OPERATION OF	OPERATION OF	OPERATION OF	
	n	E & GENERAL (ACCUM.	PLANT (SQUARE	PLANT-MOB (SQUARE	PLANT-POB (SQUARE	
		COST)	FEET)	FEET)	FEET)	
	5A	5.00	7.00	7.01	7.02	
2.00 OO200 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 EQUI P-POB						2.02
2. 03 00203 NEW CAP REL COSTS-MVBLE EQUIP- WJ						2.03
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL	-6, 992, 871	25, 964, 853				4.00 5.00
7. 00 00700 OPERATI ON OF PLANT	-0, 772, 071	1, 425, 275	63, 926			7.00
7.01 00701 OPERATION OF PLANT-MOB	0	63, 409	0	5, 519		7.01
7. 02 00702 OPERATION OF PLANT-POB	0	100, 362	0	0	8, 998	7.02
7. 03 00703 0PERATI ON OF PLANT-WJ 8. 00 00800 LAUNDRY & LI NEN SERVI CE	0	4, 709 130, 364	0 445	0	0	7.03 8.00
9. 00 00900 HOUSEKEEPI NG	Ő	611, 811	497	Ő	0	9.00
10. 00 01000 DI ETARY	0	495, 238	2, 083	0	0	10.00
11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON	0	176, 443	2,055	0	0	11.00 13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	1, 445, 055 121, 402	1, 667 1, 258	0	0	13.00
16.00 01600 MEDICAL RECORDS & LIBRARY	Ő	534, 722	1, 420	Ő	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS				I		
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T	0	2, 211, 021	11, 918 0	0	0	
31.00 03100 INTENSIVE CARE UNIT 33.00 03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	31.00 33.00
40. 00 04000 SUBPROVI DER – I PF	0	1, 199, 479	4, 594	0	0	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 ANCI LLARY SERVI CE COST CENTERS	0	161, 004	1, 033	0	0	43.00
50. 00 05000 OPERATING ROOM	0	1,837,203	5, 410	0	4, 722	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	35, 646	127	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 57. 00 05700 CT SCAN	0	1, 878, 445	6, 269 0	0	0	54.00 57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59.00
	0	2, 215, 297	2, 557	0	0	60.00
60. 01 06001 BLOOD LABORATORY 65. 00 06500 RESPI RATORY THERAPY	0	0 383, 660	0 558	0	0	60. 01 65. 00
66.00 06600 PHYSI CAL THERAPY	0	568, 243	109	0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	74, 188	0	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	19, 224	0	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	433, 592	2,002	0	0	69.00 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	31, 310	0	0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	1, 952, 416	1, 026	0	0	73.00
0UTPATI ENT SERVI CE COST CENTERS 88.00 08800 RURAL HEALTH CLI NI C			0	~	0	88.00
88.00 08800 RURAL HEALTH CLINIC 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	88.00 89.00
90. 00 09000 CLINIC	0	48, 076	0	0	0	90.00
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	0	952, 707	0	5, 519	0	90.01
90. 02 09002 JAY FAMILY MEDICINE 91. 00 09100 EMERGENCY	0	1, 194, 215 1, 700, 057	8,640	0	0	90.02 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1, 700, 057	4, 542	0	0	91.00
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTER	О	20, 031	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
99.10 09910 CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS 106. 00 10600 HEART ACQUI SI TI ON	0	0	0	0	0	106.00
109. 00 10900 PANCREAS ACQUISITION	0	0	0	0		109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0		110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0	0	0	0	111.00
113.00 11300 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-6, 992, 871	22, 024, 604	58, 210	5, 519	1 700	113.00 118.00
NONREI MBURSABLE COST CENTERS	0, 772, 071	22, 024, 004	30, 210	3, 317	7,722	110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	19, 883	906	0		190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192.00
193. 00 19300 NONPALD WORKERS 194. 00 07950 MOB	0	0	0	0		193.00 194.00
194. 01 07951 P0B	0	0	0	0		194.00
194.0207952 WEST JAY CLINIC	0	255, 901	0	0	0	194.02
194. 03 07953 CONVENI ENT CARE	0	91, 962	942	0		194.03
194. 04 07954 OTHER NONREI MBURSABLE COST CENTERS 194. 05 07955 OTHER NONREI MBURSABLE COST CENTERS	0	0	0	0		194. 04 194. 05
	، ۹	9	0	9	0	

Health Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		Period:	Worksheet B-1	
		_		rom 10/01/2016 To 09/30/2017	Date/Time Pre 2/26/2018 1:5	
Cost Center Description	Reconciliatio	ADMI NI STRATI V	OPERATION OF	OPERATION OF	OPERATION OF	
	n	E & GENERAL	PLANT	PLANT-MOB	PLANT-POB	
		(ACCUM.	(SQUARE	(SQUARE	(SQUARE	
		COST)	FEET)	FEET)	FEET)	
	5A	5.00	7.00	7.01	7.02	
194. 06 07956 TRI COUNTY	0	1, 604, 649	(0 0	4, 276	194.06
194. 07 07957 HOSPI TALI ST	0	684, 713	(0 0	0	194.07
194.08 07958 FAMILY FIRST HEALTH	0	1, 283, 141	3, 868	3 0	0	194.08
194.09 07959 MERIDIAN HEALTH CONVENIENT CARE	0	0	(0 0	0	194.09
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B,		6, 992, 871	1, 809, 131	80, 486	127, 392	202.00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)		0. 269321	28. 300394	14. 583439	14. 157813	203.00
204.00 Cost to be allocated (per Wkst. B,		189, 918	140, 694	464	734	204.00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part		0. 007314	2. 200889	0. 084073	0. 081574	205.00
11)						

Health Financial Systems	JAY COUNTY				u of Form CMS-2	
COST ALLOCATION - STATISTICAL BASIS		Provider C	Fr	riod: om 10/01/2016	Worksheet B-1	
			То		Date/Time Pre 2/26/2018 1:5	
Cost Center Description	OPERATION OF PLANT-WJ	LAUNDRY &	HOUSEKEEPI NG (SQUARE	DI ETARY (MEALS	CAFETERI A (FTE' S)	
	(SQUARE	(POUNDS OF	FEET)	SERVED)	(
	FEET) 7. 03	LAUNDRY) 8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS	1	I				
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.01 00201 NEW CAP REL COSTS-MVBLE EQUIP MOB						2.00 2.01
2. 02 00202 NEW CAP REL COSTS-MVBLE EQUI P-POB						2.02
2. 03 00203 NEW CAP REL COSTS-MVBLE EQUIP- WJ 4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						2.03 4.00
5. 00 00500 ADMINI STRATI VE & GENERAL						5.00
7.00 00700 OPERATION OF PLANT 7.01 00701 OPERATION OF PLANT-MOB						7.00 7.01
7.02 00702 OPERATION OF PLANT-POB						7.02
7.03 00703 OPERATION OF PLANT-WJ	3, 300	44 000				7.03
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG	0	46, 080 5, 580	76, 559			8.00 9.00
10. 00 01000 DI ETARY	0	1, 440	2, 083	38, 335		10.00
11. 00 01100 CAFETERIA 13. 00 01300 NURSING ADMINISTRATION	0	0	2, 055 1, 667	0	14, 695 1, 514	11.00 13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	0	1, 258	0	220	14.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY INPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0	1, 420	0	922	16.00
30. 00 03000 ADULTS & PEDI ATRI CS	0	21, 125	11, 918	27, 627	2, 827	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	0	0	0	0	31.00
33. 00 03300 BURN I NTENSI VE CARE UNI T 40. 00 04000 SUBPROVI DER – I PF	0	0 1, 140	0 4, 594	0 10, 708	0 1, 431	33.00 40.00
41. 00 04100 SUBPROVI DER – I RF	0	0	0	0	0	41.00
42. 00 04200 SUBPROVI DER 43. 00 04300 NURSERY	0	0 835	0 1, 033	0	0 177	42.00 43.00
ANCI LLARY SERVICE COST CENTERS	0	000	1,035	0	177	43.00
50. 00 05000 OPERATING ROOM	0			0	1, 455	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM 53.00 05300 ANESTHESI OLOGY	0	0	127 0	0	36 0	52.00 53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	3, 660		0	1, 352	54.00
57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	57.00 58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59.00
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY	0	0	2, 557 0	0	1, 590 0	60.00 60.01
65. 00 06500 RESPIRATORY THERAPY	0	0	558	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	300	109	0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	67.00 68.00
69. 00 06900 ELECTROCARDI OLOGY	0	960	2, 002	0	674	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 0	71.00 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0			0	624	
0UTPATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLI NI C	0	0	0	o	0	88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90. 00 09000 CLINIC	0	0	0	0	0	90.00
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY 90. 02 09002 JAY FAMILY MEDICINE	0		5, 519 8, 640	0	0	90. 01 90. 02
91.00 09100 EMERGENCY	0	6, 240		0	1, 873	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 93.00 04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	o	0	92.00 93.00
OTHER REIMBURSABLE COST CENTERS		-				
99. 10 09910 CORF SPECI AL PURPOSE COST CENTERS	0	0	0	0	0	99.10
106. 00 10600 HEART ACQUISITION	0	0	0	0	0	106.00
109.00 10900 PANCREAS ACQUI SI TI ON	0	0	0	0		109.00
110. 00 11000 NTESTI NAL ACQUI SI TI ON 111. 00 11100 SLET ACQUI SI TI ON	0		0	0		110.00 111.00
113.00 11300 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	0	46,080	67, 509	38, 335	14, 695	118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	906	0		190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 193. 00 19300 NONPALD WORKERS	0	0	0	0		192.00 193.00
193. 00 19300 NONPALD WORKERS 194. 00 07950 MOB	0	0	0	0		193.00 194.00
194. 01 07951 POB	0	0	0	0		194.01
194. 02 07952 WEST JAY CLINIC 194. 03 07953 CONVENI ENT CARE	3, 300 0	0	0	o		194.02 194.03
194.0407954 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

Health Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		Period:	Worksheet B-1	
				From 10/01/2016 To 09/30/2017		nared
				10 07/30/2017	2/26/2018 1:5	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	PLANT-WJ	LINEN SERVICE	(SQUARE	(MEALS	(FTE'S)	
	(SQUARE	(POUNDS OF	FEET)	SERVED)		
	FEET)	LAUNDRY)				
	7.03	8.00	9.00	10.00	11.00	
194. 06 07956 TRI COUNTY	0	0	4, 27	6 0	0	194.06
194. 07 07957 H0SPI TALI ST	0	0		0 0	0	194.07
194.0807958 FAMILY FIRST HEALTH	0	0	3, 86	8 0	0	194.08
194.0907959 MERIDIAN HEALTH CONVENIENT CARE	0	0		0 0	0	194.09
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B,	5, 977	178, 068	812, 21	3 715, 230	303, 921	202.00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)	1.811212	3. 864323	10. 60898	1 18. 657363	20. 681933	203.00
204.00 Cost to be allocated (per Wkst. B,	34	11, 698	17, 89	3 54, 773	51, 394	204.00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	0. 010303	0. 253863	0. 23371	5 1. 428799	3. 497380	205.00

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	JAY COUNTY	HOSPI TAL Provi der CC	`N· 15_1320	In Lie Period:	u of Form CMS Worksheet B	
COST ALLOWITON STATISTICAL DAVIS			N. 13 1320	From 10/01/2016 To 09/30/2017	Date/Time Pi	
Cost Center Description	NURSI NG	CENTRAL	MEDI CAL		2/26/2018 1:	
	ADMI NI STRATI O	SERVICES & SUPPLY	RECORDS &			
	N (DI RECT	(SUPPLY COST)	LI BRARY (GROSS			
	NRSING FTE) 13.00	14.00	CHARGES) 16.00	_		
GENERAL SERVICE COST CENTERS	13.00	14.00	10.00			
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 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 4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						2.03 4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL						5.00
7.00 00700 OPERATION OF PLANT 7.01 00701 OPERATION OF PLANT-MOB						7.00 7.01
7. 02 00702 OPERATION OF PLANT-MOB						7.01
7.03 00703 OPERATION OF PLANT-WJ						7.03
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG						8.00 9.00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON	7, 799					11.00 13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0					14.00
16.00 01600 MEDI CAL RECORDS & LI BRARY	0	3, 042	91, 151, 82	24		16.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	2, 827	137, 205	5, 731, 66	52		30.00
31. 00 03100 I NTENSI VE CARE UNI T	0			0		31.00
33. 00 03300 BURN I NTENSI VE CARE UNI T 40. 00 04000 SUBPROVI DER – I PF	0 1, 431	0 8, 534	877, 20	0		33.00 40.00
41. 00 04100 SUBPROVI DER – I RF	0	0		0		41.00
42. 00 04200 SUBPROVI DER 43. 00 04300 NURSERY	0 177		155, 19	0		42.00 43.00
ANCI LLARY SERVICE COST CENTERS			155, 15			43.00
50.00 05000 0PERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 455 36		13, 921, 50			50.00 52.00
53. 00 05300 ANESTHESI OLOGY	0		212, 07	0		52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0		28, 297, 39			54.00
57.00 05700 CT SCAN 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI)	0	0		0		57.00 58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0		59.00
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY	0	600, 217 0	19, 367, 60	0		60.00 60.01
65. 00 06500 RESPI RATORY THERAPY	0	16, 843	969, 02	22		65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	0	6, 264 0	2, 311, 15 403, 35			66.00 67.00
68.00 06800 SPEECH PATHOLOGY	0		84, 38			68.00
69.00 06900 ELECTROCARDI OLOGY	0	34, 978	2, 663, 77			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0		87, 38	0 37		71.00 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	16, 238	5, 273, 41			73.00
OUTPATI ENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC	0	0		0		88.00
89.00 08900 FEDERALLY QUALI FI ED HEALTH CENTER	0	0		0		89.00
90. 00 09000 CLINIC 90. 01 09001 FAMILY PRACTICE OF JAY COUNTY	0	20, 766 237, 955	6, 51 1, 108, 42			90.00 90.01
90. 02 09002 JAY FAMILY MEDICINE	0	143, 696	785, 33	33		90.02
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 873	112, 293	8, 856, 70	02		91.00 92.00
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	39, 71	19		93.00
OTHER REIMBURSABLE COST CENTERS 99. 10 09910 CORF	0	0		0		99.10
SPECIAL PURPOSE COST CENTERS	0					77.10
106. 00 10600 HEART ACQUI SI TI ON 109. 00 10900 PANCREAS ACQUI SI TI ON	0			0		106.00 109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0		0		1109.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0		111.00
113.00 11300 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	7, 799	2, 104, 034	91, 151, 82	24		113.00 118.00
NONREI MBURSABLE COST CENTERS						
190. 00 19000 GLFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0 0	0		0		190. 00 192. 00
193. 00 19300 NONPAI D WORKERS	0	0		0		193.00
194. 00 07950 M0B 194. 01 07951 P0B	0	0		0		194.00 194.01
194.0207952 WEST JAY CLINIC	0	4, 790		õ		194.02
194. 03 07953 CONVENI ENT CARE 194. 04 07954 OTHER NONREI MBURSABLE COST CENTERS	0	11, 149 0		0		194.03 194.04
177. 0407734 OTTER NONKET MOUSABLE COST GENTERS	0	ו U		9		1174.04

Health Financial Systems	JAY COUNTY	HOSPI TAL		In Lieu	u of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CC		Peri od:	Worksheet B-1
				From 10/01/2016 To 09/30/2017	Date/Time Prepared: 2/26/2018 1:56 pm
Cost Center Description	NURSI NG	CENTRAL	MEDI CAL		
	ADMI NI STRATI O	SERVICES &	RECORDS &		
	N	SUPPLY	LI BRARY		
	(DI RECT	(SUPPLY COST)	(GROSS		
	NRSING FTE)		CHARGES)		
	13.00	14.00	16.00		
194.0507955 OTHER NONREI MBURSABLE COST CENTERS	0	0		0	194.05
194.0607956 TRI COUNTY	0	24, 403		0	194.06
194. 07 07957 HOSPI TALI ST	0	0		0	194.07
194.0807958 FAMILY FIRST HEALTH	0	99, 316		0	194.08
194.0907959 MERIDIAN HEALTH CONVENIENT CARE	0	0		0	194.09
200.00 Cross Foot Adjustments					200.00
201.00 Negative Cost Centers					201.00
202.00 Cost to be allocated (per Wkst. B,	1, 930, 413	207, 596	753, 33	6	202.00
Part I)					
203.00 Unit cost multiplier (Wkst. B, Part I)	247. 520580	0. 092524	0. 00826	5	203.00
204.00 Cost to be allocated (per Wkst. B,	56, 508	32, 328	41,80)1	204.00
Part II)					
205.00 Unit cost multiplier (Wkst. B, Part	7. 245544	0. 014408	0. 00045	i9	205.00
11)					

OMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-1320	Peri od:	u of Form CMS-: Worksheet C	
				From 10/01/2016 To 09/30/2017	Part I	nared
				10 07/30/2017	2/26/2018 1:5	56 pm
		Title	XVIII	Hospi tal	Cost	-
			T 1 1 0 1	Costs	T I I O I	
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B, Part I,	Adj .		Di sal I owance		
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	<u> </u>
INPATIENT ROUTINE SERVICE COST CENTERS		2100	0.00		0100	
D. 00 03000 ADULTS & PEDI ATRI CS	4, 685, 573		4, 685, 57	3 0	4, 685, 573	30.0
1.00 03100 INTENSIVE CARE UNIT	0			0 0		
3.00 03300 BURN INTENSIVE CARE UNIT	0			0 0	0	33.0
D. 00 04000 SUBPROVIDER - IPF	2, 297, 300		2, 297, 30	0 0	2, 297, 300	40.0
1.00 04100 SUBPROVIDER - IRF	0			0 0	0	41.0
2. 00 04200 SUBPROVI DER	0			0 0	0	42.0
3. 00 04300 NURSERY	296, 541		296, 54	1 0	296, 541	43.C
ANCI LLARY SERVICE COST CENTERS		1		-1		
D. OO O5000 OPERATING ROOM	3, 233, 553		3, 233, 55			
2. 00 05200 DELIVERY ROOM & LABOR ROOM	61, 596		61, 59			
3. 00 05300 ANESTHESI OLOGY	0			0 0	-	
4. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 924, 834		2, 924, 83		-, ,	
7.00 05700 CT SCAN	0			0 0	0	
B. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 9. 00 05900 CARDIAC CATHETERIZATION	0			-	0	
9. 00 05900 CARDI AC CATHETERI ZATI ON 0. 00 06000 LABORATORY	3, 159, 897		3, 159, 89	0 0 7 0		
D. 01 06001 BLOOD LABORATORY	3, 139, 897			0 0	3, 139, 897	
5. 00 06500 RESPIRATORY THERAPY	518, 267			-	518, 267	
6. 00 06600 PHYSI CAL THERAPY	746, 365				746, 365	
7. 00 06700 OCCUPATI ONAL THERAPY	97, 502		97, 50		97, 502	
B. 00 06800 SPEECH PATHOLOGY	25, 098		25, 09		25, 098	
9. 00 06900 ELECTROCARDI OLOGY	671, 165		671, 16		671, 165	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0 0	0	
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	40, 464		40, 46	4 0	40, 464	72.0
3. 00 07300 DRUGS CHARGED TO PATIENTS	2, 576, 157		2, 576, 15	7 0	2, 576, 157	73.0
OUTPATIENT SERVICE COST CENTERS						
B. OO 08800 RURAL HEALTH CLINIC	0			0 0		
9.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0 0		
D. 00 09000 CLINIC	62, 999		62, 99		62, 999	
D. 01 09001 FAMILY PRACTICE OF JAY COUNTY	1, 379, 506		1, 379, 50		1, 379, 506	
D. 02 09002 JAY FAMILY MEDICINE	1, 871, 805		1, 871, 80		1, 871, 805	
	2, 944, 691		2, 944, 69		2, 944, 691	
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	443, 619		443, 61		443, 619	
3. 00 04040 OTHER OUTPATIENT SERVICE COST CENTER OTHER REIMBURSABLE COST CENTERS	25, 754		25, 75	4 0	25, 754	93.0
9. 10 09910 CORF	0	1		0	0	99.1
SPECIAL PURPOSE COST CENTERS	0			0	0	77.
D6. 00 10600 HEART ACQUI SI TI ON	0			0	0	106.0
09. 00 10900 PANCREAS ACQUISITION	0			0		109.0
10. 00 11000 I NTESTI NAL ACQUI SI TI ON	0			0		110.0
11. 00 11100 I SLET ACQUI SI TI ON	0			0		111.0
13. 00 11300 I NTEREST EXPENSE						113.
00.00 Subtotal (see instructions)	28, 062, 686	0	28, 062, 68	6 0	28, 062, 686	
01.00 Less Observation Beds	443, 619		443, 61		443, 619	
02.00 Total (see instructions)	27, 619, 067	0	27, 619, 06	7 0	27, 619, 067	202 (

Health Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-1320	Period: From 10/01/2016 To 09/30/2017	Worksheet C Part I Date/Time Pre 2/26/2018 1:5	epared:
		Title	e XVIII	Hospi tal	2/20/2018 1:5 Cost	o pili
		Charges			0031	
Cost Center Description	Inpati ent	Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS	,		1			
30. 00 03000 ADULTS & PEDI ATRI CS	5, 355, 003		5, 355, 00			30.00
31.00 03100 INTENSIVE CARE UNIT	0			0		31.00
33.00 03300 BURN I NTENSI VE CARE UNI T	0			0		33.00
40. 00 04000 SUBPROVIDER - IPF	877, 200		877, 20	0		40.00
41.00 04100 SUBPROVIDER - IRF	0			0		41.00
42. 00 04200 SUBPROVI DER 43. 00 04300 NURSERY	155 100		155 10	0		42.00 43.00
ANCI LLARY SERVICE COST CENTERS	155, 190		155, 19			43.00
50. 00 05000 OPERATING ROOM	2, 817, 069	11, 104, 436	13, 921, 50	0. 232270	0.00000	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	212,077	0			0. 000000	•
53. 00 05300 ANESTHESI OLOGY	0	Ő		0 0.000000	0. 000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 624, 672	26, 672, 726			0. 000000	
57. 00 05700 CT SCAN	0	0		0 0.000000	0.000000	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0.000000	0.00000	
59.00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0.000000	0.000000	
60. 00 06000 LABORATORY	2, 397, 146	16, 970, 456	19, 367, 60	0. 163154	0. 000000	60.00
60. 01 06001 BLOOD LABORATORY	0	0		0 0.000000	0. 000000	60.01
65. 00 06500 RESPI RATORY THERAPY	610, 879	358, 143	969, 02		0.000000	
66. 00 06600 PHYSI CAL THERAPY	486, 522	1, 824, 635			0. 000000	
67.00 06700 OCCUPATI ONAL THERAPY	125, 952	277, 399			0. 000000	
68.00 06800 SPEECH PATHOLOGY	20, 740	63, 641			0. 000000	
69.00 06900 ELECTROCARDI OLOGY	176, 756	2, 487, 022			0.00000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0.000000	0.00000	•
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	285	87, 102			0.00000	•
73. 00 07300 DRUGS CHARGED TO PATIENTS	1, 615, 091	3, 658, 328	5, 273, 41	9 0. 488517	0. 000000	73.00
0UTPATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC	o	0	1	0		88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0		89.00
90. 00 09000 CLINIC	0	6, 512			0. 000000	
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	12, 130	1, 096, 299			0. 000000	•
90. 02 09002 JAY FAMILY MEDICINE	9, 634	775, 699			0. 000000	
91. 00 09100 EMERGENCY	366, 324	8, 490, 378			0.000000	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	4, 400	372, 259			0.000000	
93.00 04040 OTHER OUTPATIENT SERVICE COST CENTER	0	39, 719			0. 000000	
OTHER REIMBURSABLE COST CENTERS						
99. 10 09910 CORF	0	0)	0		99.10
SPECIAL PURPOSE COST CENTERS	,,					
106.00 10600 HEART ACQUI SI TI ON	0	0		0		106.00
109.00 10900 PANCREAS ACQUI SI TI ON	0	0		0		109.00
110.00 11000 I NTESTI NAL ACQUI SI TI ON	0	0		0		110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0		111.00
113.00 11300 INTEREST EXPENSE	1/ 0/7 070	74 004 754	01 151 00			113.00
200.00 Subtotal (see instructions)	16, 867, 070	74, 284, 754	91, 151, 82	4		200.00
201.00Less Observation Beds202.00Total (see instructions)	16, 867, 070	74, 284, 754	91, 151, 82	24		201.00 202.00
	10,007,070	74,204,704	ין או אין אין די	-1	l	202.00

Heal th	Financial Systems	JAY COUNTY H	IOSPI TAL	In Lie	u of Form CMS-	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1320	Period: From 10/01/2016 To 09/30/2017		epared:
			Title XVIII	Hospi tal	Cost	
	Cost Center Description	PPS Inpatient Ratio				
		11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00				
30, 00	03000 ADULTS & PEDIATRICS					30.00
31.00	03100 I NTENSI VE CARE UNI T					31.00
33.00	03300 BURN INTENSIVE CARE UNIT					33.00
40.00	04000 SUBPROVI DER – I PF					40.00
41.00	04100 SUBPROVI DER – I RF					41.00
42.00	04200 SUBPROVI DER					42.00
43.00	04300 NURSERY					43.00
40.00	ANCI LLARY SERVICE COST CENTERS					40.00
50.00	05000 OPERATING ROOM	0. 232270				50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 290442				52.00
53.00	05300 ANESTHESI OLOGY	0. 000000				53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 103361				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. 163154				60.00
60.00	06001 BLOOD LABORATORY	0. 000000				60.01
65.00	06500 RESPI RATORY THERAPY	0. 534835				65.00
66.00	06600 PHYSI CAL THERAPY	0. 322940				66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 241730				67.00
68.00	06800 SPEECH PATHOLOGY	0. 297437				68.00
69.00	06900 ELECTROCARDI OLOGY	0. 251960				69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 463044				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 488517				73.00
75.00	OUTPATIENT SERVICE COST CENTERS	0.400317				/3.00
88.00	08800 RURAL HEALTH CLINIC					88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER					89.00
90.00	09000 CLINIC	9. 674294				90.00
90.01	09001 FAMILY PRACTICE OF JAY COUNTY	1. 244560				90.01
90.02	09002 JAY FAMILY MEDICINE	2. 383454				90.02
91.00	09100 EMERGENCY	0. 332482				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 177774				92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0. 648405				93.00
75.00	OTHER REIMBURSABLE COST CENTERS	0.040403				/0.00
99, 10	09910 CORF					99.10
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	SPECIAL PURPOSE COST CENTERS					///. 10
106 00	10600 HEART ACQUISITION					106.00
	10900 PANCREAS ACQUI SI TI ON					109.00
	11000 I NTESTI NAL ACQUI SI TI ON					110.00
	11100 I SLET ACQUI SI TI ON					111.00
	11300 I NTEREST EXPENSE					113.00
200.00						200.00
201.00						201.00
202.00						202.00
		1				

OMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 10/01/2016 To 09/30/2017	Worksheet C Part I Date/Time Pre 2/26/2018 1:5	
		Titl	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS			•			
D. 00 03000 ADULTS & PEDI ATRI CS	4, 685, 573		4, 685, 57	3 0	4, 685, 573	30.0
1.00 03100 I NTENSI VE CARE UNI T	0			0 0	0	31.0
3.00 03300 BURN INTENSIVE CARE UNIT	0			0 0	0	33.0
D. 00 04000 SUBPROVI DER – I PF	2, 297, 300		2, 297, 30	0 0	2, 297, 300	40.0
1.00 04100 SUBPROVIDER - IRF	0			0 0	0	1
2. 00 04200 SUBPROVI DER	0			0 0	0	42.0
3. 00 04300 NURSERY	296, 541		296, 54	1 0	296, 541	43.0
ANCILLARY SERVICE COST CENTERS			•			1
D. 00 05000 OPERATI NG ROOM	3, 233, 553		3, 233, 55	3 0	3, 233, 553	50.
2.00 05200 DELIVERY ROOM & LABOR ROOM	61, 596		61, 59	6 0	61, 596	52.0
3. 00 05300 ANESTHESI OLOGY	0			0 0	0	53.
4. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 924, 834		2, 924, 83	4 0	2, 924, 834	54.
7.00 05700 CT SCAN	0			0 0	0	57.
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0			0 0	0	58.
9. 00 05900 CARDI AC CATHETERI ZATI ON	0			0 0	0	59.
D. 00 06000 LABORATORY	3, 159, 897		3, 159, 89	7 0	3, 159, 897	60.
D. 01 06001 BLOOD LABORATORY	0			0 0	0	
5. 00 06500 RESPI RATORY THERAPY	518, 267	l o	518, 26	7 0	518, 267	
6. 00 06600 PHYSI CAL THERAPY	746, 365	0			746, 365	
7.00 06700 OCCUPATI ONAL THERAPY	97, 502		97, 50		97, 502	
8.00 06800 SPEECH PATHOLOGY	25, 098		25, 09		25, 098	
9. 00 06900 ELECTROCARDI OLOGY	671, 165		671, 16		671, 165	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0 0	0	
2.00 07200 I MPL. DEV. CHARGED TO PATIENTS	40, 464		40, 46	4 0	40, 464	
3. 00 07300 DRUGS CHARGED TO PATIENTS	2, 576, 157		2, 576, 15		2, 576, 157	
OUTPATIENT SERVICE COST CENTERS	2,0,0,10,		2/0/0/10		2/0/0/10/	1.0.
B. 00 08800 RURAL HEALTH CLINIC	0			0 0	0	88.
9. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0 0	0	
D. 00 09000 CLINIC	62, 999		62, 99		62, 999	
D. 01 09001 FAMILY PRACTICE OF JAY COUNTY	1, 379, 506		1, 379, 50		1, 379, 506	
D. 02 09002 JAY FAMILY MEDICINE	1, 871, 805		1, 871, 80		1, 871, 805	
1. 00 09100 EMERGENCY	2, 944, 691		2, 944, 69		2, 944, 691	
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	443, 619		443, 61		443, 619	
3. 00 04040 OTHER OUTPATIENT SERVICE COST CENTER	25, 754		25, 75		25, 754	
OTHER REIMBURSABLE COST CENTERS	207701		20//0		20,701	1 / 0.
9. 10 09910 CORF	0			0	0	99.
SPECIAL PURPOSE COST CENTERS					0	
D6. 00 10600 HEART ACQUI SI TI ON	0			0	0	106.
09. 00 10900 PANCREAS ACQUISTION	0			0		109.
10. 00 11000 I NTESTI NAL ACQUI SI TI ON	0			0		110.
11.00 11100 I SLET ACQUISITION	0			0		1111.
13. 00 11300 I NTEREST EXPENSE				Ĭ	0	113.
00.00 Subtotal (see instructions)	28,062,686	0	28, 062, 68	6 0	28, 062, 686	
01.00 Less Observation Beds					28, 062, 686 443, 619	
	443, 619		443, 61			
02.00 Total (see instructions)	27, 619, 067	I U	27, 619, 06	/ 0	27,019,067	1202.

Health Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-1320	Period: From 10/01/2016 To 09/30/2017	Date/Time Pre	epared:
		Ti +1	e XIX	Hospi tal	2/26/2018 1:5 Cost	56 pm
		Charges	e xix		CUSI	
Cost Center Description	I npati ent	Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS	E 055 000		_ _ _ _ _ _ _ _ _ _			1 00 00
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T	5, 355, 003		5, 355, 00	0		30.00 31.00
33. 00 03300 BURN I NTENSI VE CARE UNI T	0			0		31.00
40. 00 04000 SUBPROVI DER - I PF	877, 200		877, 20	-		40.00
41. 00 04100 SUBPROVI DER – I RF	077,200		077,20			41.00
42. 00 04200 SUBPROVI DER	0			0		42.00
43. 00 04300 NURSERY	155, 190		155, 19			43.00
ANCI LLARY SERVICE COST CENTERS	100,170		1 100/11			101.00
50. 00 05000 OPERATI NG ROOM	2, 817, 069	11, 104, 436	13, 921, 50	0. 232270	0. 000000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	212, 077	C			0.00000	
53.00 05300 ANESTHESI OLOGY	0	C		0 0.000000	0.000000	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	1, 624, 672	26, 672, 726	28, 297, 39	0. 103361	0.000000	54.00
57.00 05700 CT SCAN	0	C		0 0.000000	0.000000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C		0 0.000000	0. 000000	58.00
59.00 05900 CARDI AC CATHETERI ZATI ON	0	C		0 0.000000	0. 000000	59.00
60. 00 06000 LABORATORY	2, 397, 146	16, 970, 456	19, 367, 60	0. 163154	0.000000	60.00
60. 01 06001 BLOOD LABORATORY	0	C		0 0.000000	0.00000	
65. 00 06500 RESPI RATORY THERAPY	610, 879	358, 143			0. 000000	
66. 00 06600 PHYSI CAL THERAPY	486, 522	1, 824, 635			0. 000000	
67.00 06700 OCCUPATI ONAL THERAPY	125, 952	277, 399			0. 000000	
68.00 06800 SPEECH PATHOLOGY	20, 740	63, 641			0. 000000	
69. 00 06900 ELECTROCARDI OLOGY	176, 756	2, 487, 022			0.00000	
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	C		0 0.000000	0.00000	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	285	87, 102			0.00000	
73. 00 07300 DRUGS CHARGED TO PATIENTS	1, 615, 091	3, 658, 328	5, 273, 41	9 0. 488517	0.00000	73.00
0UTPATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLI NI C	0	С		0 0.000000	0. 000000	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.000000	0. 000000	
90. 00 09000 CLINIC	0	6, 512			0. 000000	
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY	12, 130	1, 096, 299			0. 000000	
90. 02 09002 JAY FAMILY MEDICINE	9, 634	775, 699			0. 000000	
91. 00 09100 EMERGENCY	366, 324	8, 490, 378			0. 000000	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	4, 400	372, 259			0. 000000	
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTER	0	39, 719			0. 000000	
OTHER REIMBURSABLE COST CENTERS	-1					
99. 10 09910 CORF	0	C		0		99.10
SPECIAL PURPOSE COST CENTERS						
106.00 10600 HEART ACQUI SI TI ON	0	C		0		106.00
109.00 10900 PANCREAS ACQUI SI TI ON	0	C		0		109.00
110.00 11000 INTESTINAL ACQUISITION	0	C		0		110.00
111.00 11100 I SLET ACQUI SI TI ON	0	C		0		111.00
113.00 11300 INTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	16, 867, 070	74, 284, 754	91, 151, 82	24		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	16, 867, 070	74, 284, 754	91, 151, 82	24		202.00

COMPUTATION OF RATIO OF COSTS TO CHA	RGES		Provider CCN: 15-1320	Peri od:	Worksheet C	
				From 10/01/2016 To 09/30/2017	Part I Date/Time Pre	
			Title XIX	Hospi tal	2/26/2018 1:5 Cost	oo pm
Cost Center Description		PPS Inpatient			0031	
		Ratio				
		11.00				
INPATIENT ROUTINE SERVICE COST	CENTERS					
30.00 03000 ADULTS & PEDIATRICS						30.0
31.00 03100 INTENSIVE CARE UNIT						31.0
33.00 03300 BURN INTENSIVE CARE UNIT						33.0
40. 00 04000 SUBPROVI DER - I PF						40.0
41.00 04100 SUBPROVIDER - IRF						41.0
42. 00 04200 SUBPROVI DER						42.0
43.00 04300 NURSERY						43.0
ANCILLARY SERVICE COST CENTERS	5					
50.00 05000 OPERATING ROOM		0. 000000				50.0
52.00 05200 DELIVERY ROOM & LABOR RC	OM	0. 000000				52.0
53. 00 05300 ANESTHESI OLOGY		0. 000000				53.0
54.00 05400 RADI OLOGY-DI AGNOSTI C		0. 000000				54.0
57.00 05700 CT SCAN		0. 000000				57.0
58.00 05800 MAGNETIC RESONANCE IMAGI	NG (MRI)	0. 000000				58.0
59.00 05900 CARDI AC CATHETERI ZATI ON		0. 000000				59.0
60. 00 06000 LABORATORY		0. 000000				60. C
60.01 06001 BLOOD LABORATORY		0. 000000				60.0
65. 00 06500 RESPI RATORY THERAPY		0. 000000				65.0
66.00 06600 PHYSI CAL THERAPY		0. 000000				66.0
67.00 06700 OCCUPATI ONAL THERAPY		0. 000000				67.0
68.00 06800 SPEECH PATHOLOGY		0. 000000				68.0
69. 00 06900 ELECTROCARDI OLOGY		0. 000000				69.0
71.00 07100 MEDICAL SUPPLIES CHARGED	TO PATIENTS	0. 000000				71.0
72.00 07200 IMPL. DEV. CHARGED TO PA	TI ENTS	0. 000000				72.0
73.00 07300 DRUGS CHARGED TO PATIENT	S	0. 000000				73.0
OUTPATIENT SERVICE COST CENTER	RS					
88.00 08800 RURAL HEALTH CLINIC		0. 000000				88.0
89.00 08900 FEDERALLY QUALIFIED HEAL	TH CENTER	0. 000000				89.0
90. 00 09000 CLINIC		0. 000000				90.0
90.01 09001 FAMILY PRACTICE OF JAY C	OUNTY	0. 000000				90.0
90.02 09002 JAY FAMILY MEDICINE		0. 000000				90.0
91. 00 09100 EMERGENCY		0. 000000				91.0
92.00 09200 OBSERVATION BEDS (NON-DI		0. 000000				92.0
93.00 04040 OTHER OUTPATIENT SERVICE	COST CENTER	0. 000000				93.0
OTHER REIMBURSABLE COST CENTER	RS					
99. 10 09910 CORF						99.1
SPECIAL PURPOSE COST CENTERS						
106.00 10600 HEART ACQUISITION						106.0
109.00 10900 PANCREAS ACQUISITION						109.0
110.00 11000 INTESTINAL ACQUISITION						110. C
111.00 11100 ISLET ACQUISITION						1111. C
113.00 11300 INTEREST EXPENSE						113.0
200.00 Subtotal (see instruction	ns)					200.0
201.00 Less Observation Beds						201.0
202.00 Total (see instructions)						202.0

Health Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT.	AL COSTS	Provider C	CN: 15-1320	Peri od:	Worksheet D	
				From 10/01/2016 To 09/30/2017		narod
				10 09/30/2017	2/26/2018 1:5	
		Title	XVIII	Hospi tal	Cost	-
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	000 707	40.004.505	0.04(0)	707 040	40.450	
50.00 05000 OPERATING ROOM	223, 737					
52. 00 05200 DELIVERY ROOM & LABOR ROOM	3, 842				0	•
53.00 05300 ANESTHESI OLOGY	0	0	0.0000		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	188, 401	28, 297, 398			3, 379	
57.00 05700 CT SCAN	0	0	0.0000		0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.0000		0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0.0000		0	59.00
60. 00 06000 LABORATORY	101, 656	19, 367, 602			4, 141	60.00
60. 01 06001 BLOOD LABORATORY	0	0	0.0000		0	60.01
65.00 06500 RESPIRATORY THERAPY	17,098					
66. 00 06600 PHYSI CAL THERAPY	8,040					66.00
67. 00 06700 OCCUPATI ONAL THERAPY	728	403, 351			123	
68. 00 06800 SPEECH PATHOLOGY	180				33	68.00
69.00 06900 ELECTROCARDI OLOGY	56, 310					
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0			0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	269					72.00
73.00 O7300 DRUGS CHARGED TO PATIENTS	44, 131	5, 273, 419	0.0083	59 536, 668	4, 491	73.00
		0	0.0000		0	00.00
88.00 08800 RURAL HEALTH CLINIC	0	0	0.0000		0	
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC	0	U (E10	0.0000		0	89.00
90.00 09000 CLINIC 90.01 09001 FAMILY PRACTICE OF JAY COUNTY	654	6, 512			0 47	90.00 90.01
90.02 09002 JAY FAMILY MEDICINE	18, 546 221, 815					
						1
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	150, 561	8, 856, 702			53	91.00 92.00
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTER	36, 598				0	92.00
200.00 Total (lines 50 through 199)	1, 072, 731			3, 221, 722	-	
200.00 [TOTAL (TITLES SO THEOUGH 199)	1,072,731	04, 704, 431	1	3, 221, 722	33, 359	l∠00.00

Health Financial Systems	JAY COUNTY H	IOSPI TAL		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PASS			Period: From 10/01/2016 To 09/30/2017		pared: 6 pm
		Title	XVIII	Hospi tal	Cost	
Cost Center Description		Nursing School ost-Stepdown Adjustments	Nursing School	Post-Stepdown Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM 52.00 05200 DELI VERY ROOM & LABOR ROOM 53.00 05300 ANESTHESI OLOGY 54.00 05400 RADI OLOGY-DI AGNOSTI C	0 0 0 0	0 0 0 0				52.00 53.00 54.00
57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 59.00 05900 CARDIAC CATHETERIZATION 60.00 06000 LABORATORY	000000000000000000000000000000000000000	0 0 0				58.00 59.00
60. 01 06000 EABORATORY 65. 00 06500 RESPIRATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY		0 0 0				60. 01 65. 00
67.00 06700 0CCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY 69.00 06900 ELECTROCARDI OLOGY	0 0 0	0 0 0				68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0 0 0	0 0 0			0 0 0	72.00
OUTPATI ENT SERVICE COST CENTERS88. 0008800RURAL HEALTH CLINIC89. 0008900FEDERALLY QUALIFIED HEALTH CENTER90. 0109000CLINIC90. 0109001FAMILY PRACTICE OF JAY COUNTY90. 0209002JAY FAMILY MEDICINE91. 0009100EMERGENCY92. 0009200OBSERVATION BEDS (NON-DISTINCT PART)93. 0004040OTHER OUTPATIENT SERVICE COST CENTER200. 00Total (lines 50 through 199)	0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0				89.00 90.00 90.01 90.02 91.00 92.00

Health Financial Systems						2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERV THROUGH COSTS	ICE OTHER PAS	S Provider C	CN: 15-1320	Period: From 10/01/2016	Worksheet D Part IV	
				To 09/30/2017	Date/Time Pre 2/26/2018 1:5	pared: 6 pm
			XVIII	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total	Total Charges		
	Medi cal	(sum of col 1		(from Wkst.	to Charges	
	Educati on	through col.	Cost (sum of		(col. 5 ÷	
	Cost	4)	col. 2, 3 an 4)	d col. 8)	col. 7)	
	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
50.00 O5000 OPERATING ROOM	0	0		0 13, 921, 505		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 212, 077	0. 000000	
53.00 05300 ANESTHESI OLOGY	0	0		0 0	0.00000	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 28, 297, 398	0.000000	54.00
57.00 05700 CT SCAN	0	0		0 0	0.00000	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0.00000	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0.00000	
60. 00 06000 LABORATORY	0	0		0 19, 367, 602	0.00000	
60.01 06001 BLOOD LABORATORY	0	0		0 0	0.00000	60. 01
65. 00 06500 RESPI RATORY THERAPY	0	0		0 969, 022	0.00000	65.00
66.00 06600 PHYSI CAL THERAPY	0	0		0 2, 311, 157	0.00000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 403, 351	0.00000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 84, 381	0.00000	68.00
69.00 06900 ELECTROCARDI OLOGY	0	0		0 2, 663, 778	0.000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 87, 387	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 5, 273, 419	0.00000	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0	0.00000	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0.000000	
90. 00 09000 CLINIC	0	0		0 6, 512	0.000000	90.00
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	0	0		0 1, 108, 429	0.00000	90.01
90. 02 09002 JAY FAMILY MEDICINE	0	0		0 785, 333	0.00000	
91. 00 09100 EMERGENCY	0	0		0 8, 856, 702	0.00000	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 376, 659	0.00000	92.00
93.00 04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0		0 39, 719	0.00000	93.00
200.00 Total (lines 50 through 199)	0	0		0 84, 764, 431		200.00

Health Financial Systems	JAY COUNTY H	OSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provider C	CN: 15-1320	Peri od:	Worksheet D	
THROUGH COSTS				From 10/01/2016 To 09/30/2017		narod
				10 09/30/2017	2/26/2018 1:5	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷		Costs (col.	8	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS			1	-		
50.00 05000 OPERATING ROOM	0. 000000	787, 348		0 0	-	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
53.00 05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	507, 534		0 0	0	54.00
57.00 05700 CT SCAN	0. 000000	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0 0	0	58.00
59.00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59.00
60. 00 06000 LABORATORY	0. 000000	788, 957		0 0	0	60.00
60. 01 06001 BLOOD LABORATORY	0. 000000	0		0 0	0	60.01
65. 00 06500 RESPI RATORY THERAPY	0. 000000	247,664		0 0	0	65.00
66.00 06600 PHYSI CAL THERAPY	0. 000000	115, 438		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	68, 081		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	15, 267		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	146, 540		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	285		0 0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	536, 668		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS	1		1			
88.00 08800 RURAL HEALTH CLINIC	0. 000000	0		0 0		
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0		0 0	0	89.00
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	0. 000000	2, 837		0 0	0	90.01
90. 02 09002 JAY FAMILY MEDICINE	0. 000000	2, 010		0 0	0	90.02
91.00 09100 EMERGENCY	0. 000000	3, 093		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	92.00
93.00 04040 OTHER OUTPATIENT SERVICE COST CENTER	0. 000000	0		0 0	0	93.00
200.00 Total (lines 50 through 199)	1	3, 221, 722	I	0 0	0	200.00

Health Financial Systems	JAY COUNTY				u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES ANI	O VACCINE COST	Provider C	CN: 15-1320	Period: From 10/01/2016 To 09/30/2017	Worksheet D Part V Date/Time Pre 2/26/2018 1:5	pared: 6 pm
		Title	× XVIII	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Reimbursed	Reimbursed	Reimbursed	(see inst.)	
	From	Services (see	Servi ces	Services Not		
	Worksheet C,	inst.)	Subject To	Subject To		
	Part I, col.		Ded. & Coins			
	9		(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 232270		2, 920, 35	2 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 290442			0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 103361	0	7, 817, 67	1 0	0	54.00
57.00 05700 CT SCAN	0. 000000	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59.00
60. 00 06000 LABORATORY	0. 163154	0	5, 913, 11	6 0	0	60.00
60. 01 06001 BLOOD LABORATORY	0. 000000	0		0 0	0	60.01
65. 00 06500 RESPI RATORY THERAPY	0. 534835	0	42, 75	1 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 322940	0	722, 37	2 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 241730		47,87	6 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 297437	0	12, 97	9 0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	0. 251960	0			0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 463044	0	53, 16	9 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATI ENTS	0. 488517	0			0	•
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 CLINIC	9.674294	0		0 0	0	90.00
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	1. 244560		190, 81	4 11, 285	0	90.01
90. 02 09002 JAY FAMILY MEDICINE	2. 383454				0	90.02
91.00 09100 EMERGENCY	0. 332482				0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 177774				0	92.00
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTER	0. 648405			0 0	0	93.00
200.00 Subtotal (see instructions)	0.010400					200.00
201.00 Less PBP Clinic Lab. Services-Program			22, 701, 24	0 73, 412	0	200.00
Only Charges						201.00
202.00 Net Charges (line 200 - line 201)		c c	22, 401, 24	1 93, 412	0	202.00
	1				0	

Health Financial Systems	JAY COUNTY	HOSPI TAL		In Lieu	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider C	CN: 15-1320	Peri od: From 10/01/2016 To 09/30/2017	Worksheet D Part V Date/Time Pre 2/26/2018 1:5	pared: 6 pm
		Title	XVIII	Hospi tal	Cost	
		sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)	-			
	6.00	7.00		· · · · · · · · · · · · · · · · · · ·		
ANCI LLARY SERVICE COST CENTERS 50. 00 05000 OPERATI NG ROOM	678, 310	0	1			50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	-				52.00
53. 00 05300 ANESTHESI OLOGY	0	Ŭ				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	808, 042					54.00
57.00 05700 CT SCAN	0	0				57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY	964, 749					60.00 60.01
	0	, o				65.00
	22, 865					
66. 00 06600 PHYSICAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	233, 283 11, 573					66.00 67.00
						68.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	3, 860 341, 212					69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0					71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	24, 620					72.00
73. 00 07200 DRUGS CHARGED TO PATIENTS	691,095		1			73.00
OUTPATIENT SERVICE COST CENTERS	091,093	50, 215				/3.00
88.00 08800 RURAL HEALTH CLINIC	0	0				88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	-				89.00
90. 00 109000 CLINIC	0					90.00
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY	237, 479	14,045				90.00
90. 02 09002 JAY FAMILY MEDICINE	322, 226		1			90.02
91. 00 09100 EMERGENCY	537,008					91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	189, 491	0				92.00
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTER	0	-				93.00
200.00 Subtotal (see instructions)	5, 065, 813	-				200.00
201.00 Less PBP Clinic Lab. Services-Program	3,003,013					200.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	5, 065, 813	69, 316				202.00

Health Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C	CN: 15-1320	Peri od:	Worksheet D	
		Component	CCN: 15-M320	From 10/01/2016 To 09/30/2017		narod
		component	CCN. 13-10320	10 077 307 2017	2/26/2018 1:5	
		Title	e XVIII	Subprovider -	PPS	
				I PF		
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col . 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	<u>col. 26)</u> 1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATI NG ROOM	223, 737	13, 921, 505	0. 0160	71 0	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	3, 842				0	52.00
53. 00 05300 ANESTHESI OLOGY	0,012		1		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	188, 401	28, 297, 398			408	54.00
57. 00 05700 CT SCAN	0	0	0.0000		0	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0.0000		0	58.00
59.00 05900 CARDI AC CATHETERI ZATI ON	0	0	0.0000		0	59.00
60. 00 06000 LABORATORY	101, 656	19, 367, 602	0.00524	19 153, 756	807	60.00
60. 01 06001 BLOOD LABORATORY	0	0	0.0000		0	60.01
65. 00 06500 RESPI RATORY THERAPY	17, 098	969, 022	0. 01764	15 27, 308	482	65.00
66. 00 06600 PHYSI CAL THERAPY	8, 040	2, 311, 157	0.0034	79 8, 158	28	66.00
67.00 06700 OCCUPATI ONAL THERAPY	728	403, 351	0.00180	3, 030	5	67.00
68.00 06800 SPEECH PATHOLOGY	180	84, 381	0.00213	33 2, 108	4	68.00
69. 00 06900 ELECTROCARDI OLOGY	56, 310	2, 663, 778			263	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	-	0.00000		0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	269				0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	44, 131	5, 273, 419	0.00830	59 187, 606	1, 570	73.00
OUTPATIENT SERVICE COST CENTERS	1		1			
88.00 08800 RURAL HEALTH CLINIC	0	-	0.0000		-	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	-	0.0000		0	89.00
90. 00 09000 CLINIC	654				0	90.00
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY	18, 546					90.01
90. 02 09002 JAY FAMILY MEDICINE 91. 00 09100 EMERGENCY	221, 815					90.02
	150, 561	8, 856, 702				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 93.00 04040 OTHER OUTPATIENT SERVICE COST CENTER	0 165				0	92.00 93.00
200.00 Total (lines 50 through 199)	1, 036, 133			497, 830	-	200.00
200.00 [TOTAL (THES SO THEOUGH 199)	1,030,133	04,704,431	I	477,030	5,010	1200.00

Health Financial Systems	JAY COUNTY	HOSPI TAL			In Lieu	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI	RVICE OTHER PAS	S Provider C	CN: 15-1320	Peri		Worksheet D	
THROUGH COSTS		Component (CCN: 15-M320	To	10/01/2016 09/30/2017	Part IV Date/Time Pre	pared:
		Titlo	XVIII	Sub	provider -	2/26/2018 1:5 PPS	6 pm
		intre			I PF		
Cost Center Description	Non Physician		Nursi ng			Allied Health	
	Anesthetist	School	School		st-Stepdown		
	Cost	Post-Stepdown		Ac	djustments		
	1.00	Adjustments 2A	2.00		3A	3.00	
ANCILLARY SERVICE COST CENTERS	1.00	28	2.00		JA	3.00	
50. 00 05000 OPERATING ROOM	0	0		0	0	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		Ö	Ő	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	О	0	54.00
57.00 05700 CT SCAN	0	0		0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	0	59.00
60. 00 06000 LABORATORY	0	0		0	0	0	60.00
60.01 06001 BLOOD LABORATORY	0	0		0	0	0	60.01
65. 00 06500 RESPI RATORY THERAPY	0	0		0	0	0	65.00
66.00 06600 PHYSI CAL THERAPY	0	0		0	0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0	0	69.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 72.00 07200 I MPL. DEV. CHARGED TO PATI ENTS	0	0		0	0	0	71.00
72.00 07200 TMPL. DEV. CHARGED TO PATTENTS 73.00 07300 DRUGS CHARGED TO PATTENTS	0	0		0	0	0	72.00 73.00
OUTPATIENT SERVICE COST CENTERS	0	0		U	0	0	73.00
88. 00 08800 RURAL HEALTH CLINIC	0	0		0	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	0	89.00
90. 00 09000 CLINIC	0	0		0	0	0	90.00
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY	0	0		0	0	0	90.01
90. 02 09002 JAY FAMILY MEDICINE	0	0		0	0	0	90.02
91.00 09100 EMERGENCY	0	0		0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0	0	0	92.00
93.00 04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0		0	0	0	93.00
200.00 Total (lines 50 through 199)	0	0		0	0	0	200.00

Health Financial Systems	JAY COUNTY	HOSPI TAL			In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEA THROUGH COSTS	RVICE OTHER PAS		CN: 15-1320 CCN: 15-M320		riod: om 10/01/2016 09/30/2017		pared:
						2/26/2018 1:5	6 pm
			e XVIII		ubprovider - IPF	PPS	
Cost Center Description	All Other	Total Cost	Total			Ratio of Cost	
	Medi cal	(sum of col 1			(from Wkst.	to Charges	
	Educati on	through col.	Cost (sum o		C, Part I,	(col. 5 ÷	
	Cost	4)	col. 2, 3 ar	nd	col. 8)	col. 7)	
			4)				
	4.00	5.00	6.00		7.00	8.00	
ANCI LLARY SERVICE COST CENTERS			1		10.001.505		
50. 00 05000 OPERATING ROOM	0	0		0	13, 921, 505	0.000000	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	212, 077	0.000000	
53. 00 05300 ANESTHESI OLOGY	0	0		0	0	0.000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	28, 297, 398	0.000000	
57. 00 05700 CT SCAN	0	0		0	0	0.000000	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0	0	0.000000	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	0.000000	
60. 00 06000 LABORATORY	0	0		0	19, 367, 602	0.000000	
60. 01 06001 BLOOD LABORATORY	0	0		0	0	0.000000	
65. 00 06500 RESPIRATORY THERAPY	0	0		0	969, 022	0.000000	
66.00 06600 PHYSI CAL THERAPY	0	0		0	2, 311, 157	0.000000	
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0	403, 351	0.000000	
68. 00 06800 SPEECH PATHOLOGY	0	0		0	84, 381	0.000000	
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	2, 663, 778	0.000000	
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	0.000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	87, 387	0.000000	
73. 00 07300 DRUGS CHARGED TO PATI ENTS OUTPATI ENT SERVI CE COST CENTERS	0	0		0	5, 273, 419	0.000000	73.00
88. 00 08800 RURAL HEALTH CLINIC	0	0	1	0	0	0,000000	88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	0.000000	
90. 00 09000 CLINIC	0	0		0	6, 512	0.000000	
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	0	0		0	1, 108, 429	0.000000	
90. 02 09002 JAY FAMILY MEDICINE	0	0		0	785, 333	0.000000	
91. 00 09100 EMERGENCY	0	0		0	8, 856, 702	0.000000	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0	376, 659	0.000000	
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0		0	39, 719	0.000000	
200.00 Total (lines 50 through 199)	0	0		0	84, 764, 431		200.00
	۱ V	0	I	9	31,701,401		

Health Financial Systems	JAY COUNTY H	OSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provider C	CN: 15-1320	Peri od:	Worksheet D	
THROUGH COSTS		Component (CCN: 15-M320	From 10/01/2016 To 09/30/2017		narod
		component	30N. 13-W320	10 077 307 2017	2/26/2018 1:5	
		Title	XVIII	Subprovider -	PPS	
				I PF		
Cost Center Description	Outpati ent	Inpati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Throug		Pass-Through	
	(col. 6 ÷		Costs (col.	8	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVICE COST CENTERS	0.000000		i		0	
50.00 O5000 OPERATING ROOM	0. 000000	0		0 0	-	
52.00 O5200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
53.00 O5300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	61, 353		0 0	0	54.00
57.00 05700 CT SCAN	0.000000	0		0 0	0	57.00
58.00 O5800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	150 754		0 0	0	59.00
	0. 000000	153, 756		0 0	0	
60. 01 06001 BLOOD LABORATORY	0. 000000	0		0 0	0	60.01
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0.000000	27, 308		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	8, 158 3, 030		0 0	0	66.00 67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	2, 108			-	•
69. 00 06900 ELECTROCARDI OLOGY	0. 000000				0	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	12, 427 0			0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0			0	72.00
	0. 000000	0 187, 606			-	72.00
73. 00 07300 DRUGS CHARGED TO PATI ENTS OUTPATI ENT SERVI CE COST CENTERS	0.000000	187,000		0 0	0	/3.00
88.00 08800 RURAL HEALTH CLINIC	0. 000000	0		0 0	0	88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0			0	89.00
90. 00 109000 CLINIC	0.000000	0			0	90.00
90.01 09000 CETNIC 90.01 09001 FAMILY PRACTICE OF JAY COUNTY	0. 000000	8, 135			0	
90. 02 09002 JAY FAMILY MEDICINE	0.000000	5, 763			0	90.01
90. 02 09002 3AT FAMILET MEDICINE 91. 00 09100 EMERGENCY	0.000000	28, 186			0	90.02
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	20, 100		0 0	0	92.00
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0		0 0	0	•
200.00 Total (lines 50 through 199)	0.00000	497, 830		0 0	-	200.00
	I I	-77,030	I	0	0	200.00

Health Financial Systems APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND		HOSPI TAL	CN: 15-1320	Peri od:	u of Form CMS- Worksheet D	
All official and the second of the second of the second of the	B WHOOTHE OUDT	in our der o	011. 10 1020	From 10/01/2016	Part V	
		Component	CCN: 15-Z320	To 09/30/2017	Date/Time Pre	epared:
					2/26/2018 1:5	56 pm
		Title		Swing Beds - SNF		
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Reimbursed	Rei mbursed	Reimbursed	(see inst.)	
	From	Services (see		Services Not		
	Worksheet C,	inst.)	Subject To	Subject To		
	Part I, col.		Ded. & Coins			
	9		(see inst.)			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS		-	1	-		
50.00 05000 OPERATING ROOM	0. 232270			0 0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 290442)	0 0	0	
53. 00 05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 103361	0		0 0	0	54.00
57.00 05700 CT SCAN	0. 000000			0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	0)	0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59.00
60. 00 06000 LABORATORY	0. 163154	0		0 0	0	60.00
60. 01 06001 BLOOD LABORATORY	0. 000000	0		0 0	0	60.01
65. 00 06500 RESPI RATORY THERAPY	0. 534835	0		0 0	0	65.00
66.00 06600 PHYSI CAL THERAPY	0. 322940	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 241730	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 297437	0		0 0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	0. 251960	l o		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			0 0	0	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0, 463044			0 0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 488517			0 0	0	
OUTPATIENT SERVICE COST CENTERS	01 100017			0 0		/ 01 00
88. 00 08800 RURAL HEALTH CLINIC	0. 000000				0	88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	
90. 00 09000 CLINIC	9. 674294			0 0	0	
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY	1. 244560				0	
90. 02 09002 JAY FAMILY MEDICINE	2. 383454				0	
91. 00 09100 EMERGENCY	0. 332482			0 0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 177774				0	
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTER	0. 648405			0 0	0	
	0. 648405			0 0	-	
200.00 Subtotal (see instructions)		0		0 0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges					~	000 00
202.00 Net Charges (line 200 - line 201)	1	0	7	0 0	0	202.00

Health Fin	ancial Systems	JAY COUNTY	HOSPI TAL		In Lieu	u of Form CMS-2552-1
APPORTI ONM	IENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-1320	Peri od:	Worksheet D
			Component	CCN: 15-Z320	From 10/01/2016 To 09/30/2017	Date/Time Prepared:
			Title	xvi i	Swing Beds - SNF	2/26/2018 1:56 pm Cost
		Cos			Swilly beus - Sive	CUSI
	Cost Center Description	Cost	Cost	1		
		Reimbursed	Reimbursed			
		Services	Servi ces Not			
		Subject To	Subject To			
			Ded. & Coins.			
		(see inst.)	(see inst.)			
		6.00	7.00			
ANC	ILLARY SERVICE COST CENTERS					
50.00 050	OO OPERATING ROOM	0	0			50.00
52.00 0520	DO DELIVERY ROOM & LABOR ROOM	0	0			52.00
	00 ANESTHESI OLOGY	0	0	1		53.00
	00 RADI OLOGY-DI AGNOSTI C	0	0			54.00
	DO CT SCAN	0	0			57.00
	DO MAGNETIC RESONANCE IMAGING (MRI)	0	0			58.00
	DO CARDI AC CATHETERI ZATI ON	0	0			59.00
	DO LABORATORY	0	0			60.00
	01 BLOOD LABORATORY	0	0			60.0
65.00 0650	00 RESPI RATORY THERAPY	0	0			65.00
	00 PHYSI CAL THERAPY	0	0			66.00
67.00 0670	DO OCCUPATI ONAL THERAPY	0	0			67.00
68.00 0680	DO SPEECH PATHOLOGY	0	0			68.00
69.00 0690	DO ELECTROCARDI OLOGY	0	0			69.00
71.00 0710	00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			71.00
	DO IMPL. DEV. CHARGED TO PATIENTS	0	0			72.00
73.00 0730	DO DRUGS CHARGED TO PATIENTS	0	0			73.00
OUTI	PATIENT SERVICE COST CENTERS					
88.00 0880	00 RURAL HEALTH CLINIC	0	0	1		88.00
89.00 0890	00 FEDERALLY QUALIFIED HEALTH CENTER	0	0			89.00
90.00 0900	DOCLINIC	0	0			90.00
90.01 0900	01 FAMILY PRACTICE OF JAY COUNTY	0	0			90.0
90.02 0900	02 JAY FAMILY MEDICINE	0	0			90.02
91.00 0910	DO EMERGENCY	0	0			91.00
92.00 0920	OO OBSERVATION BEDS (NON-DISTINCT PART)	0	0			92.00
93.00 0404	40 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	0				201.00
	Only Charges					
202.00	Net Charges (line 200 - line 201)	0	0			202.00

	Financial Systems JAY COUNTY HC ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1320	Period: From 10/01/2016 To 09/30/2017	Worksheet D-1 Date/Time Pre 2/26/2018 1:50	epare
	Cost Costor Deserinting	Title XVIII	Hospi tal	Cost	
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS				
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	us oveluding nowborn)		3, 045	1 1.
00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			2,679	
00	Private room days (excluding swing-bed and observation bed da		rivate room days,	0	
~~	do not complete this line.			0,000	
00 00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	2, 392 0	
00	reporting period			0	
00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	351	6
00	reporting period (if calendar year, enter 0 on this line)	an dava) through December	n 21 of the east	4	,
00	Total swing-bed NF type inpatient days (including private roo reporting period	Sin days) through beceinde	a si oi the cost	4	7
00	Total swing-bed NF type inpatient days (including private roo	om days) after December	31 of the cost	11	8
	reporting period (if calendar year, enter 0 on this line)				
00	Total inpatient days including private room days applicable t newborn days)	to the Program (excludin	ig swing-bed and	1, 058	9
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of	onlv (including private	room davs)	0	10
	through December 31 of the cost reporting period (see instruc	ctions)	3 /		
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of		room days) after	249	11
00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI		te room dave)	0	12
. 00	through December 31 of the cost reporting period	in only (meruaning priva	tte room days)	0	'2
. 00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13
00	after December 31 of the cost reporting period (if calendar y				
	Medically necessary private room days applicable to the Progr Total nursery days (title V or XIX only)	ram (excluding swing-bed	days)	0	
	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT				
. 00	Medicare rate for swing-bed SNF services applicable to service	ces through December 31	of the cost		17
. 00	reporting period Medicare rate for swing-bed SNF services applicable to servic	ces after December 31 of	the cost		18
	reporting period				
. 00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 c	of the cost	137.32	19
). 00	reporting period Medicaid rate for swing-bed NF services applicable to service	es after December 31 of	the cost	137.32	20
	reporting period			107102	20
	Total general inpatient routine service cost (see instruction	·		4, 685, 573	
2.00	Swing-bed cost applicable to SNF type services through Decemb 5 x line 17)	per 31 of the cost repor	ting period (line	0	22
3. 00	Swing-bed cost applicable to SNF type services after December	r 31 of the cost reporti	ng period (line 6	0	23
	x line 18)		51 (
. 00	Swing-bed cost applicable to NF type services through December	er 31 of the cost report	ing period (line	549	24
5. 00	7 x line 19) Swing-bed cost applicable to NF type services after December	31 of the cost reportin	a period (line 8	1, 511	25
. 00	x line 20)			1,011	20
	Total swing-bed cost (see instructions)			544, 604	
. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		4, 140, 969	27
00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	ed and observation bed o	harges)	0	28
	Private room charges (excluding swing-bed charges)		and gooy	0	
	Semi-private room charges (excluding swing-bed charges)			0	
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	
	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 0.00	
	Average per diem private room charge differential (line 32 mi	inus line 33)(see instru	ictions)	0.00	
. 00	Average per diem private room cost differential (line 34 x li		-	0.00	35
. 00	Private room cost differential adjustment (line 3 x line 35)			0	
	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost d	IITTERENTIAL (LINE	4, 140, 969	37
. 00					1
. 00	PART II - HUSPITAL AND SUBPROVIDERS UNLY				1
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.				
. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD. Adjusted general inpatient routine service cost per diem (see	e instructions)		1, 545. 71	
. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.	e instructions) e 38)		1, 545. 71 1, 635, 361 0	39

45. col BURNINTENSIVE CARE UNIT 0 0 0.00 0 6. do 45. col SUBCLACARE (SPECIFY) 1 0 0.00 0 6. do 47. col Others SPECIAL CARE (SPECIFY) 1 0 0.00		Financial Systems	JAY COUNTY				u of Form CMS-2	
Thill with the service of the service of the service for the service for the service of the service ser	COMPUT	ATION OF INPATIENT OPERATING COST		Provider C	1	rom 10/01/2016	Date/Time Pre	pared:
Cost Center Description Intelling Intelling Program Lays Program Lays Program Cost 42.00 MURSERY (LITO V A XIX orty) 100 2.00 0.00				Title	e XVIII	Hospi tal		o pili
42.00 NURSERY (LILE V & XLX only) 0 0 0.00 0		Cost Center Description	Inpatient Cost	Total I npati ent Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
Intensive Care Type Inpatient Hospital Units Intensive Care Unit Intensive Care Unit <th< td=""><td>42.00</td><td>NUDCEDV (+; +Lo V & VLV optiv)</td><td></td><td></td><td></td><td></td><td></td><td>42.00</td></th<>	42.00	NUDCEDV (+; +Lo V & VLV optiv)						42.00
3.00 INTERSIVE CARE UNIT 0 0 0.00 0 4.40 4.100 INTERSIVE CARE UNIT 0 0 0.00 0 4.40 4.100 INTERSIVE CARE UNIT 0 0 0.00 0 6.40 4.100 INTERSIVE CARE UNIT 0 0 0.00 0 6.40 4.100 INTERSIVE CARE UNIT 0 0 0.00 0 6.40 4.100 OTHER SPECIAL CARE (FORCETP) 4 4.40 4.40 4.100 Intel Program Inpattent costs (sum of lines 41 through 48) (see instructions) 2.498, 730 4.00 5.100 Pass through costs applicable to Program Inpattent ancillary services (from Wkst. D. sum of Parts I and IIII) 0 5.100 6.100 Program Inpattent to careful prost second part of a test and part a test and part of a test and part of a test	42.00		U	L	0.00	0	0	42.00
44.00 COROMARY CARE UNIT 0 0 0.00 0 0 45.00 50 BURK CAL INTENSIVE CARE UNIT 0 0 0.00 0.00 0.00 0 0.00 0 0.00 0 0.00 0.00 0.00 0.00 <td>43 00</td> <td></td> <td>0</td> <td></td> <td>0.00</td> <td>0 0</td> <td>0</td> <td>43 00</td>	43 00		0		0.00	0 0	0	43 00
45.00 BURN INTENSIVE CARE UNIT 0 0 0.00 0 45.00 45.00 BURN INTENSIVE CARE (SPECIPY) 100 100 100 45.00 47.00 OITHE SECIAL CARE (SPECIPY) 100 86.3.207 45.00 47.00 OITHE SECIAL CARE (SPECIPY) 86.3.207 40.00 48.00 Frongare Inpatient costs (sum of lines 41 brough 40) (see instructions) 2.499, 70 40.00 50.00 Frass Through costs applicable to Program Inpatient nuclilary services (from Wkst. D, sum of Parts I and one second costs applicable cost (sum of lines 50 and 51) 51.00 52.00 1013 100 52.00 1014 60.00 53.00 50.00 53.00 <td></td> <td></td> <td>U.S.</td> <td></td> <td></td> <td>5</td> <td></td> <td>44.00</td>			U.S.			5		44.00
47.00 OPTHER SPECIAL CARE (SPECIFY) 47.00 47.00 OPTHER SPECIAL CARE (SPECIFY) 1.00 48.00 Program inpatient ancillary service cost (West D. 3, line 20) 263, 360 49.00 Program inpatient ancillary service cost (West D. 3, line 20) 263, 360 40.00 Prost Introduct Cost applicable to Program inpatient nuclines services (from West D. sum of Parts I and 10) 0 50.00 Prost Introduct Cost applicable to Program inpatient ancillary services (from West D. sum of Parts I and 10) 0 50.00 Total Program inpatient operating cost excluding applicable to Program inpatient operating cost excluding applicable to Program inpatient operating cost and target amount (line 56 minus line 53) 0 51.00 Target amount per discharge 0.0 52.00 Program discharges 0.0 50.00 Target amount per discharge 0.0 50.00 Target amount per discharge 0.0 60.00 Issues SJ/54 or 55 from the cost reporting period ending 1996, updated and compounded by the amount per discharge 0.00 61.00 Issues SJ/54 or 55 from the cost reporting period start backet 0.00 0.0 62.00 Issues SJ/54 or 55 from prior year costs show explected costs (line 54 x 60), or 13 of the mount by anich operating ocosts with			0	C	0.00	0 0	0	45.00
Cost Conter Description 100 48:00 Program Inpatient ancillary service cost (Wist. D-3, col. 3, line 200) 100 48:03 48:03 48:03 48:03 48:03 48:03 48:03 48:03 48:03 48:03 48:03 48:00 48:03								46.00
Accord Program Input int ancillary service cost (Wist D-3, col. 3, line 200) 1.00 Accord Program Input int costs (sum of lines 31 through 48) (see instructions) 2,498,730 40 Accord Pass Through costs applicable to Program input int routine services (from Wist. D, sum of Parts I and one and IV) 0 51.00 Data Program excludable cost (sum of lines 50 and 51) 0 52.00 0 52.00 0 52.00 0 52.00 0 52.00 0 52.00 0 52.00 0 52.00 0 52.00 0 52.00 0 52.00 0 52.00 0 52.00 0 52.00 0 52.00 0 52.00 0 52.00 0 52.00 0 53.00 0 55.00 0 55.00 0 0 54.00 55.00 0 0 54.00 55.00 0 0 55.00 0 0 55.00 0 0 55.00 0 0 55.00 0 0 55.00 <td< td=""><td>47.00</td><td></td><td></td><td></td><td></td><td></td><td></td><td>47.00</td></td<>	47.00							47.00
42:00 Program Inpattent costs (sum of lines 41 funcuph 48) (see instructions) 2,498,739 49.00 10:01 Program Inpattent costs (sum of lines 41 funcuph 48) (see instructions) 2,498,739 49.00 10:02 Program Inpattent costs (sum of lines 41 funcuph 48) (see instructions) 2,498,739 49.00 10:02 Program Inpattent costs (sum of lines 41 funcuph 48) (see instructions) 2,498,739 49.00 11:02 O Total Program Inpattent operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52) 0 53.00 11:02:00 Total Program Inpattent operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52) 0 0 54.00 12:00 Torgram inpattent coperating cost excluding capital related, non-physician anesthetist, and medical education costs (line 63 minus line 53) 0 55.00 12:00 O Forgram inpattent coperating cost and target amount (line 56 minus line 53) 0 55.00 10:00 Forgram inpattent coperating cost and target amount (line 50 minus line 53) 0 55.00 10:00 Becaser of lines 53.75 of 56 from program cost resporting period see instructions) 0.00 66.00 10:00 Becaser of lines 50, stree reless than espended by t		Cost Center Description					1 00	
40.00 Total Program inpatient costs (sum of Lines 41 through 48)(see instructions) 2,498,730 49.00 PASS Through costs applicable to Program inpatient routine services (from Wkst. 0, sum of Parts I and 0 111) 05.00 0 11.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. 0, sum of Parts II 0 51.00 0 0 12.00 Total Program excluduable cost (sum of Lines 52) 0 0 120 0 120 0 120 0 120 0 120 0 120 0 120 0 120 0 120 0 120 0 120 0 120 0 120 0 120 <	48.00	Program inpatient ancillary service cost (Wk	st. D-3. col. 3	3. line 200)	-			48.00
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D. sum of Parts I and III) 0 50.00 1111 and IV) 0 51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D. sum of Parts II and IV) 0 52.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 0 52.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 0 54.00 50.00 Target anount (Ine 54 x line 55) 0 54.00 0 55.00 1 0 55.00 1 0 55.00 0 55.00 0 54.00 0 55.00 0 55.00 0 55.00 0 55.00 0 55.00 0 0 56.00 0 56.00 0 56.00 0 56.00 0 56.00 0 56.00 0 56.00 0 0 56.00 0 0 56.00 0 0 56.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					ons)			1
111) 111) 111) 111) 111) 111 111 1110) 111 111 111 111 1110) 1111 1111 1111 1111 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D. sum of Parts II 0 51.00 52.00 Total Program excludable cost (sum of lines 50 and 51) 0 52.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 0 53.00 0 Total Regram inpatient operating cost excluding capital related, non-physician anesthetist, and 0 54.00 0 Torget amount (ine 54 x line 55) 0 56.00 0 56.00 0 56.00 0 56.00 0 56.00 0 56.00 0 56.00 0 0 56.00 0 0 56.00 0 0 56.00 0 0 56.00 0 0 56.00 0 0 0 66.00 0 67.00 0 0 66.00 0 0 67.00 0 0 67.00 0 67.00 0 0 67.00 0 0 67.00 0 0 67.00 0 0 67.00 0 0 67.00 0 0 67.00 0 0 67.00 0 0	50.00		atient routine	services (fro	m Wkst. D, sum	of Parts I and	0	50.00
and IV) and IV) and IV) and IV) and IV) and IV) and IV program excludable cost (sum of lines 50 and 51) and IV) and IV program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52) tracet anount (line 54 x line 55) and I arget anount (line 54 x line 55) and I arget anount (line 54 x line 55) and I arget anount (line 54 x line 55) and I arget anount (line 54 x line 55) and I arget anount (line 54 x line 55) and I arget anount (line 54 x line 55) and I arget anount (line 54 x line 55) and I arget anount (line 54 x line 55) and I arget anount (line 54 x line 55) and I arget anount (line 54 x line 55) beam of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket basket basket 53/54 or 55 from pior year cost report, updated by the market basket basket saket line 53/54 or 55 from pior year cost report (see linstructions) bit (line 53/54 or 55 from pior year cost report (see linstructions) bit (line 53/54 or 55 from pior year cost report (see linstructions) bit (line 53/54 or 55 from pior year less than expected costs (line 54 x 60), or 1% of the target anount (line 55), otherwise enter zero (see instructions) bit (line 54 x line 50) bit (line 51 x line 53/54 or 55 from proute costs through becember 31 of the cost reporting period (See bit (line 54 x line 50) bit (line 54 x line	E1 00		ationt ancillar	w convioos (f	rom Wkat D a	um of Dorte II	0	E1 00
52.00 Total Program excludable cost (sum of lines 50 and 51) 00 52.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and edical education costs (line 49 minus line 52) 0 0 52.00 Total Program discharges 0 54.00 0 0 64.00 76.00 65.00 0 65.00 0 0 65.00 0	51.00			y services (i	TOHT WEST. D, S	Sum OF Parts II		51.00
medical education costs (line 40 [*] minus line 52) 64.00 TARGET #AMONT AND LINT COMPUTATION 0.0 54.00 Program discharges 0.0 55.00 Target amount per discharge 0.0 56.00 Target amount (line 54 x line 55) 57.00 57.01 Dipterence batewen dusted inpatient operating cost and target amount (line 56 minus line 53) 0.57.00 58.00 Denus payment (see instructions) 0.0 64.00 58.01 Display the start is than the lower of lines 55.90 of 0.0 entor the basket 0.00 0.00 61.00 Fir for payment (see instructions) 0.6 64.00 65.00 62.00 Relief payment (see instructions) 0.6 62.00 62.00 64.00 66.00 Mil compared SNF inpatient routine costs after December 31 of the cost reporting period (See 0.4.10 64.00 66.00 Total medicare sing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVII only) 384.882 66.00 67.00 Total medicare sing-bed SNF inpatient routine costs sthrough December 31 of the cost reporting period 68.00 68.00 Total structions) 0.6 0	52.00		50 and 51)				0	52.00
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74.00Total Program general inpatient routine service costs (line 72 + line 73)74.0075.00Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)75.0076.00Per diem capital -related costs (line 75 + line 2)76.0077.00Program capital -related costs (line 74 minus line 77)78.0079.00Aggregate charges to beneficiaries for excess costs (from provider records)79.0080.00Total Program routine service cost for comparison to the cost limitation (line 78 minus line 79)80.0081.00Inpatient routine service cost ger diem limitation81.0082.00Reasonable inpatient routine services (see instructions)83.0084.00Program inpatient ancillary services (see instructions)84.0085.00Utilization review - physician compensation (see instructions)85.0086.00Total Program inpatient operating costs (sum of lines 83 through 85)87.0070.01Total observation bed days (see instructions)87.0080.00Adjusted general inpatient routine cost per diem (line 27 + line 2)1,545.7188.00Adjusted general inpatient routine cost per diem (line 27 + line 2)1,545.71								72.00
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26, line 45)76.00Per diem capital -related costs (line 75 ÷ line 2)77.00Program capital -related costs (line 9 x line 76)77.00Inpatient routine service cost (line 74 minus line 77)79.00Aggregate charges to beneficiaries for excess costs (from provider records)70.0070.0170.0270.0370.0470.0470.0570.0570.0670.0770.0770.0870.0970.0970.0070.0070.0070.0170.0270.0270.0370.0470.0470.0570.0570.0670.0670.0770.0770.0870.0970.0970.0970.0970.0970.0970.0970.0070.0170.0270.0270.0370.0370.0470.0570.0570.0670.0670.0770.0770.09 <t< td=""><td></td><td></td><td>•</td><td></td><td></td><td>art II ooluw-</td><td></td><td>74.00</td></t<>			•			art II ooluw-		74.00
76.00Per diem capital -related costs (line 75 ÷ line 2)76.0077.00Program capital -related costs (line 9 x line 76)77.0078.00Inpatient routine service cost (line 74 minus line 77)78.0079.00Aggregate charges to beneficiaries for excess costs (from provider records)78.0080.00Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)80.0081.00Inpatient routine service cost per diem limitation81.0082.00Inpatient routine service costs (see instructions)82.0083.00Reasonable inpatient routine services (see instructions)83.0084.00Program inpatient ancillary services (see instructions)84.0085.00Utilization review - physician compensation (see instructions)85.0086.00Total Program inpatient operating costs (sum of lines 83 through 85)PART IV - COMPUTATION OF DBSERVATION BED PASS THROUGH COST28787.00Total observation bed days (see instructions)88.00Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)1, 545.7188.0080.00	75.00			CUSIS (ITUM	WUIKSHEELB, F	art II, COLUMN		/5.00
77.00Program capital -related costs (line 9 x line 76)77.0078.00Inpatient routine service cost (line 74 minus line 77)78.0079.00Aggregate charges to beneficiaries for excess costs (from provider records)78.0080.00Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)80.0081.00Inpatient routine service cost per diem limitation81.0082.00Inpatient routine service cost s (see instructions)82.0083.00Reasonable inpatient routine services (see instructions)83.0084.00Program inpatient ancillary services (see instructions)84.0085.00Utilization review - physician compensation (see instructions)85.0086.00Total Program inpatient operating costs (sum of lines 83 through 85)86.0077.00Total observation bed days (see instructions)28787.00Total observation bed days (see instructions)28788.00Adjusted general inpatient routine cost per diem (line 27 + line 2)1, 545.71	76.00		ne 2)					76.00
79.00Aggregate charges to beneficiaries for excess costs (from provider records)79.0080.00Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)80.0081.00Inpatient routine service cost per diem limitation81.0082.00Inpatient routine service cost limitation (line 9 x line 81)82.0083.00Reasonable inpatient routine service costs (see instructions)83.0084.00Program inpatient ancillary services (see instructions)83.0085.00Utilization review - physician compensation (see instructions)84.0086.00Total Program inpatient operating costs (sum of lines 83 through 85)86.00PART IV - COMPUTATION OF DBSERVATION BED PASS THROUGH COST28787.00Total observation bed days (see instructions)28788.00Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)1,545.71	77.00	Program capital-related costs (line 9 x line	76)					77.00
80.00Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)80.0081.00Inpatient routine service cost per diem limitation81.0082.00Inpatient routine service cost limitation (line 9 x line 81)82.0083.00Reasonable inpatient routine service costs (see instructions)83.0084.00Program inpatient ancillary services (see instructions)84.0085.00Utilization review - physician compensation (see instructions)84.0086.00Total Program inpatient operating costs (sum of lines 83 through 85)86.00PART IV - COMPUTATION OF DBSERVATION BED PASS THROUGH COST28787.00Total observation bed days (see instructions)28788.00Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)1,545.71			,					78.00
81.00 Inpatient routine service cost per diem limitation 81.00 82.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 83.00 Reasonable inpatient routine service costs (see instructions) 83.00 84.00 Program inpatient ancillary services (see instructions) 84.00 85.00 Utilization review - physician compensation (see instructions) 84.00 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) 85.00 87.00 Total observation bed days (see instructions) 86.00 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,545.71		00 0 0						79.00
82.00Inpatient routine service cost limitation (line 9 x line 81)82.0083.00Reasonable inpatient routine service costs (see instructions)83.0084.00Program inpatient ancillary services (see instructions)84.0085.00Utilization review - physician compensation (see instructions)84.0086.00Total Program inpatient operating costs (sum of lines 83 through 85)85.00PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST28787.00Total observation bed days (see instructions)28788.00Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)1,545.71				JUST IIMITATIO	n (ine /8 mir	ius i i ne 79)		
83.00Reasonable inpatient routine service costs (see instructions)83.0084.00Program inpatient ancillary services (see instructions)84.0085.00Utilization review - physician compensation (see instructions)85.0086.00Total Program inpatient operating costs (sum of lines 83 through 85)85.00PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST28787.00Total observation bed days (see instructions)28788.00Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)1,545.71)			1	81.00
84.00 Program inpatient ancillary services (see instructions) 84.00 85.00 Utilization review - physician compensation (see instructions) 85.00 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,545.71								83.00
85.00Utilization review - physician compensation (see instructions)85.0086.00Total Program inpatient operating costs (sum of lines 83 through 85)86.00PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST87.0087.00Total observation bed days (see instructions)28788.00Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)1,545.71				-				84.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 287 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1, 545.71	85.00			ons)				85.00
87.00Total observation bed days (see instructions)28787.0088.00Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)1,545.7188.00	86.00			rough 85)			L	86.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,545.71 88.00	07 00						007	07.00
		3 • •		line 2)				
				,				
			· · · · · ·					

Health Financial Systems	JAY COUNTY	HOSPI TAL		In Lieu of Form CMS-2552			
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 10/01/2016	Worksheet D-1		
				To 09/30/2017		pared: 6 pm	
		Title	XVIII	Hospi tal	Cost		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on		
		(from line	column 2	Observati on	Bed Pass		
		21)		Bed Cost	Through Cost		
				(from line	(col. 3 x		
				89)	col. 4) (see		
					instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST						
90.00 Capital-related cost	386, 557	4, 685, 573	0. 08249	9 443, 619	36, 598	90.00	
91.00 Nursing School cost	0	4, 685, 573	0.00000	0 443, 619	0	91.00	
92.00 Allied health cost	0	4, 685, 573	0.00000	0 443, 619	0	92.00	
93.00 All other Medical Education	0	4, 685, 573	0.00000	0 443, 619	0	93.00	

		Component CCN: 15-M320	From 10/01/2016 To 09/30/2017 Subprovi der -	Worksheet D-1 Date/Time Pre 2/26/2018 1:5 PPS	pare
	Cost Center Description		I PF	FFJ	
	·			1.00	
	PART I – ALL PROVIDER COMPONENTS				
00	Inpatient days (including private room days and swing-bed da	ays, excluding newborn)		1,069	1 1
00	Inpatient days (including private room days, excluding swing			1,069	2
00	Private room days (excluding swing-bed and observation bed d	lays). If you have only p	rivate room days,	0	3
20	do not complete this line.			1 0/0	
00	Semi-private room days (excluding swing-bed and observation Total swing-bed SNF type inpatient days (including private r		er 31 of the cost	1, 069 0	4
	reporting period	com days) through become		0	
00	Total swing-bed SNF type inpatient days (including private r	room days) after December	31 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line)		24		
00	Total swing-bed NF type inpatient days (including private ro reporting period	oom days) through Decembe	r 31 of the cost	0	7
00	Total swing-bed NF type inpatient days (including private ro	oom days) after December :	31 of the cost	0	8
	reporting period (if calendar year, enter 0 on this line)				
00	Total inpatient days including private room days applicable	to the Program (excluding	g swing-bed and	673	9
00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII	only (including private)	coom dave)	0	10
00	through December 31 of the cost reporting period (see instru		Com days)	0	
00	Swing-bed SNF type inpatient days applicable to title XVIII		room days) after	0	11
	December 31 of the cost reporting period (if calendar year,				
00	Swing-bed NF type inpatient days applicable to titles V or X through December 31 of the cost reporting period	(IX only (including priva	te room days)	0	12
00	Swing-bed NF type inpatient days applicable to titles V or X	(IX only (including priva	te room days)	0	13
	after December 31 of the cost reporting period (if calendar			0	
	Medically necessary private room days applicable to the Prog	fram (excluding swing-bed	days)	0	
	Total nursery days (title V or XIX only)			0	
00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16
00	Medicare rate for swing-bed SNF services applicable to servi	ces through December 31	of the cost		1 17
	reporting period	5			
00	Medicare rate for swing-bed SNF services applicable to servi	ces after December 31 of	the cost		18
00	reporting period Medicaid rate for swing-bed NF services applicable to servic	es through December 31 o	f the cost	0.00	10
00	reporting period	th ough becember 51 0		0.00	'
00	Medicaid rate for swing-bed NF services applicable to servic	es after December 31 of	the cost	0.00	20
00	reporting period	>		2 207 200	01
00	Total general inpatient routine service cost (see instructio Swing-bed cost applicable to SNF type services through Decem		ting period (line	2, 297, 300 0	21
. 00	5 x line 17)	bei 31 01 the cost repor	ting period (inte	0	22
. 00	Swing-bed cost applicable to SNF type services after Decembe	er 31 of the cost reportio	ng period (line 6	0	23
~~	x line 18)				
00	Swing-bed cost applicable to NF type services through Decemb 7 x line 19)	per 31 of the cost report	ng period (line	0	24
00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	a period (line 8	0	25
	x line 20)				
	Total swing-bed cost (see instructions)			0	
00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		2, 297, 300	27
00	General inpatient routine service charges (excluding swing-b	ed and observation bed c	narges)	0	28
	Private room charges (excluding swing-bed charges)		5,	0	29
	Semi -private room charges (excluding swing-bed charges)			0	
	General inpatient routine service cost/charge ratio (line 27	'÷line 28)		0.00000	
	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 0.00	
	Average per diem private room charge differential (line 32 m		ctions)	0.00	
-	Average per diem private room cost differential (line 34 x l			0.00	
00	Private room cost differential adjustment (line 3 x line 35)			0	36
00	General inpatient routine service cost net of swing-bed cost	and private room cost d	fferential (line	2, 297, 300	37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.	JUSTMENTS			1
00	Adjusted general inpatient routine service cost per diem (se			2, 149. 02	
	Dragram ganaral inpatient routing carving cast (line 0 v lin	28)		1, 446, 290	39
	Program general inpatient routine service cost (line 9 x lin Medically necessary private room cost applicable to the Prog	-		0	

OMPUT	Financial Systems ATION OF INPATIENT OPERATING COST	JAY COUNTY		CN: 15-1320	Peri od:	u of Form CMS- Worksheet D-1	
			Component	CCN: 15-M320	From 10/01/2016 To 09/30/2017	Date/Time Pre	
			Title	e XVIII	Subprovider -	2/26/2018 1:5 PPS	oo pr
	Cost Center Description	Total	Total	Average Per	0 5	Program Cost	
		Inpatient Cost	Inpatient Days	Diem (col. ÷ col. 2)		(col. 3 x col. 4)	
2.00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00 00 0	5.00	42
	Intensive Care Type Inpatient Hospital Units						
. 00	I NTENSI VE CARE UNI T CORONARY CARE UNI T	0	C	0.	0 00	0	43
	BURN INTENSIVE CARE UNIT	0	C	0.	0 00	0	
. 00	SURGICAL INTENSIVE CARE UNIT						46
. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47
						1.00	
	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			ons)		178, 038 1, 624, 328	
. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst D si	m of Parts I and	0	50
. 00	Pass through costs applicable to Program inp and IV)	atient ancilla	ry services (f	rom Wkst. D,	sum or Parts II	5, 810	/ 51
. 00	Total Program excludable cost (sum of lines		alatad are at		botict and	5, 810 1, 618, 518	
. 00	Total Program inpatient operating cost exclu medical education costs (line 49 minus line		erated, non-ph	ysi ci an anesi	netist, and	1, 018, 518	5 53
. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54
. 00	Target amount per discharge					0.00	
. 00	Target amount (line 54 x line 55)					0	
	Difference between adjusted inpatient operat	ing cost and t	arget amount (line 56 minus	s line 53)	0	
. 00 . 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	porting period	endi na 1996	updated and o	compounded by the	0 0.00	
	market basket	por ening por roa	sharing 1770,				
0.00	Lesser of lines 53/54 or 55 from prior year					0.00	
. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less tha					0	61
	amount (line 56), otherwise enter zero (see			00), 01 1/0 0	ine target		
	Relief payment (see instructions)					0	
. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instr	uctions)			0	63
. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Dec	ember 31 of th	e cost report	ing period (See	0	64
. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decem	ber 31 of the	cost reportir	ng period (See	0	65
. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 nlus line	65)(title XVI	LL only) For	0	66
	CAH (see instructions)				5,	_	
. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs throug	h December 31	of the cost r	reporting period	0	67
. 00	Title V or XIX swing-bed NF inpatient routin	e costs after	December 31 of	the cost rep	oorting period	0	68
. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient					0	69
). 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil				7)		70
. 00	Adjusted general inpatient routine service c)		71
. 00	Program routine service cost (line 9 x line	71)					72
. 00 . 00	Medically necessary private room cost applic Total Program general inpatient routine serv						73
. 00	Capital -related cost allocated to inpatient			·	Part II, column		75
00	26, line 45)						
. 00 . 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76
. 00	Inpatient routine service cost (line 74 minu	s line 77)					78
. 00	Aggregate charges to beneficiaries for exces				pup Line 70)		79
. 00 . 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		cost rimitatio	n (iine /8 mi	nus i ne 79)		80
. 00	Inpatient routine service cost per dreim rimi		1)				82
. 00	Reasonable inpatient routine service costs (ns)				83
. 00	Program inpatient ancillary services (see in		one)				84
. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						86
	PART IV - COMPUTATION OF OBSERVATION BED PAS	S THROUGH COST	~ /			· 	
. 00 . 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per		÷line 2)			0 0.00	
	Observation bed cost (line 87 x line 88) (se	•	····· /			0.00	1 00

Health Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider C	CN: 15-1320	Period: From 10/01/2016	Worksheet D-1	
		Component	CCN: 15-M320	To 09/30/2017		pared: 6 pm
		Title	XVIII	Subprovider -	PPS	
				I PF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	0	2, 297, 300	0.0000	0 0	0	90.00
91.00 Nursing School cost	0	2, 297, 300	0.00000	0 0	0	91.00
92.00 Allied health cost	0	2, 297, 300	0.0000	0 0	0	92.00
93.00 All other Medical Education	0	2, 297, 300	0.00000	0 0	0	93.00

COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1320	Period: From 10/01/2016 To 09/30/2017	Worksheet D-1 Date/Time Pre 2/26/2018 1:50	
	Cost Center Description	Title XIX	Hospi tal	Cost	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS		1		
. 00 2. 00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			3, 045 2, 679	1.00 2.00
3. 00	Private room days (excluding swing-bed and observation bed da		rivate room days,	2,079	3.00
	do not complete this line.		-	2, 202	4 00
1.00 5.00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	2, 392 0	4.00 5.00
	reporting period			054	
b. 00	Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	351	6.0
. 00	Total swing-bed NF type inpatient days (including private roo	m days) through Decembe	r 31 of the cost	4	7.0
3. 00	reporting period Total swing-bed NF type inpatient days (including private roo	m davs) after December	31 of the cost	11	8.0
. 00	reporting period (if calendar year, enter 0 on this line)	in days) arter becember	ST OF the cost	11	0.0
9.00	Total inpatient days including private room days applicable t	o the Program (excludin	g swing-bed and	16	9.0
0.00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private	room days)	0	10. 0
	through December 31 of the cost reporting period (see instruc	tions)	5 .		
1.00	Swing-bed SNF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (if calendar year, e		room days) after	0	11.0
2.00	Swing-bed NF type inpatient days applicable to titles V or XI		te room days)	0	12.0
3.00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI	Y only (including priva	te room dave)	0	13.0
5.00	after December 31 of the cost reporting period (if calendar y			0	15.0
4.00	Medically necessary private room days applicable to the Progr	am (excluding swing-bed	days)		14.0
5.00 6.00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			186 0	15. 0 16. 0
	SWING BED ADJUSTMENT				
7.00	Medicare rate for swing-bed SNF services applicable to servic reporting period	es through December 31	of the cost		17.0
8.00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost		18.0
9.00	reporting period Medicaid rate for swing-bed NF services applicable to service	s through December 31 o	f the cost	0.00	19.0
7.00	reporting period			0.00	17.0
20.00	Medicaid rate for swing-bed NF services applicable to service reporting period	s after December 31 of	the cost	0.00	20. 0
21.00	Total general inpatient routine service cost (see instruction	s)		4, 685, 573	21.0
22.00	Swing-bed cost applicable to SNF type services through Decemb 5×1 (ine 17)	er 31 of the cost repor	ting period (line	0	22.0
23.00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporti	ng period (line 6	0	23.0
1 00	x line 18)	- 01 -6 the rest meret			24.0
24.00	Swing-bed cost applicable to NF type services through December 7×10^{-1} x line 19)	er 31 of the cost report	ing period (line	0	24.0
25.00	Swing-bed cost applicable to NF type services after December	31 of the cost reportin	g period (line 8	0	25.0
26.00	x line 20) Total swing-bed cost (see instructions)			542, 783	26.0
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)	-	4, 142, 790	
28.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	d and observation hed c	harges)	0	28.0
	Private room charges (excluding swing-bed charges)		nar ges)	0	29.0
	Semi-private room charges (excluding swing-bed charges)			0	30.0
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.00000	31.0
	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.0
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.0
	Average per diem private room charge differential (line 32 mi	, ,	ctions)	0.00	
35.00 36.00	Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35)			0.00 0	35.0 36.0
87.00 87.00	General inpatient routine service cost net of swing-bed cost	and private room cost d	ifferential (line	-	
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PART IT - HOSPITAL AND SUBPROVIDERS UNLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	USTMENTS			
38.00	Adjusted general inpatient routine service cost per diem (see			1, 546. 39	38.0
	Program general inpatient routine service cost (line 9 x line	-		24, 742	
39.00					
39.00 10.00	Medically necessary private room cost applicable to the Progr			0	40.0

44. 00 CORENARY CARE UNIT 0 <th></th> <th>Financial Systems</th> <th>JAY COUNTY</th> <th></th> <th>ON 15 1220</th> <th></th> <th>u of Form CMS-</th> <th></th>		Financial Systems	JAY COUNTY		ON 15 1220		u of Form CMS-	
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69.00Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)069.00PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY70.00Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)70.0071.00Adjusted general inpatient routine service cost per diem (line 70 + line 2)70.0072.00Program routine service cost (line 9 x line 71)72.0073.00Medically necessary private room cost applicable to Program (line 14 x line 35)73.0074.00Total Program general inpatient routine service costs (line 72 + line 73)74.0075.00Capital -related costs (line 75 + line 2)76.0076.00Per diem capital -related costs (line 75 + line 2)76.0077.00Program capital -related costs (line 74 minus line 77)70.0078.00Inpatient routine service costs (from provider records)78.0080.00Total Program routine service costs (see instructions)80.0081.00Inpatient routine service costs (see instructions)81.0082.00Total Program inpatient ancillary services (see instructions)83.0084.00Total Program inpatient operating costs (sum of lines 83 through 85)85.0094.00Total observation bed days (see instructions)85.0085.00Adjusted general inpatient routine cost per diem (line 27 + line 2)1,546.39	68.00		e costs after l	December 31 of	the cost repo	rting period	0	68.00
PART 111 - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY70.00Skilled nursing facility/other nursing facility//CF/ID routine service cost (line 37)71.00Adjusted general inpatient routine service cost per diem (line 70 + line 2)72.00Program routine service cost (line 9 x line 71)73.00Medically necessary private room cost applicable to Program (line 14 x line 35)74.00Total Program general inpatient routine service costs (line 72 + line 73)75.00Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column26, line 45)76.0077.00Program capital -related costs (line 75 + line 2)78.00Inpatient routine service cost (from provider records)79.00Aggregate charges to beneficiaries for excess costs (from provider records)80.00Total Program routine service costs (see instructions)81.00Reasonable inpatient routine service costs (see instructions)82.00Utilization review - physician compensation (see instructions)84.00Program inpatient operating costs (sum of lines 83 through 85)9ART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST85.00Total Program inpatient routine cost per diem (line 27 + line 2)86.00Total observation bed days (see instructions)87.00Adjusted general inpatient routine service cost per diem (line 27 + line 2)88.00Adjusted general inpatient routine cost per diem (line 27 + line 2)88.00Adjusted general inpatient routine cost per diem (line 27 + line 2)	(0.00				(0)			(0.00
70.00Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)70.0071.00Adjusted general inpatient routine service cost per diem (line 70 + line 2)71.0072.00Program routine service cost (line 9 x line 71)72.0073.00Medically necessary private room cost applicable to Program (line 14 x line 35)73.0074.00Total Program general inpatient routine service costs (line 72 + line 73)74.0075.00Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)76.0076.00Per diem capital -related costs (line 75 + line 2)76.0077.00Program capital -related costs (line 74 ninus line 77)78.0079.00Aggregate charges to beneficiaries for excess costs (from provider records)79.0080.00Inpatient routine service cost for comparison to the cost limitation (line 78 minus line 79)80.0081.00Reasonable inpatient orutine services (see instructions)83.0082.00Willization review - physician compensation (see instructions)83.0085.00Utilization review - physician compensation (see instructions)84.0086.00PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST86.0088.00Adjusted general inpatient routine cost per diem (line 27 + line 2)1,546.3988.00Adjusted general inpatient routines cost per diem (line 27 + line 2)1,546.39	69.00						0	69.00
72.00Program routine service cost (line 9 x line 71)72.0073.00Medically necessary private room cost applicable to Program (line 14 x line 35)73.0074.00Total Program general inpatient routine service costs (line 72 + line 73)74.0075.00Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)76.0076.00Per diem capital-related costs (line 75 + line 2)76.0077.00Program capital-related costs (line 74 minus line 77)77.0079.00Aggregate charges to beneficiaries for excess costs (from provider records)79.0080.00Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)80.0081.00Inpatient routine service cost (see instructions)81.0082.00Program inpatient routine services (see instructions)82.0085.00Utilization review - physician compensation (see instructions)85.0086.00PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST87.0088.00Adjusted general inpatient routine cost per diem (line 27 + line 2)1,546.3988.00Adjusted general inpatient routine cost per diem (line 27 + line 2)1,546.39	70.00							70.00
73.00Medically necessary private room cost applicable to Program (line 14 x line 35)73.0074.00Total Program general inpatient routine service costs (line 72 + line 73)74.0075.00Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)76.0076.00Per diem capital -related costs (line 75 + line 2)76.0077.00Program capital -related costs (line 74 minus line 77)77.0078.00Inpatient routine service cost for excess costs (from provider records)78.0080.00Total Program routine service cost per diem limitation79.0081.00Inpatient routine service cost (see instructions)81.0082.00Inpatient routine service costs (see instructions)84.0084.00Program inpatient ancillary services (see instructions)83.0085.00Utilization review - physician compensation (see instructions)83.0086.00Adjusted general inpatient routine cost per diem (line 27 + line 2)28787.00Adjusted general inpatient routine cost per diem (line 27 + line 2)88.00				ine 70 ÷ line	2)			71.00
74.00Total Program general inpatient routine service costs (line 72 + line 73)74.0075.00Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)75.0076.00Per diem capital -related costs (line 75 + line 2)76.0077.00Program capital -related costs (line 74 minus line 77)77.0079.00Aggregate charges to beneficiaries for excess costs (from provider records)79.0080.00Total Program routine service cost per diem limitation 1 npatient routine service cost per diem limitation 82.0079.0081.00Inpatient routine service costs (see instructions) 83.0080.0082.00Program inpatient ancillary services (see instructions) 84.0083.0084.00Program inpatient ancillary services (see instructions) 85.0083.0087.00Total Program inpatient operating costs (sum of line 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST87.0088.00Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)1,546.39				m (line 14 x l	ine 35)			72.00
26, line 45)76.00Per diem capital -related costs (line 75 + line 2)77.00Program capital -related costs (line 9 x line 76)78.00Inpatient routine service cost (line 74 minus line 77)79.00Aggregate charges to beneficiaries for excess costs (from provider records)70.0179.0280.00Total Program routine service cost per diem limitation82.001npatient routine service cost s for comparison to the cost limitation (line 78 minus line 79)83.0083.00Reasonable inpatient routine services (see instructions)84.0085.00Utilization review - physician compensation (see instructions)86.0070.0170.0270.0270.0370.0470.0470.0570.0570.0670.0770.0870.0970.0970.0970.0070.0070.0170.0270.0270.0370.0370.0470.0570.0570.0670.0670.0770.0770.0870.0970.0970.0970.0970.0970.0970.0970.0070.0970.0070.0970.0070.0970.0070.0970.0970.0970.09		Total Program general inpatient routine serv	ice costs (line	e 72 + line 73)			74.00
76.00Per diem capital -related costs (line 75 + line 2)76.0077.00Program capital -related costs (line 9 x line 76)77.0078.00Inpatient routine service cost (line 74 minus line 77)78.0079.00Aggregate charges to beneficiaries for excess costs (from provider records)78.0080.00Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)80.0081.00Inpatient routine service cost per diem limitation81.0082.00Inpatient routine service cost s (see instructions)82.0083.00Reasonable inpatient routine services (see instructions)83.0084.00Program inpatient ancillary services (see instructions)84.0085.00Utilization review - physician compensation (see instructions)85.0086.00Total Program inpatient operating costs (sum of lines 83 through 85)86.00PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST28787.00Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)1, 546.39	75.00		routine service	e costs (from	Worksheet B, P	art II, column		75.00
77.00Program capital -related costs (line 9 x line 76)77.0078.00Inpatient routine service cost (line 74 minus line 77)78.0079.00Aggregate charges to beneficiaries for excess costs (from provider records)78.0080.00Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)80.0081.00Inpatient routine service cost per diem limitation81.0082.00Inpatient routine service cost s (see instructions)81.0083.00Reasonable inpatient routine services (see instructions)83.0084.00Program inpatient ancillary services (see instructions)84.0085.00Utilization review - physician compensation (see instructions)85.0086.00Total Program inpatient operating costs (sum of lines 83 through 85)85.00PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST28787.00Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)1, 546.39	76.00		ne 2)					76.00
79.00Aggregate charges to beneficiaries for excess costs (from provider records)79.0080.00Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)80.0081.00Inpatient routine service cost per diem limitation81.0082.00Inpatient routine service cost limitation (line 9 x line 81)82.0083.00Reasonable inpatient routine services (see instructions)83.0084.00Program inpatient ancillary services (see instructions)83.0085.00Utilization review - physician compensation (see instructions)85.0086.00Total Program inpatient operating costs (sum of lines 83 through 85)86.00PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST28787.00Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)1,546.39		5 1	· · · · · · · · · · · · · · · · · · ·				-	77.00
80.00Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)80.0081.00Inpatient routine service cost per diem limitation81.0082.00Inpatient routine service cost limitation (line 9 x line 81)82.0083.00Reasonable inpatient routine service costs (see instructions)83.0084.00Program inpatient ancillary services (see instructions)83.0085.00Utilization review - physician compensation (see instructions)84.0086.00Total Program inpatient operating costs (sum of lines 83 through 85)86.00PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST28787.00Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)1,546.39			,	orovi der recor	de)			
82.00Inpatient routine service cost limitation (line 9 x line 81)82.0083.00Reasonable inpatient routine service costs (see instructions)83.0084.00Program inpatient ancillary services (see instructions)84.0085.00Utilization review - physician compensation (see instructions)84.0086.00Total Program inpatient operating costs (sum of lines 83 through 85)85.00PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST28787.00Total observation bed days (see instructions)28788.00Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)1,546.39		00 0 0				us line 79)		80.00
83.00 Reasonable inpatient routine service costs (see instructions) 83.00 84.00 Program inpatient ancillary services (see instructions) 84.00 85.00 Utilization review - physician compensation (see instructions) 85.00 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) 85.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 287 87.00 Total observation bed days (see instructions) 287 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,546.39				1)				81.00
84.00Program inpatient ancillary services (see instructions)84.0085.00Utilization review - physician compensation (see instructions)85.0086.00Total Program inpatient operating costs (sum of lines 83 through 85)86.00PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST87.0087.00Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)1,546.3988.001,546.39								82.00 83.00
86.00Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST86.0087.00Total observation bed days (see instructions) 88.0028787.0088.00Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)1,546.39								84.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1, 546.39 88.00			•					85.00
87.00Total observation bed days (see instructions)28787.0088.00Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)1,546.3988.00	86.00			nrougn 85)				86.00
	87.00						287	87.00
07. UDSETVATION DED COST (TTHE 07 X TTHE 00) (SEE THIST DUCTIONS) 443,814 89.00								
	09.00	TODSETVATION DEG COST (TIME 87 X TIME 88) (Se		,			443, 814	07.00

Health Financial Systems	JAY COUNTY	HOSPI TAL		In Lieu of Form CMS-2552			
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 10/01/2016	Worksheet D-1		
				To 09/30/2017		pared: 6 pm	
		Titl	e XIX	Hospi tal	Cost		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on		
		(from line	column 2	Observati on	Bed Pass		
		21)		Bed Cost	Through Cost		
				(from line	(col. 3 x		
				89)	col. 4) (see		
					instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST						
90.00 Capital-related cost	386, 557	4, 685, 573	0. 08249	9 443, 814	36, 614	90.00	
91.00 Nursing School cost	0	4, 685, 573	0.00000	0 443, 814	0	91.00	
92.00 Allied health cost	0	4, 685, 573	0.00000	0 443, 814	0	92.00	
93.00 All other Medical Education	0	4, 685, 573	0.00000	443, 814	0	93.00	

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1320 Component CCN: 15-M320	Period: From 10/01/2016 To 09/30/2017	Worksheet D-1 Date/Time Pre	
		Title XIX	Subprovi der -	2/26/2018 1:5 Cost	6 pm
	Cost Center Description		I PF		
				1.00	
	PART I – ALL PROVIDER COMPONENTS INPATIENT DAYS				
00	Inpatient days (including private room days and swing-bed day	/s, excluding newborn)		1, 069	1.
00	Inpatient days (including private room days, excluding swing-			1, 069	
00	Private room days (excluding swing-bed and observation bed da do not complete this line.	ays). If you have only p	rivate room days,	0	3.
00	Semi-private room days (excluding swing-bed and observation b	ped days)		1,069	4
00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	0	
	reporting period			_	
00	Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	oom days) after December	31 of the cost	0	6
00	Total swing-bed NF type inpatient days (including private roc	om days) through December	- 31 of the cost	0	7
	reporting period			0	<i>'</i>
00	Total swing-bed NF type inpatient days (including private roc	om days) after December 3	31 of the cost	0	8
20	reporting period (if calendar year, enter 0 on this line)		n and an least and	21	
00	Total inpatient days including private room days applicable t newborn days)	to the program (excluding	g swing-bed and	21	9
00	Swing-bed SNF type inpatient days applicable to title XVIII o	onlv (including private i	room davs)	0	10
	through December 31 of the cost reporting period (see instruct	ctions)	5 ,		
00	Swing-bed SNF type inpatient days applicable to title XVIII of		room days) after	0	11
00	December 31 of the cost reporting period (if calendar year, ϵ Swing-bed NF type inpatient days applicable to titles V or XI		to room days)	0	12
00	through December 31 of the cost reporting period	x only (therading priva	te room days)	0	'2
00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including priva-	te room days)	0	13
	after December 31 of the cost reporting period (if calendar y	year, enter O on this lin	ne)		
	Medically necessary private room days applicable to the Progr	ram (excluding swing-bed	days)	0	
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			186 0	
. 00	SWING BED ADJUSTMENT		I		1 '
00	Medicare rate for swing-bed SNF services applicable to servic	ces through December 31 (of the cost		17
00	reporting period		11		10
00	Medicare rate for swing-bed SNF services applicable to servic reporting period	ces after December 31 of	the cost		18
00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	f the cost	0.00	19
	reporting period	5			
00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of	the cost	0.00	20
00	reporting period Total general inpatient routine service cost (see instruction))		2, 297, 300	21
00	Swing-bed cost applicable to SNF type services through Decemb		ting period (line	2, 277, 300	
	5 x line 17)		510 0	-	
00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportion	ng period (line 6	0	23
00	x line 18) Swing-bed cost applicable to NF type services through Decembe	an 21 of the east report	ng pariod (line	0	24
00	7 x line 19)	a si ol the cost report	ng period (inne	0	24
00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	g period (line 8	0	25
	x line 20)				
00	Total swing-bed cost (see instructions)			0	
00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(The 21 minus The 26)		2, 297, 300	27
00	General inpatient routine service charges (excluding swing-be	ed and observation bed cl	narges)	0	28
00	Private room charges (excluding swing-bed charges)			0	29
00	Semi-private room charges (excluding swing-bed charges)			0	
00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.00000	
00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
00 00	Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li			0.00 0.00	
	Private room cost differential adjustment (line 3 x line 35)			0.00	
00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	2, 297, 300	
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	UCTMENTS			-
00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ Adjusted general inpatient routine service cost per diem (see			2, 149. 02	38
00	Program general inpatient routine service cost per diem (see			2, 149. 02 45, 129	
	Medically necessary private room cost applicable to the Progr	ram (line 14 x line 35)		0	40

OMPUT	Financial Systems ATION OF INPATIENT OPERATING COST		HOSPITAL Provider C	CN: 15-1320	Peri od:	u of Form CMS- Worksheet D-1	
			Component	CCN: 15-M320	From 10/01/2016 To 09/30/2017	Date/Time Pre	
			Ti tl	e XIX	Subprovider -	2/26/2018 1:5 Cost	
	Cost Center Description	Total I npati ent Cost	Total I npati ent Days	Average Per Diem (col. ÷ col. 2)	0 5	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
2.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	C	0.	00 0	0	42.
3.00	INTENSIVE CARE UNIT	0	C	0.	00 0	0	43.
4.00	CORONARY CARE UNI T						44.
5.00 6.00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	0	C	0.	00 0	0	45. 46.
	OTHER SPECIAL CARE (SPECIFY)						47.
	Cost Center Description					1.00	
8.00	Program inpatient ancillary service cost (Wk	st. D-3, col.	3, line 200)			8, 868	48.
9.00	Total Program inpatient costs (sum of lines	41 through 48)	(see instructi	ons)		53, 997	49.
0. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, su	um of Parts I and	0	50.
				ware With the D			F 1
I. 00	Pass through costs applicable to Program inp and IV)	atient anciita	ry services (r	rom wkst. D,	sum of Parts II	0	51.
2.00	Total Program excludable cost (sum of lines					0	
3. 00	Total Program inpatient operating cost exclu medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION		elated, non-ph	ysician anest	thetist, and	0	53.
	Program di scharges					0	
5.00 5.00	Target amount per discharge Target amount (line 54 x line 55)					0.00	
	Difference between adjusted inpatient operat	ing cost and t	arget amount (line 56 minus	s line 53)	0	
3.00	Bonus payment (see instructions)					0	
. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	eporting period	ending 1996,	updated and o	compounded by the	0.00	59.
). 00 I. 00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line which operating costs (line 53) are less tha	es 55, 59 or 60	enter the les	ser of 50% of	f the amount by	0.00 0	
	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)			5	0	
8.00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	nent (see instru	uctions)			0	63.
. 00	Medicare swing-bed SNF inpatient routine cos	sts through Dec	ember 31 of th	e cost report	ting period (See	0	64.
5.00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	sts after Decem	ber 31 of the	cost reportir	ng period (See	0	65.
5.00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 nlus line	65)(title XVI	ll only) For	0	66.
	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin				•	_	
. 00	(line 12 x line 19)	5			1 31		
3. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	ne costs after l	December 31 of	the cost rep	porting period	0	68.
9.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69.
0. 00	Skilled nursing facility/other nursing facil	ity/ICF/IID ro	utine service	cost (line 37	7)		70.
. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		line 70 ÷ line	2)			71.
	Medically necessary private room cost applic		m (line 14 x l	ine 35)			73.
. 00	Total Program general inpatient routine serv	•			Dart II calum		74.
5.00	Capital-related cost allocated to inpatient 26, line 45)	TOULTHE SERVIC	e costs (Trom	WULKSHEEL B,	raitii, COLUMN		75.
. 00	Per diem capital-related costs (line 75 ÷ li						76.
. 00 . 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77.
. 00	Aggregate charges to beneficiaries for exces	s costs (from					79.
. 00	Total Program routine service costs for comp		cost limitatio	n (line 78 mi	nus line 79)		80.
. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I		1)				81.
3. 00	Reasonable inpatient routine service costs (83.
4.00	Program inpatient ancillary services (see in	istructions)					84.
5.00 5.00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 86.
,. 00	PART IV - COMPUTATION OF OBSERVATION BED PAS					I	00.
7.00	Total observation bed days (see instructions Adjusted general inpatient routine cost per					0	
B. 00	LANDING THAT HADALENT LANT FOUTING COST DAT	urem (Line 27 -	÷ LINĖ Z)			0.00	88.

Health Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 10/01/2016	Worksheet D-1	
		Component (CCN: 15-M320	To 09/30/2017		
		Ti tl	e XIX	Subprovider - IPF	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
COST CENTER DESCRIPTION	COST					
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	152, 267	2, 297, 300	0. 06628	31 0	0	90.00
91.00 Nursing School cost	0	2, 297, 300	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	2, 297, 300			0	92.00
93.00 All other Medical Education	0	2, 297, 300			0	93.00

	HOSPI TAL			u of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1320	Peri od:	Worksheet D-3	
			From 10/01/2016		
			To 09/30/2017	Date/Time Pre	
	Titlo	XVIII	Hospi tal	2/26/2018 1:5 Cost	o pili
Cost Center Description	Intre	Ratio of Cos		Inpati ent	
cost center Description					
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
		1.00	2.00	col . 2) 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDI ATRICS			1, 831, 860		30.00
31. 00 03100 I NTENSI VE CARE UNI T			0		31.00
33. 00 03300 BURN INTENSIVE CARE UNIT			0		33.00
40. 00 04000 SUBPROVI DER - I PF			0		40.00
40. 00 04000 SUBPROVI DER - I RF			0		40.00
			0		
			0		42.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS		0 2222	70 707 240	100 077	50.00
50. 00 05000 OPERATING ROOM		0. 2322		182, 877	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 2904		0	52.00
53. 00 05300 ANESTHESI OLOGY		0.0000		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1033		52, 459	
57. 00 05700 CT SCAN		0.0000		0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0.0000		0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.0000		0	59.00
60. 00 06000 LABORATORY		0. 1631		128, 721	60.00
60. 01 06001 BLOOD LABORATORY		0.0000		0	60.01
65. 00 06500 RESPI RATORY THERAPY		0. 5348		132, 459	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 3229		37, 280	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 2417	30 68, 081	16, 457	67.00
68.00 06800 SPEECH PATHOLOGY		0. 2974		4, 541	68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 2519	60 146, 540	36, 922	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.0000	0 00	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 4630	44 285	132	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 4885	17 536, 668	262, 171	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC		0.0000	00	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000	00	0	89.00
90. 00 09000 CLINIC		9.6742	94 0	0	90.00
90.01 09001 FAMILY PRACTICE OF JAY COUNTY		1. 2445	60 2, 837	3, 531	90.01
90.02 09002 JAY FAMILY MEDICINE		2. 3834	54 2, 010	4, 791	90.02
91. 00 09100 EMERGENCY		0. 3324	3, 093	1, 028	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 1777	74 0	0	92.00
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTER		0. 6484	05 0	0	93.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			3, 221, 722	863, 369	200.00
201 00 Less DDD Clinic Laboratory Carvings Dragram only the	racc (line 61)		0		201.00
201.00 Less PBP Clinic Laboratory Services-Program only cha	IYES (ITTLE OT)		0		201.00

NPATIENT AND	CILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1320	Peri od:	Worksheet D-3	3
		Component	CCN: 15-M320	From 10/01/2016 To 09/30/2017		epared
		·			2/26/2018 1:5	56 pm
		Title	e XVIII	Subprovider - IPF	PPS	
(Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x	
			1.00		col . 2)	
			1.00	2.00	3.00	-
	ENT ROUTI NE SERVI CE COST CENTERS		1	0	[30.
	INTENSI VE CARE UNI T			0		31.
	BURN I NTENSI VE CARE UNI T			0		33.
	SUBPROVIDER - IPF			538, 400		40.
	SUBPROVIDER - IRF			0		41.
	SUBPROVI DER			0		42.
3.00 04300 N						43.
	ARY SERVICE COST CENTERS		1		1	
0.00 05000 0	DPERATING ROOM		0. 2322	70 0	0	50.
2.00 05200 E	DELIVERY ROOM & LABOR ROOM		0. 2904	42 0	0	52.
	ANESTHESI OLOGY		0.0000		0	
	RADI OLOGY-DI AGNOSTI C		0. 1033			
	CT SCAN		0.0000		-	
1 1	MAGNETIC RESONANCE IMAGING (MRI)		0.0000		-	
	CARDI AC CATHETERI ZATI ON		0.0000		0	
	LABORATORY		0. 1631			
	BLOOD LABORATORY		0.0000		0	
	RESPI RATORY THERAPY		0. 5348			
	PHYSICAL THERAPY		0. 3229			
	DCCUPATIONAL THERAPY		0.2417			
	SPEECH PATHOLOGY ELECTROCARDI OLOGY		0. 2974			
	MEDICAL SUPPLIES CHARGED TO PATIENTS		0.2319		3, 131 0	
	IMPL. DEV. CHARGED TO PATIENTS		0.4630		0	
	DRUGS CHARGED TO PATIENTS		0. 4885			
	I ENT SERVICE COST CENTERS		0. 1000	107,000	,,,,,,,,	/0.
	RURAL HEALTH CLINIC		0.0000	00	0	88.
9.00 08900 F	FEDERALLY QUALIFIED HEALTH CENTER		0.0000	00	0	89.
09000 0			9.6742	94 0	0	90.
	FAMILY PRACTICE OF JAY COUNTY		1. 2445			
	JAY FAMILY MEDICINE		2. 3834			
	EMERGENCY		0. 3324			
	DBSERVATION BEDS (NON-DISTINCT PART)		1. 1777			
	OTHER OUTPATIENT SERVICE COST CENTER		0. 6484		0	
	Total (sum of lines 50 through 94 and 96 through 98)			497, 830	178, 038	
	Less PBP Clinic Laboratory Services-Program only char	rges (line 61)		0		201.
02.00	Net charges (line 200 minus line 201)			497, 830		202.

Health Financial Systems	JAY COUNTY H	IOSPI TAL		In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPOR	TIONMENT	Provider C	CN: 15-1320	Peri od:	Worksheet D-3	}
		Component	CCN: 15-Z320	From 10/01/2016 To 09/30/2017	Date/Time Pre 2/26/2018 1:5	
		Title	XVIII	Swing Beds - SNF		-
Cost Center Description			Ratio of Cos		Inpatient	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x	
				Ŭ	col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST (CENTERS					
30. 00 03000 ADULTS & PEDIATRICS				0		30.00
31.00 03100 INTENSIVE CARE UNIT				0		31.00
33.00 03300 BURN INTENSIVE CARE UNIT				0		33.00
40.00 04000 SUBPROVIDER - IPF				0		40.00
41.00 04100 SUBPROVIDER - IRF				0		41.00
42.00 04200 SUBPROVI DER				0		42.00
43.00 04300 NURSERY						43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM			0. 2322	70 40	9	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	l		0. 2904	42 0	0	52.00
53.00 05300 ANESTHESI OLOGY			0.0000	00 00	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C			0. 1033	61 12, 327	1, 274	54.00
57.00 05700 CT SCAN			0.0000	00 00	0	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING	(MRI)		0.0000	00 00	0	58.00
59.00 05900 CARDI AC CATHETERI ZATI ON			0.0000	00 00	0	59.00
60.00 06000 LABORATORY			0. 1631	54 39, 399	6, 428	60.00
60.01 06001 BLOOD LABORATORY			0.0000	00 00	0	60.01
65. 00 06500 RESPI RATORY THERAPY			0. 5348	35 35, 990	19, 249	65.00
66.00 06600 PHYSI CAL THERAPY			0. 3229	40 67, 978	21, 953	66.00
67.00 06700 OCCUPATI ONAL THERAPY			0. 2417	30 54, 841	13, 257	67.00
68.00 06800 SPEECH PATHOLOGY			0. 2974		1, 001	68.00
69.00 06900 ELECTROCARDI OLOGY			0. 2519	60 4, 615	1, 163	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED T	O PATI ENTS		0.0000	00 00	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATI	ENTS		0. 4630	44 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS			0. 4885	17 60, 417	29, 515	73.00
OUTPATIENT SERVICE COST CENTERS			•			
88.00 08800 RURAL HEALTH CLINIC			0.0000	00	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH	CENTER		0.0000		0	89.00
90. 00 09000 CLINIC			9.6742		0	90.00
90.01 09001 FAMILY PRACTICE OF JAY COL	INTY		1. 2445		312	90.01
90. 02 09002 JAY FAMILY MEDICINE			2. 3834		422	
91.00 09100 EMERGENCY			0. 3324		0	1
92.00 09200 OBSERVATION BEDS (NON-DIST	INCT PART)		1. 1777		5, 182	92.00
93.00 04040 OTHER OUTPATIENT SERVICE C			0. 6484		0	1
	ough 94 and 96 through 98)			283, 800	99, 765	200.00
	Services-Program only charge	es (line 61)		0		201.00
202.00 Net charges (line 200 minu				283, 800		202.00
			1		I	

Health Financial Systems JAY COUNTY H	IOSPI TAL		In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1320	Period:	Worksheet D-3	3
			From 10/01/2016		
			To 09/30/2017	Date/Time Pre	
				2/26/2018 1:5	56 pm
	Titl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
				col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS			22, 421		30.00
31.00 03100 INTENSIVE CARE UNIT			0		31.00
33.00 03300 BURN INTENSIVE CARE UNIT			0		33.00
40. 00 04000 SUBPROVI DER – I PF			0		40.00
41.00 04100 SUBPROVIDER - IRF			0		41.00
42. 00 04200 SUBPROVI DER			0		42.00
43. 00 04300 NURSERY			0		43.00
ANCI LLARY SERVI CE COST CENTERS		1	0		10.00
50. 00 05000 OPERATING ROOM		0. 2322	70 28, 146	6, 537	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 2904		0, 337	
53. 00 05300 ANESTHESI OLOGY		0. 2904		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1033		943	
		0.0000		0	
58.00 O5800 MAGNETIC RESONANCE I MAGI NG (MRI)		0.0000		0	
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.0000		0	
60. 00 06000 LABORATORY		0. 1631		1, 670	
60.01 06001 BLOOD LABORATORY		0.0000		0	
65. 00 06500 RESPI RATORY THERAPY		0. 5348		1, 024	
66. 00 06600 PHYSI CAL THERAPY		0. 3229	40 156	50	66.00
67.00 06700 OCCUPATI ONAL THERAPY		0. 2417	30 0	0	67.00
68.00 06800 SPEECH PATHOLOGY		0. 2974	37 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 2519	60 317	80	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.0000	00 00	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0.4630	44 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 4885	17 6, 660	3, 254	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC		0.0000	00 00	0	88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000		0	
90. 00 09000 CLINIC		9.6742		0	
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY		1. 2445		1, 074	
90. 01 109001 PAMILET PRACTICE OF SAT COUNTY 90. 02 109002 JAY FAMILY MEDICINE		2. 3834		1, 074	
91. 00 09100 EMERGENCY		0. 3324		1, 499	
		1. 1777		0	
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTER		0. 6484		0	
200.00 Total (sum of lines 50 through 94 and 96 through 98)			62, 334	17, 558	200.00
201.00 Less PBP Clinic Laboratory Services-Program only charg	es (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)		1	62, 334		202.00

PATIENT ANCILLARY SERVICE	COST APPORTI ONMENT	Provider C	CN: 15-1320	Peri		Worksheet D-3	3
		Component	CCN: 15-M320	Fron To	n 10/01/2016 09/30/2017	Date/Time Pre 2/26/2018 1:5	
		Ti tl	e XIX	Sul	bprovider - IPF	Cost	•
Cost Center Des	cription		Ratio of Cos	st	Inpatient	I npati ent	
			To Charges		Program Charges	Program Costs (col. 1 x	
					charges	col. 2)	
			1.00		2.00	3.00	
INPATIENT ROUTINE SER			1				
0.00 03000 ADULTS & PEDIAT					0		30.
. 00 03100 INTENSIVE CARE					0		31.
3. 00 03300 BURN I NTENSI VE					0		33.
0. 00 04000 SUBPROVI DER - I					16, 705		40
. 00 04100 SUBPROVIDER - I	RF				0		41
2. 00 04200 SUBPROVI DER					0		42
8. 00 04300 NURSERY ANCI LLARY SERVI CE COS	T CENTERS				0		43
0. 00 05000 OPERATING ROOM	di centens		0. 2322	70	0	0	50
.00 05200 DELIVERY ROOM &	LABOR ROOM		0. 2904		Ō	0	
. 00 05300 ANESTHESI OLOGY			0.0000		Ō	0	
. 00 05400 RADI OLOGY-DI AGN	OSTIC		0. 1033		1, 874	194	
. 00 05700 CT SCAN			0.0000	00	0	0	57
. 00 05800 MAGNETIC RESONA	NCE IMAGING (MRI)		0.0000	00	0	0	58
. 00 05900 CARDI AC CATHETE	RIZATION		0.0000	00	0	0	59
. 00 06000 LABORATORY			0. 1631	54	10, 902	1, 779	60
01 06001 BLOOD LABORATOR	Y		0.0000	00	0	0	60
. 00 06500 RESPIRATORY THE	RAPY		0. 5348	35	448	240	65
00 06600 PHYSI CAL THERAP			0. 3229	40	164	53	66
00 06700 OCCUPATIONAL TH	ERAPY		0. 2417	30	0	0	67
. 00 06800 SPEECH PATHOLOG	Y		0. 2974	37	0	0	68
. 00 06900 ELECTROCARDI OLO	GY		0. 2519	60	68	17	69
. 00 07100 MEDICAL SUPPLIE			0.0000		0	0	
2.00 07200 IMPL. DEV. CHAR			0. 4630		0	0	
. 00 07300 DRUGS CHARGED T			0. 4885	17	6, 639	3, 243	73
OUTPATIENT SERVICE CC 00 08800 RURAL HEALTH CL			0.0000	00	o	0	88
0. 00 08900 FEDERALLY QUALI			0.0000		0	0	
00 09000 CLINIC	THE HEALTH CENTER		9.6742		0	0	
01 09001 FAMILY PRACTICE	OF LAY COUNTY		1. 2445		35	44	
0. 02 09002 JAY FAMILY MEDI			2. 3834		995	2, 372	
. 00 09100 EMERGENCY			0. 3324		2, 785	926	
2. 00 09200 OBSERVATION BED	S (NON-DISTINCT PART)		1. 1777		2,703	0	
. 00 04040 OTHER OUTPATIEN	· /		0. 6484		0	0	
	ines 50 through 94 and 96 through	98)	0.0404		23, 910	8, 868	
	Laboratory Services-Program only		1		20, 710	0,000	201
	ne 200 minus line 201)	goo (o or)			23, 910		202

Health Financial Systems JAY COU	NTY HOSPITAL		In Lie	eu of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1320	Peri od:	Worksheet D-3	
	Component	CCN: 15-Z320	From 10/01/2016 To 09/30/2017		
	Ti tl	e XIX	Swing Beds - SN		
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
			5	col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			()	30.00
31. 00 03100 I NTENSI VE CARE UNI T			(31.00
33. 00 03300 BURN I NTENSI VE CARE UNI T			(33.00
40. 00 04000 SUBPROVIDER - IPF			(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					1
50. 00 05000 OPERATI NG ROOM		0. 2322	70 (0 0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 2904	42 (0	52.00
53. 00 05300 ANESTHESI OLOGY		0.0000	00 00	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1033	51 (0	54.00
57.00 05700 CT SCAN		0.0000	00 00	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0.0000	00 00	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.0000	00 00	0	59.00
60. 00 06000 LABORATORY		0. 1631	54 (0	60.00
60.01 06001 BLOOD LABORATORY		0.0000	00 00	0	60.01
65. 00 06500 RESPI RATORY THERAPY		0. 5348		0	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 3229	40 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY		0.2417		0	•
68.00 06800 SPEECH PATHOLOGY		0. 2974	37 (0	68.00
69. 00 06900 ELECTROCARDI OLOGY		0.2519		0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.0000		0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0.4630		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 4885		0	73.00
OUTPATIENT SERVICE COST CENTERS				`	
88.00 08800 RURAL HEALTH CLINIC		0.0000	00 00	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000		0	
90. 00 09000 CLINIC		9.6742		0	•
90.01 09001 FAMILY PRACTICE OF JAY COUNTY		1. 2445		0	•
90. 02 09002 JAY FAMILY MEDICINE		2. 3834		0	
91. 00 09100 EMERGENCY		0. 3324		0	•
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 1777		0	
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTER		0. 64840		0	
200.00 Total (sum of lines 50 through 94 and 96 through 9	98)		(-	200.00
201.00 Less PBP Clinic Laboratory Services-Program only of	,		(201.00
202.00 Net charges (line 200 minus line 201)			(202.00
		I	1	1	

	Financial Systems JAY COUNTY HO ATION OF REIMBURSEMENT SETTLEMENT	DSPITAL Provider CCN: 15-1320	In Lie Period: From 10/01/2016 To 09/30/2017		pared:
		Title XVIII	Hospi tal	Cost	
				1.00	
1.00 2.00 3.00 4.00 4.01 5.00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instruct OPPS payments Outlier payment (see instructions) Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instruct			5, 135, 129 0 0 0 0 0 0, 000	4.00 4.01
6.00 7.00 8.00 9.00 10.00 11.00	Line 2 times line 5 Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt. Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges			0, 00 0, 00 0 0 5, 135, 129	6.00 7.00 8.00 9.00 10.00
12. 00 13. 00 14. 00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I Total reasonable charges (sum of lines 12 and 13) Customary charges	line 69)		0 0 0	12.00 13.00 14.00
15.00 16.00	Aggregate amount actually collected from patients liable for Amounts that would have been realized from patients liable for had such payment been made in accordance with 42 CFR §413.130	or payment for services	0	0 0	16.00
17.00 18.00 19.00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete or instructions)	nlyifline 18 exceeds l	ine 11) (see	0. 000000 0 0	17.00 18.00 19.00
20.00 21.00	Excess of reasonable cost over customary charges (complete or instructions) Lesser of cost or charges (line 11 minus line 20) (see instru	5	ine 18) (see	0 5, 186, 480	
22. 00 23. 00 24. 00	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see inst Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			0 0 0	22.00 23.00 24.00
25. 00 26. 00 27. 00	Deductibles and coinsurance (for CAH, see instructions) Deductibles and Coinsurance relating to amount on line 24 (for Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) instructions)			97, 144 3, 307, 980 1, 781, 356	26.00
30. 00 31. 00	Direct graduate medical education payments (from Wkst. E-4, I ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29) Primary payer payments Subtotal (line 30 minus line 31))		0 0 1, 781, 356 708 1, 780, 648	31.00
33. 00 34. 00 35. 00 37. 00 38. 00 39. 00 39. 50 39. 97 39. 98 39. 99 40. 00 40. 01 40. 02 41. 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI Composite rate ESRD (from Wkst. 1-5, line 11) Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for repla RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions) Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration Interim payments Tentative settlement (for contractors use only)	tructions) ns)	ıcti ons)	0 576, 206 374, 534 540, 492 2, 155, 182 0 0 0 0 2, 155, 182 43, 104 0 2, 270, 919 0	33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 50 39. 97 39. 98 39. 99 40. 00 40. 01 40. 02
43.00 44.00 90.00 91.00 92.00 93.00	Balance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accorda §115.2 TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money Time Value of Money (see instructions) Total (sum of lines 91 and 93)	ance with CMS Pub. 15-2,	chapter 1,	-158, 841 0 0 0 0 0.00 0	43.00 44.00 90.00 91.00 92.00

	Financial Systems JAY COUNTY SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CO	CN: 15-1320	Period:	worksheet E-1	
				From 10/01/2016 To 09/30/2017		pared:
		Title	XVIII	Hospi tal	Cost	o pili
			t Part A		T B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00 2.00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		2, 177, 5	11 0	2, 190, 719 0	1.00 2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.00
3. 01	ADJUSTMENTS TO PROVIDER			0 03/20/2017	80, 200	3.01
3. 02				0	0	3.02
3.03				0	0	3.03
3.04 3.05				0	0	3.04 3.05
5.05	Provider to Program			0	0	3.00
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3.51				0	0	3.51
3.52				0	0	3.52
3.53 3.54				0	0	3.53 3.54
3.54 3.99	Subtotal (sum of lines 3.01–3.49 minus sum of lines			0	80, 200	3. 54
4.00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99)		0 177 F	11	2, 270, 919	4.00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2, 177, 5	11	2, 270, 919	4.00
	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 "NONE" or enter a zero. (1)					5.00
F 01	Program to Provider TENTATIVE TO PROVIDER			0	0	E O1
5. 01 5. 02	ILIVIATIVE TO PROVIDER			0	0	5.01 5.02
5.02				0	0	5.03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM			0	0	5.50
5.51 5.52				0	0	5.51 5.52
5. 99 5. 99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0	0	5.99
6.00	5.50-5.98) Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6.01	SETTLEMENT TO PROVIDER		-	0	0	6.01
6. 02 7. 00	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		7 2, 176, 7	71	158, 841 2, 112, 078	6.02 7.00
7.00			2,170,7	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
		(1.00	2.00	

IALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider Concernent	CN: 15-1320 CCN: 15-M320	Period: From 10/01/2016 To 09/30/2017		parec
		Title	XVIII	Subprovider -	PPS	
		Inpatien	t Part A		rt B	
	-	mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
00	Total intorim payments paid to provider	1.00	2.00	3.00	4.00	1.0
00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 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		660, 2	0	0	3. (
	payment. If none, write "NONE" or enter a zero. (1)					
01	Program to Provider ADJUSTMENTS TO PROVIDER			0	0	3.
02	Absostiments to thoriber			0	0	3.
03				0	0	3
04				0	0	3
)5	Provider to Program			0	0	3
50	ADJUSTMENTS TO PROGRAM			0	0	3
51				0	0	
52				0	0	
53 54				0	0	3
99 99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)			0	0	3
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as		660, 2	31	0	4
	appropriate) TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5
	Program to Provider				1	
)1)2	TENTATI VE TO PROVI DER			0	0	
)2)3				0		
	Provider to Program					Ĭ
50	TENTATI VE TO PROGRAM			0	0	
51				0	0	
52 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5
00	5.50-5.98) Determined net settlement amount (balance due) based on					6
N1	the cost report. (1)					,
01 02	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM			0	0	6
)2)0	Total Medicare program liability (see instructions)		660, 2	0	0	
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
0	Name of Contractor	()	1.00	2.00	8

IALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider C	CN: 15-1320	Period: From 10/01/201	Worksheet E-1 6 Part I	1
		Component	CCN: 15-Z320	To 09/30/201		epare 56 pm
		Title	XVIII	Swing Beds - SM		
		Inpati en	t Part A	Pa	art B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	+
		1.00	2.00	3.00	4.00	<u> </u>
00	Total interim payments paid to provider		463, 9	00	0) 1.
00	Interim payments payable on individual bills, either			0	0) 2.
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
00	write "NONE" or enter a zero					1
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate					3.
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					1
D1	ADJUSTMENTS TO PROVIDER			0	0) 3.
)2				0	0	
)3				0	0	
)4				0	0	
)5				0	0) 3
	Provider to Program					
0	ADJUSTMENTS TO PROGRAM			0	0	-
51 52				0	0	-
o∠ 53				0		-
53 54				0		-
99	Subtotal (sum of lines 3.01–3.49 minus sum of lines			0	0	-
	3. 50-3. 98)			0		
00	Total interim payments (sum of lines 1, 2, and 3.99)		463, 9	00	0	4
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after					5
	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
)1	TENTATI VE TO PROVI DER			0	0) 5
)2				0	0) 5
)3				0	0) 5
	Provider to Program				-	
50	TENTATI VE TO PROGRAM			0	0	
51 52				0	0	
12 19	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0		-
9	5. 50-5. 98)			0	0	/ ⁵
00	Determined net settlement amount (balance due) based on					6
	the cost report. (1)					Ĭ
01	SETTLEMENT TO PROVIDER		12, 2	92	0	6
)2	SETTLEMENT TO PROGRAM			0	0	
00	Total Medicare program liability (see instructions)		476, 1		0) 7
				Contractor	NPR Date	
			2	Number	(Mo/Day/Yr)	
		()	1.00	2.00	

Heal th	Financial Systems JAY COUNTY H	OSPI TAL	In Lie	u of Form CMS	-2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1320	Period: From 10/01/2016 To 09/30/2017		repared:
		Title XVIII	Hospi tal	Cost	
				1 00	
	TO DE COMPLETED DV CONTRACTOR FOR NONSTANDARD COST DEPORTS			1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATIO	N			-
1.00	Total hospital discharges as defined in AARA §4102 from Wkst		e 14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1,				2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1,	8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3				6.00
7.00	CAH only - The reasonable cost incurred for the purchase of line 168	certified HIT technology	Wkst. S-2, Pt. I		7.00
8.00	Calculation of the HIT incentive payment (see instructions)				8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestration) (see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
	Initial/interim HIT payment adjustment (see instructions)				30.00
	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and	line 31) (see instructio	ns)		32.00

ALCULA	TION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-1320	Period: From 10/01/2016	Worksheet E-2	
	C	Component CCN: 15-Z320	To 09/30/2017	Date/Time Pre 2/26/2018 1:5	
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
	Inpatient routine services - swing bed-SNF (see instructions)		388, 731	0	1.0
	Inpatient routine services - swing bed-NF (see instructions)	A and sum of Wkst D	100, 763	0	2.0 3.0
	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see inst		100, 703	0	3.0
	Per diem cost for interns and residents not in approved teachir			0.00	4.0
	instructions)	31 3 ()			
. 00	Program days		249	0	5.0
	Interns and residents not in approved teaching program (see ins			0	
	Utilization review - physician compensation - SNF optional meth	iod only	0		7.0
	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		489, 494	0	
	Primary payer payments (see instructions) Subtotal (line 8 minus line 9)		489, 494	0	9. 0 10. 0
	Deductibles billed to program patients (exclude amounts applica	ble to physician	409, 494	0	11.0
	professional services)		0	0	
	Subtotal (line 10 minus line 11)		489, 494	0	12.0
	Coinsurance billed to program patients (from provider records)	(excl ude coi nsurance	3, 584	0	13.0
	for physician professional services)				
	80% of Part B costs (line 12 x 80%)			0	14.0
1	Subtotal (enter the lesser of line 12 minus line 13, or line 14	.)	485, 910	0	15.0
1	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.0 16.5
	Pioneer ACO demonstration payment adjustment (see instructions) Rural community hospital demonstration project (§410A Demonstra		0	0	16.5
	adjustment (see instructions)	rtron) payment	0		10.0
	Demonstration payment adjustment amount before sequestration		0	0	16.9
	Allowable bad debts (see instructions)		0	0	17.0
7.01	Adjusted reimbursable bad debts (see instructions)		0	0	17.0
	Allowable bad debts for dual eligible beneficiaries (see instru	ıcti ons)	0	0	18.0
	Total (see instructions)		485, 910	0	19.0
	Sequestration adjustment (see instructions)		9, 718	0	
	Demonstration payment adjustment amount after sequestration) Interim payments		0 463, 900	0	19.0 20.0
	Tentative settlement (for contractor use only)		403, 900	0	20.0
	Balance due provider/program (line 19 minus lines 19.01, 20, ar	nd 21)	12, 292	0	22.0
	Protested amounts (nonallowable cost report items) in accordance	-	0	0	23.0
	chapter 1, §115.2				
	Rural Community Hospital Demonstration Project (§410A Demonstra				
	Is this the first year of the current 5-year demonstration peri	od under the 21st			200. (
	Century Cures Act? Enter "Y" for yes or "N" for no.				
	Cost Reimbursement Medicare swing-bed SNF inpatient routine service costs (from Wk	st D_1 Pt II line			201.0
01.00	66 (title XVIII hospital))	St. D-1, Ft. 11, 111e			201.0
02.00	Medicare swing-bed SNF inpatient ancillary service costs (from	Wkst. D-3, col. 3, lir	ne		202.0
	200 (title XVIII swing-bed SNF))				
03.00	Total (sum of lines 201 and 202)				203. (
	Medicare swing-bed SNF discharges (see instructions)				204. (
	Computation of Demonstration Target Amount Limitation (N/A in f	irst year of the curre	ent 5-year demons	tration	
	period) Madiaara awing had SNE targat amaunt				205 (
	Medicare swing-bed SNF target amount Medicare swing-bed SNF inpatient routine cost cap (line 205 tim	as line 204)			205. (206. (
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburse				200.0
	Program reimbursement under the §410A Demonstration (see instru				207.0
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2,	-	1		208.0
	and 3)				
	Adjustment to Medicare swing-bed SNF PPS payments (see instruct	i ons)			209.0
	Reserved for future use				210. 0
45	Comparision of PPS versus Cost Reimbursement				04-
	Total adjustment to Medicare swing-bed SNF PPS payment (line 20 instructions)	prus rine 210) (see			215. (

LCUL	ATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS Prov	/ider CCN: 15-1320		ri od:	Worksheet E-2	2
	Сотр	oonent CCN: 15-Z320	To	om 10/01/2016 09/30/2017	Date/Time Pre 2/26/2018 1:5	
		Title XIX	Swi	ng Beds - SNF	Cost	
				Part A	Part B	
				1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES					
	Inpatient routine services - swing bed-SNF (see instructions)			0		1.
	Inpatient routine services - swing bed-NF (see instructions)			0		2.
00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A,		, I	0		3.
00	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instruc Per diem cost for interns and residents not in approved teaching p			0.00		4.
	instructions)	n ogi alli (see		0.00		4
	Program days			0		5
	Interns and residents not in approved teaching program (see instru	uctions)		0		6
	Utilization review - physician compensation - SNF optional method			0		7
00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	5		0		8
00	Primary payer payments (see instructions)			0		9
. 00	Subtotal (line 8 minus line 9)			0		10
. 00	Deductibles billed to program patients (exclude amounts applicable	e to physician		0		11
	professi onal servi ces)					
	Subtotal (line 10 minus line 11)			0		12
	Coinsurance billed to program patients (from provider records) (ex	clude coinsurance		0		13
	for physician professional services)					1 1 4
	80% of Part B costs (line 12 x 80%)			0		14
	Subtotal (enter the lesser of line 12 minus line 13, or line 14) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0		10
	Pioneer ACO demonstration payment adjustment (see instructions)			0		16
	Rural community hospital demonstration project (§410A Demonstratic	n) navment		0		16
	adjustment (see instructions)	n) payment				
	Demonstration payment adjustment amount before sequestration			0		16
	Allowable bad debts (see instructions)			0		17
	Adjusted reimbursable bad debts (see instructions)			0		17
. 00	Allowable bad debts for dual eligible beneficiaries (see instructi	ons)		0		18
. 00	Total (see instructions)			0		19
. 01	Sequestration adjustment (see instructions)			0		19
	Demonstration payment adjustment amount after sequestration)			0		19
	Interim payments			0		20
	Tentative settlement (for contractor use only)			0		21
	Balance due provider/program (line 19 minus lines 19.01, 20, and 2			0		22
	Protested amounts (nonallowable cost report items) in accordance w	VITH CMS PUB. 15-2,		0		23
	chapter 1, §115.2 Rural Community Hospital Demonstration Project (§410A Demonstratic	n) Adjustment				-
	Is this the first year of the current 5-year demonstration period					200
	Century Cures Act? Enter "Y" for yes or "N" for no.					
	Cost Reimbursement			·		
1. 00	Medicare swing-bed SNF inpatient routine service costs (from Wkst.	D-1, Pt. II, line				201
	66 (title XVIII hospital))					
	Medicare swing-bed SNF inpatient ancillary service costs (from Wks	st. D-3, col. 3, li	ne			202
	200 (title XVIII swing-bed SNF))					000
	Total (sum of lines 201 and 202) Medicara swing bod SNE discharges (see instructions)					203 204
	Medicare swing-bed SNF discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in firs	t year of the curr	ant	5-vear demons	tration	1204
	period)	st year of the curry	JIIL	o year demons		
	Medicare swing-bed SNF target amount					205
	Medicare swing-bed SNF inpatient routine cost cap (line 205 times	line 204)				206
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursemen			·		
7.00	Program reimbursement under the §410A Demonstration (see instructi	ons)				207
3. 00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, co	ol. 1, sum of lines	1			208
	and 3)					
	Adjustment to Medicare swing-bed SNF PPS payments (see instruction	is)				209
	Reserved for future use					210
	Comparision of PPS versus Cost Reimbursement					

ALCUI	Financial Systems JAY COUNTY ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1320	Peri od:	u of Form CMS-2 Worksheet E-3	
			From 10/01/2016	Part V	
			To 09/30/2017	Date/Time Pre 2/26/2018 1:5	
		Title XVIII	Hospi tal	Cost	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICA			1.00	
00	Inpatient services	ARE PART A SERVICES - COS		2, 498, 730	1 1
00	Nursing and Allied Health Managed Care payment (see instruc	rtions)		2,470,730	
00	Organ acquisition			0	
00	Subtotal (sum of lines 1 through 3)			2, 498, 730	-
00	Primary payer payments			7, 719	
00	Total cost (line 4 less line 5). For CAH (see instructions))		2, 515, 998	
	COMPUTATION OF LESSER OF COST OR CHARGES	·			
	Reasonabl e charges		-		
00	Routine service charges			0	
00	Ancillary service charges			0	
00	Organ acquisition charges, net of revenue			0	
. 00	Total reasonable charges			0	10
	Customary charges				١.,
. 00	Aggregate amount actually collected from patients liable for			0	
. 00	Amounts that would have been realized from patients liable		on a charge basis	0	12
~~	had such payment been made in accordance with 42 CFR 413.13	3(e)		0 000000	
. 00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000	
. 00	Total customary charges (see instructions)	anly if line 14 avecade l	100 () (000	0	
6.00	Excess of customary charges over reasonable cost (complete	only if line 14 exceeds i	The 6) (see	0	1!
. 00	instructions) Excess of reasonable cost over customary charges (complete	only if line 6 exceeds li	no 14) (soo	0	1
. 00	instructions)	only if the o exceeds if	116 14) (See	0	
. 00		nstructions)		0	17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				1.
. 00	Direct graduate medical education payments (from Worksheet	E-4, line 49)		0	118
. 00	Cost of covered services (sum of lines 6, 17 and 18)			2, 515, 998	10
. 00	Deductibles (exclude professional component)			302, 064	20
. 00	Excess reasonable cost (from line 16)			0	2
. 00	Subtotal (line 19 minus line 20 and 21)			2, 213, 934	22
. 00	Coinsurance			4, 277	
. 00	Subtotal (line 22 minus line 23)			2, 209, 657	
. 00	Allowable bad debts (exclude bad debts for professional ser	rvices) (see instructions)		17, 702	
. 00	Adjusted reimbursable bad debts (see instructions)			11, 506	
. 00	Allowable bad debts for dual eligible beneficiaries (see in	nstructions)		10, 507	
8.00	Subtotal (sum of lines 24 and 25, or line 26)			2, 221, 163	
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
. 50	Pioneer ACO demonstration payment adjustment (see instructi			0	
. 99	Demonstration payment adjustment amount before sequestration	on		0	
. 00	Subtotal (see instructions)			2, 221, 163	
0.01	Sequestration adjustment (see instructions)			44, 423	
). 02	Demonstration payment adjustment amount after sequestration	1		0	
. 00	Interim payments			2, 177, 511	
2.00	Tentative settlement (for contractor use only)	202 21 and 22		0	
3.00	Balance due provider/program (line 30 minus lines 30.01, 30		obortor 1	-771	
1.00	Protested amounts (nonallowable cost report items) in accor §115.2	uance with two Pub. 15-2,	chapter I,	0	34

CULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1320	Peri od:		
		From 10/01/2016		
	Component CCN: 15-M320	To 09/30/2017	Date/Time Prep 2/26/2018 1:50	
	Title XVIII	Subprovider -	PPS	<u>o pii</u>
			1.00	
PART II - MEDICARE PART A SERVICES - IPF PPS			1.00	
00 Net Federal IPF PPS Payments (excluding outlier, ECT, a	nd medical education payments)	635, 769	1.
00 Net IPF PPS Outlier Payments			99, 781	
00 Net IPF PPS ECT Payments			0	
00 Unweighted intern and resident FTE count in the most real 15, 2004. (see instructions)	cent cost report filed on or l	before November	0.00	4.
01 Cap increases for the unweighted intern and resident FT			0.00	4.
program or hospital closure, that would not be counted	1 3 1 3	tment under 42		
CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions) New Teaching program adjustment. (see instructions))		0.00	5.
00 Current year's unweighted FTE count of L&R excluding FT	Es in the new program growth u	period of a "new	0.00	
teaching program" (see instuctions)			0.00	0.1
O Current year's unweighted I&R FTE count for residents w teaching program" (see instuctions)	ithin the new program growth p	period of a "new	0.00	7.
00 Intern and resident count for IPF PPS medical education	adjustment (see instructions)		0.00	8.
00 Average Daily Census (see instructions)			2. 928767	
00 Teaching Adjustment Factor {((1 + (line 8/line 9)) rais	ed to the power of .5150 -1}.		0.000000	
00 Teaching Adjustment (line 1 multiplied by line 10).			0	11.
00 Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and	d 11)		735, 550	12
00 Nursing and Allied Health Managed Care payment (see ins	truction)		0	13.
00 Organ acquisition (DO NOT USE THIS LINE)				14
00 Cost of physicians' services in a teaching hospital (see	e instructions)		0	
00 Subtotal (see instructions) 00 Primary payer payments			735, 550 0	
00 Primary payer payments 00 Subtotal (line 16 less line 17).			735, 550	
00 Deductibles			60, 200	
00 Subtotal (line 18 minus line 19)			675, 350	
00 Coi nsurance			1, 645	
00 Subtotal (line 20 minus line 21)			673, 705	22
00 Allowable bad debts (exclude bad debts for professional	services) (see instructions)		0	23
00 Adjusted reimbursable bad debts (see instructions)			0	
00 Allowable bad debts for dual eligible beneficiaries (see	e instructions)		0	
00 Subtotal (sum of lines 22 and 24)	F () (i = - (0)		673, 705	
00 Direct graduate medical education payments (from Wkst. 1 00 Other pass through costs (see instructions)	E-4, 11he 49)		0	
00 Outlier payments reconciliation			0	
00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
50 Pioneer ACO demonstration payment adjustment (see instru	uctions)		Ō	
99 Demonstration payment adjustment amount before sequestra	ation		0	30
00 Total amount payable to the provider (see instructions)			673, 705	31
01 Sequestration adjustment (see instructions)			13, 474	
02 Demonstration payment adjustment amount after sequestra	tion		0	
00 Interim payments			660, 231	
00 Tentative settlement (for contractor use only)	21 02 22 and 22)			33
00 Balance due provider/program (line 31 minus lines 31.01 00 Protested amounts (nonallowable cost report items) in a		chapter 1,	0 0	
<u>§115.2</u> TO BE COMPLETED BY CONTRACTOR				-
00 Original outlier amount from Worksheet E-3, Part II, Iii	ne 2		99, 781	50
5			0	
00 Outlier reconciliation adjustment amount (see instruction				

	Financial Systems JAY COUNTY I ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1320	Peri od:	u of Form CMS-2 Worksheet E-3	
			From 10/01/2016 To 09/30/2017		pared
		Title XIX	Hospi tal	Cost	-
		·	I npati ent	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH	SERVICES FOR TITLES V OR 2	KIX SERVICES		-
00	COMPUTATION OF NET COST OF COVERED SERVICES		42,200		1 1 0
. 00 . 00	Inpatient hospital/SNF/NF services		42, 300	0	1.0
. 00	Medical and other services Organ acquisition (certified transplant centers only)		0	0	3.0
. 00	Subtotal (sum of lines 1, 2 and 3)		42, 300	0	
. 00	Inpatient primary payer payments		12,000	0	5.0
. 00	Outpatient primary payer payments			0	
. 00	Subtotal (line 4 less sum of lines 5 and 6)		42, 300	0	7.0
	COMPUTATION OF LESSER OF COST OR CHARGES		*		
	Reasonable Charges				
. 00	Routine service charges		0		8.0
. 00	Ancillary service charges		62, 334	0	
0.00	Organ acquisition charges, net of revenue		0		10.0
1.00	Incentive from target amount computation		42 224	0	11. C
2.00	Total reasonable charges (sum of lines 8 through 11) CUSTOMARY CHARGES		62, 334	0	1 12.0
3.00	Amount actually collected from patients liable for payment	for services on a charge	0	0	13.0
0.00	basi s	for services on a onarge	Ŭ	0	
4.00	Amounts that would have been realized from patients liable	for payment for services (on 0	0	14.0
	a charge basis had such payment been made in accordance wit				
5.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.00000	15.0
6.00	Total customary charges (see instructions)		62, 334	0	16.0
7.00	Excess of customary charges over reasonable cost (complete	only if line 16 exceeds	20, 034	0	17.C
0 00	line 4) (see instructions)			0	10.0
8.00	Excess of reasonable cost over customary charges (complete	only if line 4 exceeds iii	ne U	0	18.0
9.00	16) (see instructions) Interns and Residents (see instructions)		0	0	19.0
	Cost of physicians' services in a teaching hospital (see in	structions)	0	0	20.0
	Cost of covered services (enter the lesser of line 4 or lin		42, 300	0	
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only I				
2.00	Other than outlier payments	· · ·	0	0	22.0
3.00	Outlier payments		0	0	23.0
4.00	Program capital payments		0		24.0
5.00	Capital exception payments (see instructions)		0		25.
6.00	Routine and Ancillary service other pass through costs		0	0	
7.00	Subtotal (sum of lines 22 through 26)	`	0	0	27.0
8.00 9.00	Customary charges (title V or XIX PPS covered services only)	42, 300	0	28.0
9.00	Titles V or XIX (sum of lines 21 and 27) COMPUTATION OF REIMBURSEMENT SETTLEMENT		42, 300	0	29.
0 00	Excess of reasonable cost (from line 18)		0	0	30.0
1.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and	6)	42, 300	0	
2.00	Deducti bl es	0)	12,000	0	
3.00	Coinsurance		0	0	
4.00	Allowable bad debts (see instructions)		0	0	
5.00	Utilization review		0		35.0
6.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32	and 33)	42, 300	0	36. (
7.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
8.00	Subtotal (line 36 ± line 37)		42, 300	0	
9.00	Direct graduate medical education payments (from Wkst. E-4)		0	-	39.
0.00	Total amount payable to the provider (sum of lines 38 and 3	9)	42, 300	0	
1.00	Interim payments Polance due provider (program (Line 40 minus Line 41)		29, 360	0	41.
2.00 3.00	Balance due provider/program (line 40 minus line 41) Protested amounts (nonallowable cost report items) in accor	danco with CMS Rub 15 2	12, 940	0	42. 43.
J. UU	notested amounts (nonarrowable cost report ritems) IN accor	uance writh GWS PUD 19-2,	0	0	1 43.1

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1320	Peri od:	Worksheet E-3	
		Component CCN: 15-M320	From 10/01/2016 To 09/30/2017	Part VII Date/Time Pre 2/26/2018 1:5	
		Title XIX	Subprovider - IPF	Cost	
			Inpatient	Outpati ent	
				2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH COMPUTATION OF NET COST OF COVERED SERVICES	SERVICES FOR TITLES V OR A	ATA SERVICES		1
00	Inpatient hospital/SNF/NF services		53, 997		1 -
00	Medical and other services			0	
00	Organ acquisition (certified transplant centers only)		0		
00	Subtotal (sum of lines 1, 2 and 3)		53, 997	0	
00	Inpatient primary payer payments		0		5
00	Outpatient primary payer payments		50.007	0	
00	Subtotal (line 4 less sum of lines 5 and 6)		53, 997	0	
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges				-
00	Routi ne servi ce charges		0		1
00	Ancillary service charges		23, 910	0	
. 00	Organ acquisition charges, net of revenue		0	Ũ	10
. 00	Incentive from target amount computation		0		1
. 00	Total reasonable charges (sum of lines 8 through 11)		23, 910	0	12
	CUSTOMARY CHARGES				
. 00	Amount actually collected from patients liable for payment	for services on a charge	0	0	13
00	basis			0	1
. 00	Amounts that would have been realized from patients liable a charge basis had such payment been made in accordance wi		on 0	0	14
. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	til 42 CFR 9413. 13(e)	0. 000000	0.000000	1
. 00	Total customary charges (see instructions)		23, 910	0.000000	
. 00	Excess of customary charges over reasonable cost (complete	only if line 16 exceeds	0	0	
	line 4) (see instructions)	5			
. 00	Excess of reasonable cost over customary charges (complete	only if line 4 exceeds lin	ne 30, 087	0	18
	16) (see instructions)				
. 00	Interns and Residents (see instructions)		0	0	
0.00	Cost of physicians' services in a teaching hospital (see in		0	0	
. 00	Cost of covered services (enter the lesser of line 4 or lin PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only		23, 910	0	2'
. 00	Other than outlier payments	be compreted for FFS provi	0	0	22
. 00	Outlier payments		0	0	
. 00	Program capital payments		0		24
. 00	Capital exception payments (see instructions)		0		2
. 00	Routine and Ancillary service other pass through costs		0	0	20
. 00	Subtotal (sum of lines 22 through 26)		0	0	
. 00	Customary charges (title V or XIX PPS covered services only	у)	0	0	28
. 00	Titles V or XIX (sum of lines 21 and 27)		23, 910	0	29
00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		20.007	2	
. 00	Excess of reasonable cost (from line 18) Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and	d 6)	30, 087 23, 910	0	
	Deductibles	u 0)	23, 910	0	
. 00	Coinsurance		0	0	
. 00	Allowable bad debts (see instructions)		0	0	
. 00	Utilization review		0	-	3!
. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32	and 33)	23, 910	0	30
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
. 00	Subtotal (line 36 ± line 37)		23, 910	0	
. 00	Direct graduate medical education payments (from Wkst. E-4)		0		30
. 00	Total amount payable to the provider (sum of lines 38 and 3	39)	23, 910	0	
. 00	Interim payments Palance due provider(program (line 40 minus line 41)		10, 137	0	
2.00 3.00	Balance due provider/program (line 40 minus line 41) Protested amounts (nonallowable cost report items) in acco	rdance with CMS Dub 15 2	13, 773 0	0	
. 00	chapter 1, §115.2	Tuance with GWS PUD 13-2,	0	0	43

	Financial Systems JAY COUNTY E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C	Fi		Worksheet G Date/Time Pre 2/26/2018 1:5	pared:
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
1.00 2.00	Cash on hand in banks Temporary investments	5, 151, 106 -17, 389, 072	0 0	0 0	0	1.00 2.00
3.00 4.00 5.00	Notes recei vabl e Accounts recei vabl e Other recei vabl e	0 23, 490, 483 750, 910	0 0 0	0 0 0	0 0 0	3.00 4.00 5.00
6.00 7.00 8.00	Allowances for uncollectible notes and accounts receivable Inventory Prepaid expenses	0 6, 066, 460 0	0 0 0	0 0 0	0 0 0	6.00 7.00 8.00
	Other current assets Due from other funds Total current assets (sum of lines 1-10)	0 0 18, 069, 887	0 0 0	0 0 0	0 0 0	9.00 10.00 11.00
12 00	FIXED ASSETS	247 722		o	0	12.00
	Land Land improvements	347, 733 952, 332	0	0 0	0	12.00 13.00
	Accumulated depreciation	0	0	0	0	14.00
	Buildings Accumulated depreciation	25, 412, 220	0	0	0	15.00 16.00
17.00	Leasehold improvements	0	0	0	0	17.00
	Accumul ated depreciation	0	0	0	0	18.00
	Fixed equipment Accumulated depreciation	2, 464, 521 -30, 853, 903	0	0	0	19.00 20.00
	Automobiles and trucks	0	0	0	0	21.00
	Accumulated depreciation	0 15, 078, 667	0	0	0	22.00 23.00
	Major movable equipment Accumulated depreciation	15, 078, 007	0	0	0	23.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
	Accumulated depreciation HIT designated Assets	0	0	0	0	26.00 27.00
	Accumul ated depreciation	0	0	0	0	27.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
	Total fixed assets (sum of lines 12-29) OTHER ASSETS	13, 401, 570	0	0	0	30.00
	Investments Deposits on Leases	0	0	0	0	31.00 32.00
	Due from owners/officers	0	0	0	0	32.00
34.00	Other assets	6, 602, 987	0	0	0	34.00
	Total other assets (sum of lines 31-34) Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES	6, 602, 987 38, 074, 444	0	0	0 0	35.00 36.00
	Accounts payable	1, 615, 416	0	0	0	37.00
	Salaries, wages, and fees payable Payroll taxes payable	2, 710, 582 0	0	0	0	38.00 39.00
	Notes and Loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
	Accel erated payments Due to other funds	0	0	0	0	42.00 43.00
	Other current liabilities	337, 966	-	0	0	1
45.00	Total current liabilities (sum of lines 37 thru 44)	4, 663, 964	0	0	0	45.00
46.00	LONG TERM LIABILITIES Mortgage payable	0	0	0	0	46.00
	Notes payable	0	0	0	0	47.00
	Unsecured Loans	0	0	0	0	48.00
	Other long term liabilities Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	49.00 50.00
	Total liabilities (sum of lines 45 and 50)	4, 663, 964	0	0	0	51.00
	CAPI TAL ACCOUNTS					
	General fund balance Specific purpose fund	33, 410, 480	0			52.00 53.00
	Donor created - endowment fund balance - restricted		0	0		54.00
	Donor created - endowment fund balance - unrestricted			0		55.00
	Governing body created - endowment fund balance Plant fund balance - invested in plant			0	0	56.00 57.00
	Plant fund balance - reserve for plant improvement,				0	58.00
	replacement, and expansion					
59.00 60.00	Total fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and	33, 410, 480 38, 074, 444	0	0	0	59.00 60.00
00.00	59)	30, 074, 444	0	0	0	00.00

Heal th	Financial Systems	JAY COUNTY H	IOSPI TAL			In Lieu	u of Form CM	S-2	552-10
	IENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-1320	Peri Froi To		Worksheet C Date/Time F 2/26/2018 1	G-1 Prep	bared:
		General	Fund	Speci al	Purp	ose Fund	Endowment Fund		
		1.00	2.00	3.00		4.00	5.00		
$\begin{array}{c} 1.00\\ 2.00\\ 3.00\\ 4.00\\ 5.00\\ 6.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 12.00\\ 13.00\\ 14.00\\ 15.00\\ 15.00\\ 16.00\\ 17.00\\ 18.00\\ 19.00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	31, 562, 436 1, 848, 044 33, 410, 480 0 33, 410, 480 0 33, 410, 480		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	$\begin{array}{c} 1.00\\ 2.00\\ 3.00\\ 4.00\\ 5.00\\ 6.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 12.00\\ 13.00\\ 13.00\\ 14.00\\ 15.00\\ 14.00\\ 15.00\\ 14.00\\ 19.00\\ 19.00\\ \end{array}$
		Endowment Fund	PI ant	Fund					
1.00	Fund hal anneas at having ing of paging	6.00	7.00	8.00					1 00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0 0		0				1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0	0 0 0 0 0		0 0 0 0				10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

STATEM						2552-10
	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider C	CN: 15-1320	Period: From 10/01/2016 To 09/30/2017	Worksheet G-2 Parts I & II Date/Time Pre 2/26/2018 1:5	pared:
	Cost Center Description		I npati ent	Outpati ent	Total	
			1.00	2.00	3.00	
	PART I - PATIENT REVENUES					-
	General Inpatient Routine Services					
1.00	Hospi tal		5, 510, 1		5, 510, 193	•
2.00	SUBPROVIDER - IPF		877, 2		877, 200	
3.00	SUBPROVIDER - IRF			0	0	
4.00	SUBPROVIDER			0	0	
5.00	Swing bed - SNF			0	0	
6.00	Swing bed - NF			0	0	
7.00	SKILLED NURSING FACILITY					7.00
8.00	NURSING FACILITY					8.00
9.00	OTHER LONG TERM CARE					9.00
10.00	Total general inpatient care services (sum of lines 1-9)		6, 387, 3	93	6, 387, 393	10.00
	Intensive Care Type Inpatient Hospital Services					
11.00	I NTENSI VE CARE UNI T			0	0	
12.00	CORONARY CARE UNIT					12.00
13.00	BURN INTENSIVE CARE UNIT			0	0	
14.00	SURGICAL INTENSIVE CARE UNIT					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)					15.00
16.00	Total intensive care type inpatient hospital services (sur 11-15)	n of lines		0	0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and	d 16)	6, 387, 3	93	6, 387, 393	17.00
18.00	Ancillary services		9, 940, 4	97 63, 650, 580	73, 591, 077	18.00
19.00	Outpatient services		366, 3	24 10, 807, 030	11, 173, 354	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	СМНС					24.00
24.10	CORF			0 0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D. P.)					25.00
26.00	HOSPI CE					26.00
27.00	PRO FEES		2, 332, 7	29 15, 263, 401	17, 596, 130	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer colur	nn 3 to Wkst.	19, 026, 9	43 89, 721, 011	108, 747, 954	28.00
	G-3, line 1)					
	PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)			38, 586, 616		29.00
30.00	ADD (SPECIFY)			0		30.00
31.00				0		31.00
32.00				0		32.00
33.00				0		33.00
34.00				0		34.00
35.00				0		35.00
36.00	Total additions (sum of lines 30-35)			0		36.00
37.00	DEDUCT (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
	1 · · · · · · · · · · · · · · · · ·	102 (1	1	00 504 444		1 42 00
43.00	Total operating expenses (sum of lines 29 and 36 minus lin	ne 42)(transfer		38, 586, 616		43.00

Heal th	Financial Systems	JAY COUNTY HOSPITAL		In Lie	u of Form CMS-2	2552- <u>1</u> 0
STATEM	ENT OF REVENUES AND EXPENSES	Provider CC	N: 15-1320	Period: From 10/01/2016	Worksheet G-3	
				To 09/30/2017	Date/Time Pre 2/26/2018 1:5	
1 00					1.00	1.00
1.00	Total patient revenues (from Wkst. G-2, P				108, 747, 954	1.00
2.00	Less contractual allowances and discounts				71, 262, 425	
3.00	Net patient revenues (line 1 minus line 2				37, 485, 529	
4.00	Less total operating expenses (from Wkst.				38, 586, 616	
	Net income from service to patients (line OTHER INCOME	3 minus line 4)			-1, 101, 087	5.00
6.00	Contributions, donations, bequests, etc				0	6.00
7.00	Income from investments				0	7.00
8.00	Revenues from telephone and other miscell	anoous communication sorvicos			0	
9.00	Revenue from television and radio service				0	
	Purchase di scounts				0	10.00
	Rebates and refunds of expenses				0	11.00
	Parking lot receipts				0	12.00
	Revenue from Laundry and Linen service				0	13.00
	Revenue from meals sold to employees and	quests			0	14.00
	Revenue from rental of living quarters	940010			0	15.00
	Revenue from sale of medical and surgical	supplies to other than patients			0	16.00
	Revenue from sale of drugs to other than				0	
	Revenue from sale of medical records and	1			0	
19.00	Tuition (fees, sale of textbooks, uniform	s, etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops	, and canteen			0	20.00
	Rental of vending machines				0	21.00
22.00	Rental of hospital space				0	22.00
23.00	Governmental appropriations				0	23.00
	OTHER OPERATING REV				2, 742, 679	24.00
24.01	OTHER NON OPERATING REV				206, 452	24.01
25.00	Total other income (sum of lines 6-24)				2, 949, 131	25.00
26.00	Total (line 5 plus line 25)				1, 848, 044	26.00
27.00	OTHER EXPENSES (SPECIFY)				0	
28.00	Total other expenses (sum of line 27 and	subscripts)			0	28.00
29.00	Net income (or loss) for the period (line	26 minus line 28)			1, 848, 044	29.00