near til i maner	ar Systems	JAT COUNTY HOS	JIIIAL		THE LICE	a of form one	7 2002 1
This report is	required by law (42 USC 1395g;	42 CFR 413.20(b)). Fai	lure to report can	result i	n all interim	FORM APPROV	ED
payments made	since the beginning of the cost	reporting period being	deemed overpayment	s (42 US	SC 1395g).	OMB NO. 093	8-0050
						EXPIRES 05-	31-2019
HOSPITAL AND H AND SETTLEMENT	IOSPITAL HEALTH CARE COMPLEX COS SUMMARY	T REPORT CERTIFICATION	Provider CCN: 15-13		riod: om 10/01/2017 02/28/2018		repared:
PART I - COST	REPORT STATUS						
Provi der	1. [ X ] Electronically filed co	st report			Date: 7/30/20	18 Time:	1:00 pn
use only	2. [ ] Manually submitted cost	report					
	3. [ 0 ] If this is an amended r 4. [ F ] Medicare Utilization. E			der resul	omitted this o	ost report	
Contractor use only	(1) As Submitted 7.	Date Received: Contractor No. [ N ] Initial Report fo [ N ] Final Report for	or this Provider CCN	10. NPR 11. Cont 112. [ 0	ractor's Vendo	olumn 1 is 4:	

## PART II - CERTIFICATION

(5) Amended

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

CERTIFICATION BY 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 (15-1320) for the cost reporting period beginning 10/01/2017 and ending 02/28/2018 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.

(Si gned)_	
	Officer or Administrator of Provider(s)
=	itle
I	rtre
D	ate

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	102, 503	-266, 227	0	14, 423	1.00
2.00	Subprovi der - IPF	0	0	0		29, 448	2.00
3.00	Subprovi der - IRF	0	0	0		0	3.00
4.00	SUBPROVI DER I						4.00
5.00	Swing bed - SNF	0	32, 750	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	135, 253	-266, 227	0	43, 871	200.00

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

Health Financial Systems JAY COUNTY HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1320 Peri od: Worksheet S-2 From 10/01/2017 Part I 02/28/2018 Date/Time Prepared: 7/30/2018 12:58 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: 1.00 Street: 500 W. VOTAW PO Box: 1.00 State: IN 2.00 City: PORTLAND Zip Code: 47371-County: JAY 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N)
V XVIII XIX Туре Certi fi ed Number Number 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 JAY COUNTY HOSPITAL 151320 99915 01/01/2004 Ν 0 0 3.00 Hospi tal Subprovi der - IPF JAY COUNTY 99915 Р 0 4.00 15M320 4 10/01/2005 Ν 4.00 HOSPITAL-PSYCH UNIT 5.00 Subprovi der - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF JAY COUNTY HOSPITAL 157320 99915 01/01/2004 0 N 0 7 00 7 00 Swing Beds - NF 8.00 8.00 9.00 Hospital-Based SNF 9.00 10.00 Hospital -Based NF 10.00 11.00 Hospital -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 16.00 Hospital -Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 17. 10 Hospi tal -Based (CORF) I 17.10 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 10/01/2017 02/28/2018 20.00 21.00 Type of Control (see instructions) 21.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate 22.00 Ν 22.00 share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y' for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost 22 01 22 01 N Ν reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N"

for no for the portion of the cost reporting period occurring on or after October 1.

Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes

or "N" for no, for the portion of the cost reporting period prior to October 1. Enter

of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with

22.03 Did this hospital receive a geographic reclassification from urban to rural as a result

23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column

42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.

"Y" for yes or "N" for no, for the portion of the cost reporting period on

	1, enter 1 if date of admission, 2 if census days, o	r 3 if date	e of discha	rge. Is the	:			
	method of identifying the days in this cost reportin	g period di	fferent fr	om the meth	iod			
	used in the prior cost reporting period? In column	2, enter "Y	" for yes	or "N" for	no.			
		In-State	In-State	Out-of	Out-of	Medi cai d	d Other	
		Medi cai d	Medi cai d	State	State	HMO days	s Medicaid	
		pai d days	eligible	Medi cai d	Medi cai d		days	
			unpai d	paid days	eligible			
			days		unpai d			
		1.00	2. 00	3. 00	4. 00	5. 00	6. 00	1
24. 00	If this provider is an IPPS hospital, enter the	0	0	0	0		0 0	24.00
	in-state Medicaid paid days in column 1, in-state							
	Medicaid eligible unpaid days in column 2,							
	out-of-state Medicaid paid days in column 3,							
	out-of-state Medicaid eligible unpaid days in column							
	4, Medicaid HMO paid and eligible but unpaid days in							
	column 5, and other Medicaid days in column 6.							
25.00	If this provider is an IRF, enter the in-state	0	0	0	0		0	25.00
	Medicaid paid days in column 1, the in-state							
	Medicaid eligible unpaid days in column 2,							
	out-of-state Medicaid days in column 3, out-of-state							
	Medicaid eligible unpaid days in column 4, Medicaid							
	HMO paid and eligible but unpaid days in column 5.							

22. 02

22.03

23.00

Ν

Ν

N

Ν

Ν

(see instructions)

or after October 1.

in column 2,

22 02

	AL AND HOSPITAL HEALTH CARE COMPI	EX IDENTIFICATION DA	λΤΑ	Provi der Co	CN: 15-1320	Peri od: From 10/01/2017	Worksheet S-2 Part I	
						To 02/28/2018	Date/Time Pre 7/30/2018 12:	pared: 58 pm
			Y/N	IME	Direct GME	I ME	Direct GME	
			1. 00	2. 00	3. 00	4. 00	5. 00	
61. 05	Enter the number of unweighted p surgery allopathic and/or osteop current cost reporting period. (s Enter the difference between the and/or general surgery FTEs and	athic FTEs in the ee instructions). baseline primary the current year's						61. 04
61. 06	primary care and/or general surg 61.04 minus line 61.03). (see in Enter the amount of ACA §5503 aw used for cap relief and/or FTEs care or general surgery. (see in	structions) ard that is being that are nonprimary						61.06
		, , , , , , , , , , , , , , , , , , , ,	Pro	gram Name	Program Cod	e Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
				1. 00	2. 00	3. 00	4. 00	
	Of the FTEs in line 61.05, speci specialty, if any, and the numbe for each new program. (see instr column 1, the program name. Ente program code. Enter in column 3, unweighted count. Enter in colum FTE unweighted count.	r of FTE residents uctions) Enter in r in column 2, the the IME FTE				0.00	0.00	61. 10
51. 20	Of the FTEs in line 61.05, speci program specialty, if any, and t residents for each expanded prog instructions) Enter in column 1, Enter in column 2, the program c 3, the IME FTE unweighted count. the direct GME FTE unweighted co	ne number of FTE ram. (see the program name. ode. Enter in column Enter in column 4,				0. 00	0. 00	61. 20
							1. 00	
62.00	ACA Provisions Affecting the Hea Enter the number of FTE resident your hospital received HRSA PCRE	s that your hospital	trai ned			eriod for which	0.00	62.00
62. 01	Enter the number of FTE resident during in this cost reporting pe	s that rotated from a riod of HRSA THC pro	a Teachi gram. (s	ee instructio		to your hospital	0.00	62. 01
	Teaching Hospitals that Claim Re Has your facility trained reside "Y" for yes or "N" for no in col	nts in nonprovider se	ettings	during this o			N	63.00
		you, ounpre			Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col. 2))	
					1.00	2. 00	3. 00	
	Section 5504 of the ACA Base Yea				-This base ye	ar is your cost	reporti ng	
			period that begins on or after July 1, 2009 and before June 30, 2010.  64.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio					
64. 00	in the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in yo	tations occurring in number of unweighted ur hospital. Enter in	all non d non-pr n column	imary care 3 the ratio				
64. 00	in the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the	tations occurring in number of unweighted ur hospital. Enter in	all non d non-pr n column instruc	imary care 3 the ratio	Unwei ghted FTEs Nonprovi der Si te	FTEs in	Ratio (col. 3/ (col. 3 + col. 4))	

	1)): (See The Clastic Grey)				
		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider?	Υ			70.00
	Enter "Y" for yes or "N" for no.				
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most	N	N	0	71.00
	recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see				
	42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching				
	program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no.				
	Column 3: If column 2 is Y, indicate which program year began during this cost reporting period.				
	(see instructions)				
	Inpatient Rehabilitation Facility PPS				
	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF	N			75.00
	subprovider? Enter "Y" for yes and "N" for no.				

alth Financial Systems JAY COUNTY HOSPIT				of Form CN	
OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	ovider CCN: 15-1320	Period: From 10/01/	2017	Worksheet S Part I	
		To 02/28/		Date/Time F 7/30/2018 1	
o.00   If line 75 is yes: Column 1: Did the facility have an approved GM	E teaching program i	n the most	1. 00	2.00 3.0	
recent cost reporting period ending on or before November 15, 200	4? Enter "Y" for yes	or "N" for			70.
no. Column 2: Did this facility train residents in a new teaching CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Colu					
indicate which program year began during this cost reporting peri					
Long Term Care Hospital PPS				1. 00	
1. 00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and	"N" for no.		T	N	80.
.00 Is this a LTCH co-located within another hospital for part or all	of the cost reporti	ng period? E	nter	N	81.
"Y" for yes and "N" for no. TEFRA Providers					
Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFR	A? Enter "Y" for ye	s or "N" for	no.	N	85.
0.00 Did this facility establish a new Other subprovider (excluded uni	t) under 42 CFR Sect	i on			86.
§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.  '.00 Is this hospital an extended neoplastic disease care hospital cla	ssified under sectio	n		N	87.
1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.					
		1. 00		2. 00	_
Title V and XIX Services		1.00		2.00	
.00 Does this facility have title V and/or XIX inpatient hospital ser	vices? Enter "Y" for	N		Υ	90
yes or "N" for no in the applicable column.  .00 Is this hospital reimbursed for title V and/or XIX through the co	st renort either in	N		Υ	91
full or in part? Enter "Y" for yes or "N" for no in the applicabl				•	' '
.00 Are title XIX NF patients occupying title XVIII SNF beds (dual ce				N	92
instructions) Enter "Y" for yes or "N" for no in the applicable c 00 Does this facility operate an ICF/IID facility for purposes of ti		N		N	93
"Y" for yes or "N" for no in the applicable column.	tro v ana xrx. Enter				/ 0
.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "	N" for no in the	N		N	94
applicable column.  .00 If line 94 is "Y", enter the reduction percentage in the applicab	le column.	0.00		0. 00	95
.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "		N		N	96
applicable column.  .00   If line 96 is "Y", enter the reduction percentage in the applicab	lo column	0.00		0. 00	97
.00 Does title V or XIX follow Medicare (title XVIII) for the interns		V Y		V. 00	98
stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for ye	s or "N" for no in				
column 1 for title V, and in column 2 for title XIX.  .01 Does title V or XIX follow Medicare (title XVIII) for the reporti	ng of charges on Wks	t. Y		Υ	98
C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V				•	/0
title XIX.	6			.,	
.02 Does title V or XIX follow Medicare (title XVIII) for the calcula bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N"		Y		Υ	98
for title V, and in column 2 for title XIX.	70. 110 111 001 41111 1				
.03 Does title V or XIX follow Medicare (title XVIII) for a critical				N	98
reimbursed 101% of inpatient services cost? Enter "Y" for yes or for title V, and in column 2 for title XIX.	N TOL HO TH COLUMN	1			
.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimb		, N		N	98
outpatient services cost? Enter "Y" for yes or "N" for no in colu in column 2 for title XIX.	mn 1 for title V, an	d			
.05 Does title V or XIX follow Medicare (title XVIII) and add back th	e RCE disallowance o	n Y		Υ	98
Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column	1 for title V, and	i n			
column 2 for title XIX.  .06 Does title V or XIX follow Medicare (title XVIII) when cost reimb	ursed for Wkst D	Y		Υ	98
Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 fo					
column 2 for title XIX.					
Rural Providers  5.00 Does this hospital qualify as a CAH?		Y			105
$6.00 \mathrm{lf}$ this facility qualifies as a CAH, has it elected the all-inclu	sive method of payme				106
for outpatient services? (see instructions)	hursoment for LOD	NI NI			107
If this facility qualifies as a CAH, is it eligible for cost reim training programs? Enter "Y" for yes or "N" for no in column 1. (		N N			107
yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 a					
reimbursed. If yes complete Wkst. D-2, Pt. II.	foo schodulo? Soc 4	2   N			108
8.00 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.	ree scriedule: see 4	2 N			108

All Providers

HOSPITAL AND HOSPITAL HEALTH CARE COMPLE		NTY HOSPITAL Provider (	CCN: 15-1320	Peri oc	l:	u of Form CMS Worksheet S-	
					0/01/2017 02/28/2018	Part I Date/Time Pr 7/30/2018 12	
40.00 Are there any related organization chapter 10? Enter "Y" for yes or 'are claimed, enter in column 2 the	'N" for no in column 1.	If yes, and hom	e office cos		1. 00 Y	2.00	140.0
1.00		2. 00			3. 00		
If this facility is part of a characteristic office and enter the home office			ough 143 th	e name a	nd address	of the home	
11.00 Name: 12.00 Street:	Contractor's Name PO Box:		Contra	ctor's N	umber:		141. 142.
13. 00 Ci ty:	State:		Zi p Co	de:			143. (
						1. 00	+
4.00 Are provider based physicians' cos	sts included in Workshe	eet A?				Υ Υ	144.
45.00  f costs for renal services are cl	aimed on Wkst A line	2 74 are the cos	ts for		1. 00	2. 00	145. (
inpatient services only? Enter "Y' no, does the dialysis facility ind period? Enter "Y" for yes or "N" 46.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in	'for yes or "N" for no clude Medicare utilizat for no in column 2. gy changed from the pro n column 1. (See CMS Pu	o in column 1. If tion for this cos eviously filed co	column 1 is treporting ost report?		N		146. (
yes, enter the approval date (mm/o	da/yyyy) iii cordiiii 2.					1. 00	
17.00Was there a change in the statisti	cal basis? Enter "Y" 1	for yes or "N" fo	or no.			N	147.
8.00 Was there a change in the order of				_		N	148.
9.00 Was there a change to the simplifi	ed cost finding method	Part A	yes or "N" 1 Part B		Γitle V	N Title XIX	149.
		1.00	2. 00		3. 00	4. 00	1
Does this facility contain a provi or charges? Enter "Y" for yes or							
55. 00 Hospi tal	11 101 110 101 00011 001	N N	N N	. (555	N N	N	155.
56.00 Subprovi der - IPF		N	N		N	N	156.
57.00 Subprovi der – IRF 58.00 SUBPROVI DER		N	N		N	N	157. 158.
59. 00 SNF		N	N		N	N	159.
60. 00 HOME HEALTH AGENCY		N	N		N	N	160.
51.00CMHC 51.10CORF			N N		N N	N N	161. 161.
JI. IOCONI			IV.		IN		101.
Mul ti campus						1. 00	
65.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that has	s one or more can	puses in dit	ferent (	CBSAs?	N	165. (
	Name	County		Zip Code		FTE/Campus	4
66.00 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)	0	1.00	2.00	3.00	4.00	5. 00 0. 0	00 166. (
						1. 00	
Health Information Technology (HI						Υ	117
of 00 is this provider a meaningful user of 08 00 if this provider is a CAH (line 10 reasonable cost incurred for the l	D5 is "Y") and is a mea	aningful user (li	ne 167 is "\	/"), ente	er the	Y	167. 0168.
8.01 If this provider is a CAH and is a	not a meaningful user,	does this provid			rdshi p		168.
exception under §413.70(a)(6)(ii) 69.00 If this provider is a meaningful under transition factor. (see instruction	PEnter "Y" for yes or user (line 167 is "Y")	"N" for no. (see	instruction	ns)		0. (	00169.
transition ractor. (See Tristfuction	ліз)			Ве	egi nni ng	Endi ng	
					1. 00	2. 00	
70.00 Enter in columns 1 and 2 the EHR I					/01/2016	09/30/2017	170.

Health Financial Systems JAY	In Lieu	of Form CM	MS-2552-10			
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA					Worksheet	S-2
			_	From 10/01/2017		D
				o 02/28/2018	7/30/2018	
				1. 00	2. 00	
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in						0 171. 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)						

SPI T	Financial Systems JAY COUNTY I AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der Co		Period: From 10/01/2017 To 02/28/2018	7/30/2018 12:	2 epared:
				Y/N 1. 00	Date 2.00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	for all NO re	esponses. Ente			
00	Provider Organization and Operation Has the provider changed ownership immediately prior to the	hogi ppi pg. of	the cost	N		1.00
00	reporting period? If yes, enter the date of the change in c	olumn 2. (see	instructions			1.00
			Y/N	Date	V/I	
			1.00	2. 00	3. 00	
00	Has the provider terminated participation in the Medicare P yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary. Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home o	n 3, "V" for g management ffices, drug	N N			3.00
	or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members o of directors through ownership, control, or family and othe relationships? (see instructions)	f the board	VAL		D. I	
			Y/N 1.00	7ype 2. 00	3. 00	
	Financial Data and Reports		1.00	2.00	3.00	
00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	or Compiled,	N	А	10/01/2018	4.00
00	Are the cost report total expenses and total revenues diffe		N			5.00
	those on the filed financial statements? If yes, submit rec	onciliation.		Y/N	Logal Open	
				1.00	Legal Oper. 2.00	
	Approved Educational Activities				2.00	
00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?		ne provider i			6.00
00	Are costs claimed for Allied Health Programs? If "Y" see instructions.  Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.					7. 00 8. 00
00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated o	S.		N N		9.00
. 00	was an approved filtern and resident GME program in trated of cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I			N		11.00
. 00	Teaching Program on Worksheet A? If yes, see instructions.	a k ili ali Api		IV.	Y/N	11.00
	Dad Dahta				1. 00	
	Bad Debts Is the provider seeking reimbursement for bad debts? If yes	see instruc	tions		N	12.00
	If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			ost reporting	N	13.00
. 00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	nts waived? I	fyes, see in	structions.	N	14.00
5. 00	Did total beds available change from the prior cost reporti		yes, see ins t A	tructi ons. Par	N t B	15.00
		Y/N	Date	Y/N	Date	
		1. 00	2. 00	3. 00	4. 00	
	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see	Y	07/17/2018	Y	07/17/2018	16.00
. 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	N		N		17. 00
. 00	in columns 2 and 4. (see instructions)  If line 16 or 17 is yes, were adjustments made to PS&R  Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18. 00
9. 00	If line 16 or 17 is yes, see Instructions.  Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19. 00

	inancial Systems JAY COUNTY				u of Form CM	
HOSPITAL	L AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider (	CCN: 15-1320	Period: From 10/01/2017 To 02/28/2018		repared:
			i pti on	Y/N	Y/N	
00.00.1	C. L		0	1.00	3.00	00.00
	f 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	
	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1. 00	
	OMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS	HOSPI TALS)			
_	apital Related Cost				N	
23. 00 H	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost					22. 00 23. 00
24.00 W	eporting period? If yes, see instructions. Were new leases and/or amendments to existing leases entere f yes, see instructions	ed into during	this cost r	eporting period?	N	24. 00
25. 00 H	laye there been new capitalized leases entered into during instructions.	the cost repo	rting period	? If yes, see	N	25. 00
26. 00 W	Here assets subject to Sec. 2314 of DEFRA acquired during the nstructions.	ne cost report	ing period?	If yes, see	N	26. 00
27. 00 H	las the provider's capitalization policy changed during the copy.	e cost reporti	ng period? I	f yes, submit	N	27. 00
28. 00 W	nterest Expense Were new Loans, mortgage agreements or Letters of credit er	ntered into du	ring the cos	t reporting	N	28. 00
29. 00 D	period? If yes, see instructions. Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund)				Y	29. 00
30. 00 H						30.00
31.00 H	Instructions.  Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.					31.00
	urchased Services					
	Have changes or new agreements occurred in patient care ser arrangements with suppliers of services? If yes, see instru		ed through c	ontractual	N	32.00
33. 00	fline 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.		ng to compet	itive bidding? I1	N	33.00
	rovi der-Based Physi ci ans					
	Are services furnished at the provider facility under an ar f yes, see instructions.	rrangement wit	n provider-b	ased physicians?	Y	34.00
35. 00 I	fline 34 is yes, were there new agreements or amended exi physicians during the cost reporting period? If yes, see in		nts with the	provi der-based	N	35.00
				Y/N	Date	
lu.	ama Offi aa Caata			1. 00	2. 00	
	ome Office Costs  Vere home office costs claimed on the cost report?			N		36.00
	fline 36 is yes, has a home office cost statement been pr	repared by the	home office			37.00
	f yes, see instructions. f line 36 is yes , was the fiscal year end of the home off	fice different	from that o	f N		38.00
39. 00 I	the provider? If yes, enter in column 2 the fiscal year end fline 36 is yes, did the provider render services to othe			s, N		39.00
40. 00 I	see instructions.  fline 36 is yes, did the provider render services to the	home office?	If yes, see	N		40.00
1	nstructions.	1	00	2	00	
C	ost Report Preparer Contact Information	1.	00	2.	00	
41. 00 E	Enter the first name, last name and the title/position neld by the cost report preparer in columns 1, 2, and 3,	TI NA		SEVERS		41.00
	respecti vel y.					ll l
42. 00 E	Enter the employer/company name of the cost report preparer.	BLUE & CO., LI	_C			42.00

Health Financial Systems JAY COU	NTY HOSPITAL	In Lieu of Form CMS-2552-10			
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der CCN: 15-1320	Peri od:   Worksheet S-   From 10/01/2017   Part II     To 02/28/2018   Date/Time Pri 7/30/2018   12	repared:		
		77 967 28 18 11	, 00 p		
	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	ı				
respecti vel y.					
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 cos	t		43.00		
report preparer in columns 1 and 2, respectively.			1		

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

					1	To 02/28/2018	Date/Time Pre 7/30/2018 12:	
							1/P Days /	JO PIII
							0/P Visits /	
							Tri ps	
	Component	Worksheet A	No	o. of Beds	Bed Days	CAH Hours	Title V	
		Line Number			Avai I abl e			
1 00		1. 00		2. 00	3.00	4.00	5. 00	1.00
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		25	3, 775	21, 888. 00	0	1.00
	8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2							
	for the portion of LDP room available beds)							
2. 00	HMO and other (see instructions)							2.00
3. 00	HMO IPF Subprovider		ŀ					3.00
4. 00	HMO IRF Subprovider		ŀ					4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF		ŀ				0	
6. 00	Hospital Adults & Peds. Swing Bed NF						o o	
7. 00	Total Adults and Peds. (exclude observation			25	3, 775	21, 888. 00	0	7.00
	beds) (see instructions)					,		
8.00	INTENSIVE CARE UNIT	31. 00		0	(	0.00	0	8.00
9.00	CORONARY CARE UNIT							9. 00
10.00	BURN INTENSIVE CARE UNIT	33.00		0	(	0.00	0	10.00
11.00	SURGICAL INTENSIVE CARE UNIT							11.00
12.00	OTHER SPECIAL CARE (SPECIFY)							12.00
13.00	NURSERY	43. 00					0	
14.00	Total (see instructions)			25	3, 775	21, 888. 00	0	
15.00	CAH visits	40.00		4.0			0	
16.00	SUBPROVIDER - I PF	40.00		10			0	16.00
17. 00 18. 00	SUBPROVI DER - I RF SUBPROVI DER	41. 00 42. 00		0	(	1	0	17. 00 18. 00
19.00	SKILLED NURSING FACILITY	42.00		U	(		0	19.00
20. 00	NURSING FACILITY							20.00
21. 00	OTHER LONG TERM CARE							21.00
22. 00	HOME HEALTH AGENCY							22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)							23.00
24. 00	HOSPI CE							24. 00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25.00	CMHC - CMHC							25. 00
25. 10	CMHC - CORF	99. 10					0	25. 10
26.00	RURAL HEALTH CLINIC	88. 00					0	26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27.00	Total (sum of lines 14-26)			35				27.00
28. 00	Observation Bed Days						0	
29. 00								29. 00
30.00	Employee discount days (see instruction)							30.00
31.00					,			31.00
32. 00	Labor & delivery days (see instructions)			0	(	ן		32.00
32. 01	Total ancillary labor & delivery room							32. 01
33. 00	outpatient days (see instructions) LTCH non-covered days		1					33.00
	LTCH site neutral days and discharges							33.00
55. 51	12.5 5. to flower at adys and at solid ges		ı		I	I	I	1 30.01

Health Financial Systems JAY O Provider CCN: 15-1320 Peri od: Worksheet S-3 From 10/01/2017 Part I To 02/28/2018 Date/Time Prepared:

				'	0 02, 20, 20.0	7/30/2018 12:	58 pm
	·	I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
				•		'	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	372	16	912	2		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)	54	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	99	0	99			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	41			6.00
7.00	Total Adults and Peds. (exclude observation	471	16	1, 052	2		7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	0	0	(			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT	0	0	(			10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0	92	2		13.00
14.00	Total (see instructions)	471	16	1, 144	0.00	296. 16	14.00
15.00	CAH vi si ts	o	O	(			15.00
16.00	SUBPROVIDER - IPF	262	21	462	0.00	14. 31	16.00
17.00	SUBPROVIDER - IRF	o	0		0.00	0.00	17.00
18.00	SUBPROVI DER		0		0.00	0.00	18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24. 00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)	0	0	(			24. 10
25. 00	CMHC - CMHC	Ĭ	Ŭ.	Ì			25.00
25. 10	CMHC - CORF	0	0	(	0.00	0.00	
26. 00	RURAL HEALTH CLINIC	0	0			<b>l</b>	
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0				
27. 00	Total (sum of lines 14-26)	١	O.		0.00		
28. 00	Observation Bed Days		0	120		010.17	28.00
29. 00	Ambulance Trips	0	O <sub>1</sub>	120			29.00
30.00	Employee discount days (see instruction)	١					30.00
31. 00	Employee discount days (see Fristraction)						31.00
32. 00	Labor & delivery days (see instructions)	0	0		1		32.00
32. 00	Total ancillary labor & delivery room	١	o I		á		32.00
JZ. U1	outpatient days (see instructions)				Ί		32.01
33. 00	LTCH non-covered days	0					33.00
	LTCH site neutral days and discharges						33.00
55.01	121011 of to floati at days and at solidinges	١	ļ	I	1	Į.	1 33.01

| Peri od: | Worksheet S-3 | From 10/01/2017 | Part I | To 02/28/2018 | Date/Time Prepared:

				10	02/28/2018	7/30/2018 12:	
		Full Time		Di sch	arges		
		Equi val ents			Ŭ		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13. 00	14.00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	133	8	308	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)			15	0		2. 00
3. 00	HMO IPF Subprovi der				0		3. 00
4. 00	HMO IRF Subprovider				0		4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8.00
9. 00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGI CAL INTENSI VE CARE UNI T						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY			400			13.00
14.00	Total (see instructions)	0.00	0	133	8	308	
15.00	CAH visits	0.00		20			15.00
16.00	SUBPROVIDER - I PF	0.00	0	30	2	68	
17. 00	SUBPROVIDER - I RF	0.00	0	U	0	0	17.00
18. 00 19. 00	SUBPROVI DER	0.00	U		U	U	18. 00 19. 00
20. 00	SKILLED NURSING FACILITY NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21.00
21.00	HOME HEALTH AGENCY						22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )						23.00
24. 00	HOSPICE						24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25. 00
25. 10	CMHC - CORF	0.00					25. 10
26. 00	RURAL HEALTH CLINIC	0.00					26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27. 00	Total (sum of lines 14-26)	0.00					27.00
28. 00	Observation Bed Days	0.00					28.00
29. 00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days - IRF						31.00
32. 00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
32.31	outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
	LTCH site neutral days and discharges			0			33. 01
	,						

	Financial Systems  TAL UNCOMPENSATED AND INDIGENT CARE DATA  JAY COUNTY HOSP F	rovider CCN: 15-132		eu of Form CMS- Worksheet S-1	
USFII	AL UNCOMPENSATED AND THOUGHT CARE DATA	TOVICE CCN. 15-152	From 10/01/201		10
			To 02/28/201	8 Date/Time Pre 7/30/2018 12:	epared 58 pm
				1.00	
	Uncompensated and indigent care cost computation			11.00	
. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	ided by line 202 c	olumn 8)	0. 299884	1.0
	Medicaid (see instructions for each line)				
. 00	Net revenue from Medicaid			2, 013, 156	
00	Did you receive DSH or supplemental payments from Medicaid?				3.
. 00	If line 3 is yes, does line 2 include all DSH and/or supplement		edi cai d?		4.
. 00 . 00	If line 4 is no, then enter DSH and/or supplemental payments fr	om wedicald		11 420 951	1
. 00	Medicaid charges Medicaid cost (line 1 times line 6)			11, 629, 851 3, 487, 606	
. 00	Difference between net revenue and costs for Medicaid program (	line 7 minus sum o	flines 2 and 5 i		•
. 00	<pre>&lt; zero then enter zero)</pre>	TTTIC 7 IIII TIGO SGIII O	i iiilos 2 ana 0, i	1, 1, 1, 1,	] ".
	Children's Health Insurance Program (CHIP) (see instructions fo	r each line)		•	
. 00	Net revenue from stand-alone CHIP			0	1
	Stand-alone CHIP charges			0	1
1.00	Stand-alone CHIP cost (line 1 times line 10)		0.16	0	
2. 00	,	line 11 minus line	9; if < zero then	0	12.
	<pre>enter zero) Other state or local government indigent care program (see inst</pre>	ructions for each	lino)		
3. 00	Net revenue from state or local indigent care program (Not incl			T 0	13.
	Charges for patients covered under state or local indigent care				1
. 00	10)	program (Not There	adea iii iiiles e ei		1
5. 00	1 (	)		0	15.
5. 00	Difference between net revenue and costs for state or local ind	igent care program	(line 15 minus li	ne 0	16.
	13; if < zero then enter zero)				
	Grants, donations and total unreimbursed cost for Medicaid, CHI instructions for each line)	P and state/local	indigent care prog	rams (see	
7. 00	Private grants, donations, or endowment income restricted to fu	nding charity care		0	17.
	Government grants, appropriations or transfers for support of h			0	18.
9. 00	Total unreimbursed cost for Medicaid, CHIP and state and local 8, 12 and 16)	indigent care pro	grams (sum of line	s 1, 474, 450	19.
	,	Uni nsu	red Insured	Total (col. 1	
		pati er		+ col . 2)	
		1.00	2.00	3. 00	
0. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire fac	ility 22	8, 573	0 228, 573	20.
). 00	(see instructions)	111119   22	.0, 575	220, 373	20.
1. 00	Cost of patients approved for charity care and uninsured discou	nts (see 6	8, 545	0 68, 545	21.
	instructions)		,		
2. 00	Payments received from patients for amounts previously written	off as	0	0 0	22.
	charity care				
3. 00	Cost of charity care (line 21 minus line 22)		8, 545	0 68, 545	23.
				1. 00	
1. 00	Does the amount on line 20 column 2, include charges for patien	t davs bevond a Le	ngth of stav limit		24.
	imposed on patients covered by Medicaid or other indigent care		3		
5. 00	If line 24 is yes, enter the charges for patient days beyond the stay limit	e indigent care pr	ogram's length of	0	25.
5. 00	Total bad debt expense for the entire hospital complex (see ins	tructions)		0	26.
7. 00	Medicare reimbursable bad debts for the entire hospital complex	•	)		
7. 01	Medicare allowable bad debts for the entire hospital complex (s	,	,	Ö	1
8.00				0	1
9. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt exp	ense (see instruct	i ons)	0	1
0. 00	Cost of uncompensated care (line 23 column 3 plus line 29)			68, 545	
		ne 30)		1, 542, 995	

	Financial Systems	JAY COUNTY H		ON 15 1220		u of Form CMS-2	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der C		Period: From 10/01/2017	Worksheet A	
				7	To 02/28/2018	Date/Time Pre 7/30/2018 12:	
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cat	Reclassified	oo piii
	, , , , , , , , , , , , , , , , , , ,			+ col . 2)	ions (See	Trial Balance	
					A-6)	(col. 3 +-	
		1. 00	2.00	3. 00	4.00	col . 4) 5.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	0.00	1. 00	0.00	
2. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP		784, 872			784, 872	2.00
2. 01	00201 NEW CAP REL COSTS-MVBLE EQUIP MOB		5, 880			5, 880	2. 01
2. 02 2. 03	00202 NEW CAP REL COSTS-MVBLE EQUI P-POB 00203 NEW CAP REL COSTS-MVBLE EQUI P- WJ		42, 479 0	42, 479		42, 479 0	2. 02 2. 03
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	2, 633, 239	2, 633, 239	o o	2, 633, 239	4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	842, 721	2, 302, 465			3, 145, 186	5. 00
7. 00 7. 01	00700 OPERATION OF PLANT 00701 OPERATION OF PLANT-MOB	115, 592 0	391, 436 21, 095			506, 198 21, 395	7. 00 7. 01
7. 01	00701 OPERATION OF PLANT-NOB	0	38, 197			38, 526	7.01
7. 03	00703 OPERATION OF PLANT-WJ	0	0	(	201	201	7. 03
8. 00	00800 LAUNDRY & LINEN SERVICE	22, 269	20, 953	1		43, 222	8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	158, 765 145, 340	29, 233 131, 612	l .		187, 998 163, 378	9. 00 10. 00
11. 00	01100 CAFETERI A	0	131, 012	270, 752		113, 574	11.00
13.00	01300 NURSING ADMINISTRATION	427, 279	906	428, 185		428, 185	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	27, 752	4, 122	1		31, 874	14.00
16. 00	01600 MEDICAL RECORDS & LIBRARY I NPATIENT ROUTINE SERVICE COST CENTERS	142, 461	14, 906	157, 367	/  0	157, 367	16.00
30. 00	03000 ADULTS & PEDIATRICS	622, 207	74, 635	696, 842	-64, 121	632, 721	30.00
31. 00	03100 INTENSIVE CARE UNIT	0	0	(	0	0	31.00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0	247.440	0	0	33.00
40. 00 41. 00	04000   SUBPROVI DER -   PF   04100   SUBPROVI DER -   RF	314, 142	53, 303 0	367, 445	0	367, 445 0	40. 00 41. 00
42. 00	04200 SUBPROVI DER	o	0		o o	Ö	42.00
43.00	04300 NURSERY	0	0	(	51, 144	51, 144	43.00
F0 00	ANCILLARY SERVICE COST CENTERS	227 270	20/ 020	(22.20	7	/22 207	FO 00
50. 00 52. 00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	336, 369 0	296, 838 0	633, 207		633, 207 12, 977	50. 00 52. 00
53. 00	05300 ANESTHESI OLOGY	O	377, 341	1		377, 341	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	331, 070	274, 236	605, 306	0	605, 306	54.00
57. 00	05700 CT SCAN	0	0		0	0	57.00
58. 00 59. 00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	0	0			0	58. 00 59. 00
60.00	06000 LABORATORY	252, 819	432, 755	685, 574	i o	685, 574	60.00
60. 01	06001 BLOOD LABORATORY	0	0	(	0	0	60. 01
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	474, 253 279, 546			474, 253 279, 546	65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	279, 540	279, 540	0	279, 540	67.00
68. 00	06800 SPEECH PATHOLOGY	0	0		0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	79, 055	81, 287	160, 342	0	160, 342	69.00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	71. 00 72. 00
	07300 DRUGS CHARGED TO PATIENTS	189, 507	824, 774	1, 014, 28			1
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0	(	0	0	88.00
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0 116	41, 543	41, 659		0 41, 659	89. 00 90. 00
90. 01	09001 FAMILY PRACTICE OF JAY COUNTY	684, 208	116, 944			801, 152	90. 01
90. 02	09002 JAY FAMILY MEDICINE	764, 978	82, 106			847, 084	
91.00	09100 EMERGENCY	933, 457	207, 697	1, 141, 154	0	1, 141, 154	
92. 00 93. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) 04040 OTHER OUTPATIENT SERVICE COST CENTER	881	8, 627	9, 508	0	9, 508	92. 00 93. 00
73. 00	OTHER REIMBURSABLE COST CENTERS	001	0,027	7, 300	<u>,                                      </u>	7, 300	73.00
99. 10	09910 CORF	0	0	(	0	0	99. 10
104 00	SPECIAL PURPOSE COST CENTERS 10600 HEART ACQUISITION	٥	0			0	106. 00
	10900 PANCREAS ACQUISITION	0	0		0		106.00
	11000 INTESTINAL ACQUISITION	0	0		o o		110.00
	11100 ISLET ACQUISITION	0	0	(	0		111.00
113. 00 118. 00	11300 INTEREST EXPENSE	4 200 000	10 047 200	14 420 24	0		113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)     NONREIMBURSABLE COST CENTERS	6, 390, 988	10, 047, 280	16, 438, 268	3  0	16, 438, 268	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(	0	0	190.00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	(	0		192. 00
	19300   NONPAI D WORKERS   07950   MOB	0	0		0		193. 00 194. 00
	07951 POB	0	0		) 0		194.00
194. 02	07952 WEST JAY CLINIC	244, 298	27, 702	272, 000	o o	272, 000	194. 02
	07953 CONVENIENT CARE	126, 845	2, 727	1		129, 572	194. 03
	07954 OTHER NONREIMBURSABLE COST CENTERS 07955 OTHER NONREIMBURSABLE COST CENTERS	0	0		-		194. 04 194. 05
174.00	POTTON TO THE TOTAL THE PROPERTY OF THE POTTON TENTENCE	<u> </u>		1	, 0	<u> </u>	1. / 1. 00

Health Financial Systems	JAY COUNTY	HOSPI TAL		In Lieu of Form CMS-2552-10			
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	F EXPENSES	Provi der Co		eri od:	Worksheet A		
		_	rom 10/01/2017 o 02/28/2018	Date/Time Pre 7/30/2018 12:	pared: 58 pm_		
Cost Center Description	Sal ari es	0ther	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. 06 07956 TRI COUNTY	109, 360	504, 836	614, 196	0	614, 196	194.06	
194. 07 07957 HOSPI TALI ST	179, 481	32, 895	212, 376	0	212, 376	194. 07	
194.08 07958 FAMILY FIRST HEALTH	377, 422	47, 995	425, 417	0	425, 417	194. 08	
194. 09 07959 MERIDIAN HEALTH CONVENIENT CARE	0	0	C	0	0	194. 09	
200.00   TOTAL (SUM OF LINES 118 through 199)	7, 428, 394	10, 663, 435	18, 091, 829	0	18, 091, 829	200. 00	

Peri od: From 10/01/2017 To 02/28/2018 Date/Time Prepared: 7/30/2018 12:58 pm

				7/30/2018 12: 58 p	om_
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For		
		/ 00	Allocation		
	GENERAL SERVICE COST CENTERS	6. 00	7. 00		
2. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP	-24, 960	759, 912	2	. 00
2. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP MOB	-24, 700	5, 880		. 01
2. 02	00202 NEW CAP REL COSTS MVBLE EQUIP-POB	o o	42, 479	1	. 02
2. 03	00203 NEW CAP REL COSTS-MVBLE EQUIP- WJ	o o	0		. 03
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	-846, 016	1, 787, 223		. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	-852, 239	2, 292, 947		. 00
7. 00	00700 OPERATION OF PLANT	0	506, 198	1	. 00
7. 01	00701 OPERATION OF PLANT-MOB	0	21, 395	1	. 01
7.02	00702 OPERATION OF PLANT-POB	0	38, 526		. 02
7.03	00703 OPERATION OF PLANT-WJ	0	201	7.	. 03
8.00	00800 LAUNDRY & LINEN SERVICE	0	43, 222		. 00
9.00	00900 HOUSEKEEPI NG	0	187, 998	9.	. 00
10.00	01000 DI ETARY	0	163, 378		. 00
11. 00	01100 CAFETERI A	-76, 244	37, 330	1	. 00
13. 00	01300 NURSING ADMINISTRATION	-6, 201	421, 984	1	. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	31, 874	1	. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	-4, 124	153, 243	16.	. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	(22, 721	20	00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	0	632, 721 0		. 00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0		. 00
40.00	04000 SUBPROVI DER - I PF	0	367, 445		. 00
41. 00	04100 SUBPROVI DER - I RF	0	307, 443		. 00
42. 00	04200 SUBPROVI DER	o o	0	1	. 00
43. 00	04300 NURSERY	ő	51, 144	1	. 00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	-48, 000	585, 207	50.	. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	12, 977	52.	. 00
53.00	05300 ANESTHESI OLOGY	-377, 341	0	53.	. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	605, 306	54.	. 00
57.00	05700 CT SCAN	0	0	57.	. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	1	. 00
60.00	06000 LABORATORY	-25, 000	660, 574	1	. 00
60. 01	06001 BLOOD LABORATORY	0	0	1	. 01
65. 00	06500 RESPI RATORY THERAPY	0	474, 253	1	. 00
66.00	06600 PHYSI CAL THERAPY	-7, 450	272, 096		. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		. 00
68.00	06800 SPEECH PATHOLOGY	0	145.075	1	. 00
69.00	06900 ELECTROCARDI OLOGY	-14, 367	145, 975	1	. 00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 MPL. DEV. CHARGED TO PATIENTS	0	0	1	. 00 . 00
73.00	07300 DRUGS CHARGED TO PATIENTS	-188, 119	826, 162	1	. 00
73.00	OUTPATIENT SERVICE COST CENTERS	-100, 117	020, 102	13.	. 00
88. 00	08800 RURAL HEALTH CLINIC	0	0	88	. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	Ö	0		. 00
	09000 CLI NI C	-30, 173	11, 486		. 00
90. 01	09001 FAMILY PRACTICE OF JAY COUNTY	-630, 863	170, 289		. 01
90. 02	09002 JAY FAMILY MEDICINE	-664, 752	182, 332		. 02
91.00	09100 EMERGENCY	-693, 748	447, 406		. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			92.	. 00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	9, 508	93.	. 00
	OTHER REIMBURSABLE COST CENTERS				
99. 10	09910 CORF	0	0	99.	. 10
	SPECIAL PURPOSE COST CENTERS				
	10600 HEART ACQUISITION	0	0		
	10900 PANCREAS ACQUISITION	0	0	109.	
	11000   NTESTINAL ACQUISITION	0	0	110.	
	11100  ISLET ACQUISITION   11300  INTEREST EXPENSE	0	0	111.	
		4 400 F07	11 040 471	113.	
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)   NONREIMBURSABLE COST CENTERS	-4, 489, 597	11, 948, 671	118.	. 00
100 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.	00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0	0	1	
	19300 NONPALD WORKERS		0	192.	
	07950 MOB	0	0	193.	
	07951   P0B		0	194.	
	07952 WEST JAY CLINIC	-270, 577	1, 423		
	07953 CONVENI ENT CARE	-87, 030	42, 542	1	
	07954 OTHER NONREIMBURSABLE COST CENTERS	0,7,000	0	l	
	07955 OTHER NONREIMBURSABLE COST CENTERS	0	0	1	
194.00	07956 TRI COUNTY	0	614, 196	194.	. 06
				·	

Health Financial Systems JAY COUNTY					In Lieu of Form CMS-2552-10				
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES		Provi der	CCN: 15-1	Peri od: From 10/01/2017 To 02/28/2018		Prepar		
Cost Center Description	Adjustments	Net	Expense	es .					

			7/30/2018 12:58 pm
Cost Center Description	Adjustments	Net Expenses	
	(See A-8)	For	
		Allocation	
	6. 00	7. 00	
194. 07 07957 HOSPI TALI ST	0	212, 376	194. 07
194.08 07958 FAMILY FIRST HEALTH	0	425, 417	194. 08
194.09 07959 MERIDIAN HEALTH CONVENIENT CARE	0	0	194. 09
200.00   TOTAL (SUM OF LINES 118 through 199)	-4, 847, 204	13, 244, 625	200.00

Health Financial Systems

RECLASSIFICATIONS

Provider CCN: 15-1320
Period: From 10/01/2017 To 02/28/2018 Date/Time Prepared:

					То	02/28/2018	Date/Time Pr   7/30/2018 12	
		Increases		·				
	Cost Center	Li ne #	Sal ary	0ther				
	2. 00	3. 00	4. 00	5. 00				
	A - NURSERY RECLASS							
1.00	NURSERY	43.00	4 <u>2, 9</u> 54	<u>8, 1</u> 90				1.00
	TOTALS		42, 954	8, 190				
	B - DEFAULT							
1. 00	DELIVERY ROOM & LABOR ROOM	<u>52.</u> 00	1 <u>1, 5</u> 46	<u>1, 4</u> 31				1.00
	TOTALS		11, 546	1, 431				
	C - CAFETERIA RECLASS							
1. 00	CAFETERI A	1100	5 <u>9, 6</u> 02	5 <u>3, 9</u> 72				1.00
	TOTALS		59, 602	53, 972				]
	D - MOB, POB, WEST JAY MAINT							
1. 00	OPERATION OF PLANT-MOB	7. 01	300	0				1.00
2. 00	OPERATION OF PLANT-POB	7. 02	329	0				2. 00
3. 00	OPERATION OF PLANT-WJ	7. 03	201	0	1			3. 00
	TOTALS		830	0				
500.00	Grand Total: Increases		114, 932	63, 593				500.00

Heal th Financial Systems

A COUNTY HOSPITAL

Provider CCN: 15-1320

Period: From 10/01/2017 To 02/28/2018 Date/Time Prepared:

						lo	02/28/2018   Date/lime Pr 7/30/2018 12	
		Decreases						
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.			
	6. 00	7. 00	8. 00	9. 00	10. 00			
	A - NURSERY RECLASS							
1.00	ADULTS & PEDIATRICS	30.00	42, 954	<u>8, 1</u> 90				1.00
	TOTALS		42, 954	8, 190				
	B - DEFAULT							
1.00	ADULTS & PEDIATRICS	30.00	11, 546	1, 431				1.00
	TOTALS		11, 546	1, 431				
	C - CAFETERIA RECLASS							
1.00	DI ETARY	10. 00	59, 602	5 <u>3, 9</u> 72				1.00
	TOTALS		59, 602	53, 972				
	D - MOB, POB, WEST JAY MAINT							
1.00	OPERATION OF PLANT	7. 00	830	0	C			1.00
2.00		0.00	0	0	C			2.00
3.00		0.00	0	0				3.00
	TOTALS		830	0				
500.00	Grand Total: Decreases		114, 932	63, 593				500.00

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS JAY COUNTY HOSPITAL

| Peri od: | Worksheet A-7 |
| From 10/01/2017 | Part |
| To 02/28/2018 | Date/Time Prepared: Provider CCN: 15-1320

				10	02/28/2018	7/30/2018 12:	
				Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1. 00	2. 00	3.00	4. 00	5. 00	
	RT I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1. 00 Lai		347, 733	0	0	0	0	1.00
4	nd Improvements	952, 332	0	0	0	0	2.00
	ildings and Fixtures	25, 416, 788	0	0	0	0	3.00
	ilding Improvements	0	0	0	0	0	4. 00
	xed Equipment	2, 464, 521	0	0	0	0	5.00
	vable Equipment	15, 071, 264	65, 321	0	65, 321	0	6. 00
	T designated Assets	0	0	0	0	0	7. 00
	btotal (sum of lines 1-7)	44, 252, 638	65, 321	0	65, 321	0	8. 00
	conciling Items	0	0	0	0	0	,,,,,
10. 00 To	tal (line 8 minus line 9)	44, 252, 638	65, 321	0	65, 321	0	10.00
		Endi ng	Fully				
		Bal ance	Depreciated				
		/ 00	Assets				
DAE	DT I ANALYCIC OF CHANGES IN CARLTAL ACCE	6.00	7. 00				
	RT I - ANALYSIS OF CHANGES IN CAPITAL ASSE						1 00
1. 00 Lai		347, 733	U				1.00
	nd Improvements	952, 332	U				2.00
4	ildings and Fixtures	25, 416, 788	U				3.00
	ilding Improvements	2 4/4 521	U				4.00
	xed Equipment	2, 464, 521	0				5.00
	vable Equipment	15, 136, 585	0				6. 00 7. 00
	T designated Assets	44 217 050	0				
	btotal (sum of lines 1-7)	44, 317, 959	0				8.00
	conciling Items	44 217 050	0				9.00
10. 00   To	tal (line 8 minus line 9)	44, 317, 959	0				10.00

Health Financial Systems	JAY COUNTY	HOSDI TAI		In lie	u of Form CMS-:	2552_10
RECONCILIATION OF CAPITAL COSTS CENTERS	JAI COUNTI		CCN: 15-1320	Period: From 10/01/2017 To 02/28/2018	Worksheet A-7 Part II	pared:
			SUMMARY OF CAR	PLTAL		
Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
	9. 00	10. 00	11. 00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WOR			1 and 2			
2.00 NEW CAP REL COSTS-MVBLE EQUIP	784, 872	•	0	0 0	0	2.00
2. 01 NEW CAP REL COSTS-MVBLE EQUIP MOB	5, 880	•	0	0 0	0	2. 01
2. 02 NEW CAP REL COSTS-MVBLE EQUIP-POB	42, 479		0	0 0	0	2. 02
2. 03 NEW CAP REL COSTS-MVBLE EQUIP- WJ	0		0	0 0	0	2. 03
3.00 Total (sum of lines 1-2)	833, 231		0	0 0	0	3.00
	SUMMARY O	F CAPITAL				
Cost Center Description	Other	Total (1)				İ
	Capi tal -Relat	(sum of cols	S.			
	ed Costs (see	9 through 14	1)			
	instructions)					
	14. 00	15. 00				
PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A COLU	MN 2 LINES 1	1 and 2			

		This tructions)			
		14. 00	15. 00		
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	MN 2, LINES 1 a	and 2	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	784, 872		2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP MOB	0	5, 880		2. 01
2.02	NEW CAP REL COSTS-MVBLE EQUIP-POB	0	42, 479		2. 02
2.03	NEW CAP REL COSTS-MVBLE EQUIP- WJ	0	0		2.03
3.00	Total (sum of lines 1-2)	0	833, 231		3.00

Heal th	n Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	552-10
	CILIATION OF CAPITAL COSTS CENTERS		Provi der C	F	Period: From 10/01/2017 To 02/28/2018	Worksheet A-7 Part III Date/Time Prep 7/30/2018 12:5	oared:
		COMF	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi talized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	I nsurance	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C						
2.00	NEW CAP REL COSTS-MVBLE EQUIP	15, 136, 585	0	15, 136, 585		0	2.00
2. 01	NEW CAP REL COSTS-MVBLE EQUIP MOB	0	0		0.00000	0	2. 01
2. 02	NEW CAP REL COSTS-MVBLE EQUIP-POB	0	0	(	0. 000000	0	2. 02
2. 03	NEW CAP REL COSTS-MVBLE EQUIP- WJ	0	0	(	0. 000000	0	2.03
3. 00	Total (sum of lines 1-2)	15, 136, 585		15, 136, 585		0	3.00
		ALLOCA	TION OF OTHER (	CAPITAL	SUMMARY (	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
	·		Capi tal -Rel at	cols. 5	•		
			ed Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	(	763, 381	0	2.00
2. 01	NEW CAP REL COSTS-MVBLE EQUIP MOB	0	0	(	5, 880	0	2. 01
2. 02	NEW CAP REL COSTS-MVBLE EQUIP-POB	0	0	(	42, 479	0	2.02
2. 03	NEW CAP REL COSTS-MVBLE EQUIP- WJ	0	0	(	0	0	2.03
3.00	Total (sum of lines 1-2)	0	0	(	811, 740	0	3.00
			SL	JMMARY OF CAPI	ΓAL		
	Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
	•		(see	instructions)	Capi tal -Rel at		
			instructions)	1	ed Costs (see	9 through 14)	
					instructions)		
		11. 00	12. 00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
2.00	NEW CAP REL COSTS-MVBLE EQUIP	-3, 469	0	(	0	759, 912	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP MOB	0	0	(	0	5, 880	2.01
2.02	NEW CAP REL COSTS-MVBLE EQUIP-POB	0	0	(	0	42, 479	2.02
2.03	NEW CAP REL COSTS-MVBLE EQUIP- WJ	0	0	(	0	0	2.03
3.00	Total (sum of lines 1-2)	-3, 469	0	(	0	808, 271	3.00

ADJUST	MENTS TO EXPENSES			Provi der CCN: 15-1320	Peri od: From 10/01/2017	Worksheet A-8	
						Date/Time Pre 7/30/2018 12:	
			_	Expense Classification of			<u>Б</u>
			lo	/From Which the Amount is	s to be Adjusted		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
	Jose conter bescription	(2)				Ref.	
1. 00	Investment income - CAP REL	1. 00	2.00	* Cost Center Deleted **	4. 00 * 1. 00	5. 00 0	1.00
	COSTS-BLDG & FIXT (chapter 2)				1.00		
2. 00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter			W CAP REL COSTS-MVBLE ULP	2. 00	0	2.00
	2)			UIF			
2. 01	Investment income - NEW CAP REL COSTS-MVBLE EQUIP MOB			W CAP REL COSTS-MVBLE UIP MOB	2. 01	0	2. 01
	(chapter 2)			OIF WOD			
2. 02	Investment income - NEW CAP REL COSTS-MVBLE EQUIP-POB			W CAP REL COSTS-MVBLE UIP-POB	2. 02	0	2. 02
	(chapter 2)			OIF-FOD			
2. 03	Investment income - NEW CAP			W CAP REL COSTS-MVBLE	2. 03	0	2. 03
	REL COSTS-MVBLE EQUIP- WJ (chapter 2)		EU	UIP- WJ			
3. 00	Investment income - other		0		0.00	0	3.00
4. 00	(chapter 2) Trade, quantity, and time		О		0.00	0	4.00
F 00	discounts (chapter 8)	D	27.05(40	MINICEDATIVE & CENEDAL	F 00		F 00
5. 00	Refunds and rebates of expenses (chapter 8)	В	-27,856 AD	MINISTRATIVE & GENERAL	5. 00	0	5. 00
6. 00	Rental of provider space by		0		0. 00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay		О		0.00	0	7.00
	stations excluded) (chapter						
8. 00	21) Television and radio service		o		0.00	0	8.00
	(chapter 21)						
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	0 -2, 073, 758		0.00	0	9. 00 10. 00
	adj ustment						
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization	A-8-1	-7, 450			0	12.00
13. 00	transactions (chapter 10) Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		-77, 380 CA	FETERI A	11. 00		14.00
15. 00	Rental of quarters to employee and others		0		0.00	0	15.00
16. 00	Sale of medical and surgical		0		0.00	0	16. 00
	supplies to other than patients						
17. 00	Sale of drugs to other than		О		0.00	0	17.00
18. 00	patients Sale of medical records and	В	_4 124MF	DICAL RECORDS & LIBRARY	16. 00	0	18. 00
10.00	abstracts	В	T, 124 ML	DI ONE RECORDS & ELDIVIN	10.00		10.00
19. 00	Nursing and allied health education (tuition, fees,		0		0.00	0	19.00
	books, etc.)						
20.00	Vending machines Income from imposition of		0		0. 00 0. 00	0	
21.00	interest, finance or penalty				0.00	0	21.00
22.00	charges (chapter 21)		0		0.00	0	22.00
22.00	Interest expense on Medicare overpayments and borrowings to				0.00	0	22.00
22.00	repay Medicare overpayments	4 0 2	ODE	CDIDATODY THEDADY	4F 00		22.00
23.00	Adjustment for respiratory therapy costs in excess of	A-8-3	URE	SPI RATORY THERAPY	65. 00		23. 00
24.00	limitation (chapter 14)	4.0.2	OPU	VCLCAL THEDADY	// 00		24.00
24. 00	Adjustment for physical therapy costs in excess of	A-8-3	UPH	YSI CAL THERAPY	66. 00		24.00
25 22	limitation (chapter 14)			* 0+ 01 B ! ! !!			05.00
25. 00	Utilization review - physicians' compensation		0 **	* Cost Center Deleted **	* 114.00		25. 00
27.00	(chapter 21)			* 0+ 01 B ! ! !!		_	0, 0-
26. 00	Depreciation - CAP REL COSTS-BLDG & FLXT		0 **	* Cost Center Deleted **	1.00	0	26. 00
			. 1		•	•	

Health Financial Systems
ADJUSTMENTS TO EXPENSES Peri od: From 10/01/2017 To 02/28/2018 Date/Time Prepared: 7/30/2018 12:58 pm Provi der CCN: 15-1320 Peri od: Worksheet A-8

						7/30/2018 12:	58 pm
				Expense Classification on	Worksheet A		
				To/From Which the Amount is	to be Adjusted		
	0	D	A	0	1.1	14/1 . 1 A 7	
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2)				Ref.	
		1. 00	2. 00	3. 00	4. 00	5. 00	
27. 00	Depreciation - NEW CAP REL		0	NEW CAP REL COSTS-MVBLE	2. 00	0	27.00
	COSTS-MVBLE EQUIP			EQUI P			
27. 01	Depreciation - NEW CAP REL		0	NEW CAP REL COSTS-MVBLE	2. 01	0	27. 01
	COSTS-MVBLE EQUIP MOB			EQUIP MOB			
27. 02	Depreciation - NEW CAP REL		0	NEW CAP REL COSTS-MVBLE	2. 02	0	27. 02
27.02	COSTS-MVBLE EQUI P-POB		0	EQUI P-POB	2.02	0	27.02
27 02					2 02	0	27.02
27. 03	Depreciation - NEW CAP REL		0	NEW CAP REL COSTS-MVBLE	2. 03	0	27. 03
	COSTS-MVBLE EQUIP- WJ			EQUI P- WJ			
28. 00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00
29. 00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
	therapy costs in excess of						
	limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
30. 77	instructions)		0	ADOLIS & ILDIAINICS	30.00		30. 77
21 00		4 0 2		CDEECH DATHOLOGY	(0.00		21 00
31. 00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31.00
	pathology costs in excess of						
	limitation (chapter 14)						
32.00	CAH HIT Adjustment for		0		0.00	0	32.00
	Depreciation and Interest						
33.00	OTHER REVENUE-DIABETIC	В	-6. 201	NURSING ADMINISTRATION	13. 00	0	33.00
00.00	COUNSELING		0,201	NOTES ABILITY STREET	10.00	Ü	00.00
33. 01	CRNA OFFSET	А	277 2/1	ANESTHESI OLOGY	53. 00	0	33. 01
	1						1
33. 02	PHYSICIAN RECRUITMENT	Α		ADMINISTRATIVE & GENERAL	5. 00	0	
33. 03	ADVERTI SI NG EXPENSE	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 03
33. 04	SENI OR PROGRAM	A	-6, 171	ADMINISTRATIVE & GENERAL	5. 00	0	33. 04
33. 05	SWI TCHBOARD SALARY	A	-3, 690	ADMINISTRATIVE & GENERAL	5. 00	0	33. 05
33.06	SWI TCHBOARD EH&W	Α		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33.06
33. 07	PATIENT TELEPHONE EXPENSE	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 07
33. 08	PATIENT TELEPHONE DEPR			NEW CAP REL COSTS-MVBLE	2. 00	9	33.08
33.00	PATTENT TELEPHONE DEPK	A	-1,003		2.00	9	33.00
		_		EQUI P		_	
33. 09	HEALTH EDCUATION	В		ADMINISTRATIVE & GENERAL	5. 00	0	1
33. 10	VENDING MACHINE REVENUE	В	1, 136	CAFETERI A	11. 00	0	33. 10
33. 11	PHARMACY EMPLOYEE SALES	В	-29, 528	DRUGS CHARGED TO PATIENTS	73.00	0	33. 11
33. 12	PENSI ON EXPENSE	Α	-844, 813	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 12
33. 13	THA AND AHA DUES	A	-286	ADMINISTRATIVE & GENERAL	5. 00	0	33. 13
33. 14	LAND RENT	В		ADMINISTRATIVE & GENERAL	5. 00	0	33. 14
33. 14	CLINIC RENTAL	В		ELECTROCARDI OLOGY	69. 00	0	33. 15
	1				•	-	
33. 16	FLU SHOT	В		ADMINISTRATIVE & GENERAL	5. 00	0	
33. 17	VENDOR/CONTRACT REV	В		ADMINISTRATIVE & GENERAL	5. 00	0	
33. 18	EHR DEPRECIATION	A	-19, 826	NEW CAP REL COSTS-MVBLE	2. 00	9	33. 18
				EQUI P			
33. 19	HAF (HOSPITAL ASSESSMENT FEE)	A	-559, 351	ADMINISTRATIVE & GENERAL	5. 00	0	33. 19
33. 20	340B OFFSET	В		DRUGS CHARGED TO PATIENTS	73. 00	0	
33. 21	INTEREST REVENUE	В		NEW CAP REL COSTS-MVBLE	2.00	11	
JJ. Z I	I WIENEST NEVENUE	ا ا	-3, 409		2.00	1.1	33.21
22 22	OTHER DEVENUE		/0.001	EQUIP	F 00	^	22 22
33. 22	OTHER REVENUE	В		ADMINISTRATIVE & GENERAL	5. 00	0	
33. 23	JAY COUNTY ER REIMBURSEMENT	В		EMERGENCY	91. 00	0	
33. 24	MERIDIAN HEALTH WEST JAY REIMB			WEST JAY CLINIC	194. 02	0	
33. 25	MERIDIAN HEALTH CONV CARE	В	-87, 030	CONVENIENT CARE	194. 03	0	33. 25
	REIMB						
33. 26	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	33. 26
55. 25	(3)				3. 30	O	- 3. 20
33. 27	OTHER NONOPER REV	В	_21 700	ADMINISTRATIVE & GENERAL	5. 00	0	33. 27
	1	۵			3.00	Ü	
50. 00	TOTAL (sum of lines 1 thru 49)		-4, 847, 204				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						
(1) De	scription - all chapter referen	ces in this co	dumn nertain t	o CMS Pub 15-1			

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

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

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

B. Amount Received - if cost cannot be determined.

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

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

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.

12,550

20,000

5.00

			Related Organization(s) and/	or Home Office	
Symbol (1)	Name	Percentage of	Name	Percentage of	
		Ownershi p		Ownershi p	
1. 00	2. 00	3. 00	4. 00	5. 00	
B. INTERRELATIONSHIP TO RELA	FED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6. 00	С	JAY CO MED FAC	65. 00	0.00	6.00
7.00			0. 00	0.00	7.00
8. 00			0. 00	0.00	8.00
9. 00			0. 00	0.00	9.00
10.00			0. 00	0.00	10.00
100.00	G. Other (financial or				100.00
	non-financial) specify:				

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

TOTALS (sum of lines 1-4).

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

5.00

line 12.

- 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.
- 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
- 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 Syste	ems	JAY COUNTY HOSPITAL					In Lieu of Form CMS-255			
STATEME	ENT OF COSTS OF	SERVICES FROM	RELATED	ORGANI ZATI C	NS AND HOME	Provi der	CCN:	15-1320	Peri od:	Worksheet A-8	8-1
OFFICE	COSTS								From 10/01/2017		
									To 02/28/2018		
	N-+	WI+ A 7 D-6								7/30/2018 12:	:58 pm
		Wkst. A-7 Ref.									
	Adjustments										
	(col. 4 minus col. 5)*										
	6.00	7. 00									
			AENTS DEC	OULDED AC A	DECLII T OF TD	ANCACTIONS	· WI TI	II DELATED	ORGANI ZATI ONS OR	CLAIMED HOME	
		KED AND ADJUSTI	MENIS KEU	JULKED AS A	RESULT OF TR	ANSACTIONS	) WI II	H KELATED	URGANI ZATTUNS UR	CLAI WED HOWE	
	OFFICE COSTS:										1 00
1.00	-7, 450	0									1.00
2.00	0	0									2.00
3. 00	0	0									3.00
4. 00	0	0									4.00
5. 00	-7, 450										5. 00
									rksheet A, column		
									rganization or ho		
has not	been posted to	o Worksheet A,	col umns	1 and/or 2,	the amount a	allowable	shoul	d be indi	cated in column 4	of this part	
	Related Orga	ani zati on(s)									
	and/or Ho	me Office									
	Type of	Busi ness									
	•										

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE: The Secretary, by virtue of the  $\overline{authority}$  granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6. 00		6.00
7.00		7.00
8.00		8.00
9. 00		9.00
10.00		10.00
6. 00 7. 00 8. 00 9. 00 10. 00	0	100.00

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

6. 00

- 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

| Peri od: | Worksheet A-8-2 | From 10/01/2017 | To 02/28/2018 | Date/Time Prepared:

						10 02/20/2010	7/30/2018 12:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
				•			Hours	
	1. 00	2.00	3. 00	4. 00	5. 00	6. 00	7. 00	
1. 00		LABORATORY	25, 000				-	1.00
2.00		CLINIC	30, 173		0	0	1	2.00
3.00	90. 01	FAMILY PRACTICE OF JAY	630, 863	630, 863	0	0	0	3.00
		COUNTY			_	_	_	
4.00		JAY FAMILY MEDICINE	664, 752			0	0	4.00
5. 00		OPERATING ROOM	48, 000			1	0	5. 00
6. 00		EMERGENCY	813, 217	674, 970	138, 247		0	6.00
7. 00 8. 00	0. 00 0. 00		0	0	0			7. 00 8. 00
9. 00	0.00		0	0	0			9. 00
9. 00 10. 00	0.00		0	0	0			9. 00 10. 00
200.00	0.00		2, 212, 005	2, 073, 758	138, 247	· ·		
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	200.00
	WKSt. A LITIC #	I denti fi er		Unadjusted RCE		Component	of Malpractice	
		Tueller Tref		Li mi t	Continuing	Share of col.	Insurance	
				2 2	Education	12	111041 41100	
	1. 00	2.00	8. 00	9. 00	12.00	13. 00	14.00	
1. 00	60.00	LABORATORY	0	0	0	0	0	1. 00
2.00	90. 00	CLINIC	0	0	0	0	0	2.00
3.00	90. 01	FAMILY PRACTICE OF JAY	0	0	0	0	0	3.00
		COUNTY						
4. 00		JAY FAMILY MEDICINE	0	0	0	0	0	4.00
5. 00		OPERATING ROOM	0	0	0	0	0	5. 00
6. 00		EMERGENCY	0	0	0	0	0	6. 00
7. 00	0. 00		0	0	0	0	0	7. 00
8. 00	0. 00		0	0	0	0	0	8. 00
9.00	0.00		0	0	0	0	0	9.00
10.00	0. 00		0	0	_	,	1	10.00
200.00	Wkat Alina#	Cost Center/Physician	Provi der	O Adiabated DCF	RCE		U	200.00
	Wkst. A Line #	I denti fi er	Component	Adjusted RCE Limit	Di sal I owance	Adjustment		
		Tueliti i i ei	Share of col.	LIIIII	Disarrowance			
			14					
	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	0	30, 173	,	2.00
3.00	90. 01	FAMILY PRACTICE OF JAY	0	0	0	630, 863	,	3.00
		COUNTY						
4.00		JAY FAMILY MEDICINE	0	0	0	00.7.02	1	4.00
5. 00		OPERATING ROOM	0	0	0	48, 000		5.00
6. 00		EMERGENCY	0	0	0	674, 970	1	6.00
7. 00	0. 00		0	0		0	1	7.00
8. 00	0. 00		0	0	_	0		8. 00
9. 00	0. 00		0	0		0		9. 00
10.00	0. 00		0	0		1	1	10.00
200. 00			0	0	0	2, 073, 758		200. 00

Peri od: Worksheet B From 10/01/2017 Part I To 02/28/2018 Date/Ti me Prepared:

			10 02/28/2018   Date/Trille Prepared:   7/30/2018 12: 58 pm					
					CAPITAL REL	ATED COSTS		
		Cost Center Description	Net Expenses	NEW MVBLE	NEW MVBLE	NEW MVBLE	NEW MVBLE	
			for Cost Allocation	EQUI P	EQUIP MOB	EQUI P-POB	EQUIP- WJ	
			(from Wkst A					
			col. 7) 0	2. 00	2. 01	2. 02	2. 03	
	GENER	AL SERVICE COST CENTERS	9	2.00	2.01	2.02	2. 00	
2.00		NEW CAP REL COSTS-MVBLE EQUIP	759, 912	759, 912				2.00
2. 01 2. 02		NEW CAP REL COSTS-MVBLE EQUIP MOB	5, 880 42, 479	0	5, 880 0	42, 479		2. 01 2. 02
2. 03	00203	NEW CAP REL COSTS-MVBLE EQUIP- WJ	0	0	Ō	0	0	2. 03
4.00		EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL	1, 787, 223	0 153	1 022	0	0	4.00
5. 00 7. 00	1	OPERATION OF PLANT	2, 292, 947 506, 198	80, 153 48, 162	1, 033 863	3, 531 2, 548	0	5. 00 7. 00
7. 01	00701	OPERATION OF PLANT-MOB	21, 395	0	0	0	0	7. 01
7.02		OPERATION OF PLANT-POB	38, 526	0	0	0	0	7.02
7. 03 8. 00		OPERATION OF PLANT-WJ LAUNDRY & LINEN SERVICE	201 43, 222	4, 351	0	0	0	7. 03 8. 00
9. 00	00900	HOUSEKEEPI NG	187, 998	4, 859	0	О	0	
10. 00 11. 00		DI ETARY CAFETERI A	163, 378 37, 330	20, 366 20, 092	0	0	0	10. 00 11. 00
13.00		NURSING ADMINISTRATION	421, 984	16, 299	_	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	31, 874	12, 300	0	О	0	14. 00
16. 00		MEDICAL RECORDS & LIBRARY   IENT ROUTINE SERVICE COST CENTERS	153, 243	13, 884	0	0	0	16. 00
30. 00		ADULTS & PEDIATRICS	632, 721	116, 524	0	0	0	30.00
31.00		INTENSIVE CARE UNIT	0	0	0	O	0	
33. 00 40. 00		BURN INTENSIVE CARE UNIT  SUBPROVIDER - IPF	0 367, 445	0 44, 916	0	0	0	33. 00 40. 00
41. 00		SUBPROVI DER - I RF	0	44, 710	0	Ö	0	41.00
42.00	1	SUBPROVI DER	0	0	O	O	0	42.00
43. 00		NURSERY LARY SERVICE COST CENTERS	51, 144	10, 100	0	0	0	43.00
50.00		OPERATING ROOM	585, 207	52, 895	0	19, 103	0	50.00
52.00		DELIVERY ROOM & LABOR ROOM	12, 977	1, 242	0	0	0	
53. 00 54. 00	1	ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	605, 306	0 61, 293	0	0	0	53. 00 54. 00
57. 00	05700	CT SCAN	0	0 1,7 2,70	Ö	Ö	0	57.00
58. 00 59. 00		MAGNETIC RESONANCE IMAGING (MRI)   CARDIAC CATHETERIZATION	0	0	0	0	0	58. 00 59. 00
60.00		LABORATORY	660, 574	25, 000		0	0	60.00
60. 01		BLOOD LABORATORY	0	0	0	О	0	60. 01
65. 00 66. 00	1	RESPI RATORY THERAPY PHYSI CAL THERAPY	474, 253 272, 096	5, 456 1, 066	0	0	0	65. 00 66. 00
67.00		OCCUPATI ONAL THERAPY	272,070	0	o	ő	0	67.00
68.00		SPEECH PATHOLOGY	0	0	0	O	0	68.00
69. 00 71. 00		ELECTROCARDIOLOGY MEDICAL SUPPLIES CHARGED TO PATIENTS	145, 975 0	19, 574 0	0	0	0	69. 00 71. 00
		IMPL. DEV. CHARGED TO PATIENTS	0	0	_	Ö	0	
	07300	DRUGS CHARGED TO PATIENTS	826, 162	10, 031	0	0	0	73. 00
88. 00		TIENT SERVICE COST CENTERS RURAL HEALTH CLINIC	0	0	0	ol	0	88. 00
89. 00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	O		Ö	0	89. 00
90.00		CLINIC FAMILY PRACTICE OF JAY COUNTY	11, 486	0	0	0	0	90.00
90. 01 90. 02		JAY FAMILY MEDICINE	170, 289 182, 332	84, 475	3, 984 0	0	0	90. 01 90. 02
91.00	09100	EMERGENCY	447, 406	44, 408		O	0	91.00
92. 00 93. 00	1	OBSERVATION BEDS (NON-DISTINCT PART) OTHER OUTPATIENT SERVICE COST CENTER	9, 508	0	o	0	0	92.00 93.00
93.00		REIMBURSABLE COST CENTERS	9, 500	U	U		0	93.00
99. 10			0	0	0	0	0	99. 10
106.00		AL PURPOSE COST CENTERS HEART ACQUISITION	0	O	O	O	0	106. 00
		PANCREAS ACQUISITION	0	0	Ö	ő		109.00
		INTESTINAL ACQUISITION	0	0	0	0		110.00
		ISLET ACQUISITION   INTEREST EXPENSE	0	O	0	O	0	111. 00 113. 00
118.00	)	SUBTOTALS (SUM OF LINES 1 through 117)	11, 948, 671	697, 446	5, 880	25, 182	0	118.00
100.00		IMBURSABLE COST CENTERS		0.050				100.00
		GIFT, FLOWER, COFFEE SHOP & CANTEEN PHYSICIANS' PRIVATE OFFICES	0	8, 858 0	0	0		190. 00 192. 00
193.00	19300	NONPALD WORKERS	o	ō	o o	o	0	193. 00
194.00			0	0	0	0		194.00
194. 01 194. 02		POB WEST JAY CLINIC	1, 423	0	0	0		194. 01 194. 02
		I Company of the Comp	.,0	۳,		٩١		

Heal th Financial Systems

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1320
Provider CCN: 15-132

Part I Date/Time Prepared: 7/30/2018 12:58 pm CAPITAL RELATED 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) 2.00 2. 01 2. 02 2. 03 0 194. 03 07953 CONVENI ENT CARE 0 194. 03 42, 542 15, 790 0 0 0 194.04 194. 04 07954 OTHER NONREI MBURSABLE COST CENTERS 0 194. 05 07955 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 194. 05 194.06 07956 TRI COUNTY 614, 196 0 17, 297 0 194.06 0 194. 07 194. 07 07957 HOSPI TALI ST 0 212, 376 194.08 07958 FAMILY FIRST HEALTH 0 0 194. 08 425, 417 37,818 0 194. 09 07959 MERIDIAN HEALTH CONVENIENT CARE 0 0 0 194. 09 200.00 200.00 Cross Foot Adjustments 0 201.00 201.00 Negative Cost Centers 0 202.00 TOTAL (sum lines 118 through 201) 13, 244, 625 759, 912 5,880 0 202.00

				1	0 02/28/2018	Date/lime Pre   7/30/2018 12:	
	Cost Center Description	EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIV E & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT-MOB	у р
		DEPARTMENT	4.0	F 00	7.00	7.01	
	GENERAL SERVICE COST CENTERS	4. 00	4A	5. 00	7. 00	7. 01	
2. 00 2. 01 2. 02 2. 03 4. 00 5. 00 7. 01 7. 02 7. 03 8. 00 9. 00 10. 00 11. 00	00200 NEW CAP REL COSTS-MYBLE EQUIP 00201 NEW CAP REL COSTS-MYBLE EQUIP MOB 00202 NEW CAP REL COSTS-MYBLE EQUIP-POB 00203 NEW CAP REL COSTS-MYBLE EQUIP-WJ 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00701 OPERATION OF PLANT-MOB 00702 OPERATION OF PLANT-POB 00703 OPERATION OF PLANT-WJ 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01100 DIETARY	1, 787, 223 202, 753 27, 611 72 79 48 5, 358 38, 198 20, 628 14, 340	2, 580, 417 585, 382 21, 467 38, 605 249 52, 931 231, 055 204, 372 71, 762	141, 645 5, 194 9, 341 60 12, 808 55, 908 49, 452	727, 027 0 0 0 5, 008 5, 593 23, 443	26, 661 0 0 0 0 0	2. 00 2. 01 2. 02 2. 03 4. 00 5. 00 7. 01 7. 02 7. 03 8. 00 9. 00 10. 00
13. 00	01300 NURSING ADMINISTRATION	102, 800	541, 083			0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	6, 677	50, 851			0	14.00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	34, 275	201, 402	48, 733	15, 981	0	16. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	136, 586	885, 831	214, 346	134, 131	0	30.00
31. 00 33. 00 40. 00 41. 00 42. 00 43. 00	03100 INTENSIVE CARE UNIT 03300 BURN INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04200 SUBPROVIDER 04300 NURSERY	75, 580 0 75, 580 0 0 10, 334	883, 831 0 0 487, 941 0 0 71, 578	0 0 118, 067 0 0	0 0 51, 703 0 0	0 0 0 0	31. 00 33. 00 40. 00 41. 00 42. 00 43. 00
	ANCILLARY SERVICE COST CENTERS		,	,	,		
50. 00 52. 00 53. 00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	80, 928 2, 778 0	738, 133 16, 997	1		0 0 0	50. 00 52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	79, 653	746, 252	180, 571	70, 554	0	54.00
57. 00 58. 00 59. 00 60. 00 60. 01 65. 00 66. 00	05700 CT SCAN 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 BLOOD LABORATORY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	60, 826 0 0 0 60, 826	746, 400 0 746, 400 0 479, 709 273, 162	0 0 0 180, 606 0 116, 075	0 0 0 28, 778 0	0 0 0 0 0 0	57. 00 58. 00 59. 00 60. 00 60. 01 65. 00 66. 00
67. 00 68. 00 69. 00 71. 00 72. 00 73. 00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0 0 19, 020 0 0 45, 594	0 0 184, 569 0 0 881, 787	0	0	0 0 0 0 0	67. 00 68. 00 69. 00 71. 00 72. 00 73. 00
88. 00	OUTPATIENT SERVICE COST CENTERS  08800 RURAL HEALTH CLINIC	ol	0	0	0	0	88. 00
89. 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 28 164, 616 184, 048 224, 589	11, 514 338, 889 450, 855 716, 403 0 9, 720	0 2, 786 82, 001 109, 093 173, 348	0 0 0 97, 239 51, 118	0 0 26, 661 0	
99. 10	09910 CORF	0	0	0	0	0	99. 10
106. 00 109. 00 110. 00	SPECIAL PURPOSE COST CENTERS 10600 HEART ACQUISITION 10900 PANCREAS ACQUISITION 11000 INTESTINAL ACQUISITION 11100 ISLET ACQUISITION	0 0 0	0 0 0			0 0	106. 00 109. 00 110. 00 111. 00
	11300 INTEREST EXPENSE		O				113.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)   NONREIMBURSABLE COST CENTERS	1, 537, 631	11, 619, 316				118. 00
192. 00 193. 00 194. 00 194. 01 194. 02	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 19300 NONPAID WORKERS 107950 MOB 107951 POB 107952 WEST JAY CLINIC	0 0 0 0 0 58, 776	8, 858 0 0 0 0 60, 199	0 0 0 0 14, 566	0 0 0 0	0 0 0 0	190. 00 192. 00 193. 00 194. 00 194. 01 194. 02
	07953 CONVENIENT CARE 07954 OTHER NONREIMBURSABLE COST CENTERS	30, 518	88, 850 0	21, 499	18, 176 0		194. 03 194. 04
194. 05	07954 OTHER NONRELMBURSABLE COST CENTERS 07955 OTHER NONRELMBURSABLE COST CENTERS 07956 TRI COUNTY	0 26, 311	657, 804	0 0 159, 169	0	0	194. 04 194. 05 194. 06

Health Financial Systems

OST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1320

					7/30/2018 12:	58 pm
Cost Center Description	EMPLOYEE	Subtotal	ADMI NI STRATI V	OPERATION OF	OPERATION OF	
	BENEFITS		E & GENERAL	PLANT	PLANT-MOB	
	DEPARTMENT					
	4. 00	4A	5. 00	7. 00	7. 01	
194. 07 07957 HOSPI TALI ST	43, 182	255, 558	61, 837	0	0	194.07
194.08 07958 FAMILY FIRST HEALTH	90, 805	554, 040	134, 061	43, 532	0	194. 08
194. 09 07959 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, 787, 223	13, 244, 625	2, 580, 417	727, 027	26, 661	202.00

| Peri od: | Worksheet B | From 10/01/2017 | Part | To 02/28/2018 | Date/Time Prepared: 7/30/2018 12:58 pm

Cook Contain December 1	ODEDATION OF	ODEDATION OF	LAUNDDY 0	LIQUEEK EED NO	7/30/2018 12:	
Cost Center Description	OPERATION OF PLANT-POB	OPERATION OF PLANT-WJ	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
	7. 02	7. 03	8. 00	9. 00	10.00	
GENERAL SERVICE COST CENTERS  2. 00   00200   NEW CAP REL COSTS-MVBLE EQUIP						2.00
2. 00   00200   NEW CAP REL COSTS-MVBLE EQUIP 2. 01   00201   NEW CAP REL COSTS-MVBLE EQUIP MOB						2. 00 2. 01
2. 02 O0202 NEW CAP REL COSTS-MVBLE EQUI P-POB						2. 02
2.03 OO203 NEW CAP REL COSTS-MVBLE EQUIP- WJ						2. 03
4.00   00400   EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00   00500   ADMI NI STRATI VE & GENERAL						5.00
7.00   00700   0PERATION OF PLANT 7.01   00701   0PERATION OF PLANT-MOB						7.00
7. 02   00701 OPERATION OF PLANT-MOB 7. 02   00702 OPERATION OF PLANT-POB	47, 946					7. 01 7. 02
7. 03 00703 OPERATION OF PLANT-WJ	0	309				7. 02
8. 00   00800   LAUNDRY & LI NEN SERVI CE	0	0	70, 747			8. 00
9. 00   00900   HOUSEKEEPI NG	0	0	8, 567	301, 123		9. 00
10. 00   01000   DI ETARY	0	0	2, 211	8, 024	287, 502	10.00
11. 00   01100   CAFETERI A 13. 00   01300   NURSI NG   ADMI NI STRATI ON	0	0	0	7, 916 4, 421	0	11. 00 13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	0	0	6, 421 4, 846	0	14.00
16. 00 01600 MEDICAL RECORDS & LIBRARY	0	0	0	5, 470	0	16. 00
INPATIENT ROUTINE SERVICE COST CENTERS				, , ,		
30. 00   03000   ADULTS & PEDI ATRI CS	0	0	32, 434	45, 907	199, 774	30.00
31. 00 03100   NTENSIVE CARE UNIT	0	0	0	0	0	31.00
33. 00   03300   BURN   INTENSI VE CARE UNI T 40. 00   04000   SUBPROVI DER -   PF	0	0	0 1, 750	17 404	0 87, 728	33. 00 40. 00
41. 00   04100   SUBPROVI DER - 1 PF	0	0	1, 750	17, 696	07, 720	40.00
42. 00   04200   SUBPROVI DER	0	Ö	0	0	0	42. 00
43. 00 04300 NURSERY	0	0	1, 282	3, 979	0	43.00
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATI NG ROOM	25, 161	0	7, 369	39, 028	0	50.00
52. 00   05200   DELI VERY ROOM & LABOR ROOM	0	0	0	489	0	52.00
53. 00   05300   ANESTHESI OLOGY 54. 00   05400   RADI OLOGY	0	0	5, 619	24, 148	0	53. 00 54. 00
57. 00   05700 CT   SCAN	0	0	3, 019	24, 146	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	Ö	0	Ö	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	9, 849	0	60.00
60. 01   06001   BLOOD LABORATORY	0	0	0	0	0	60. 01
65. 00   06500   RESPI RATORY THERAPY 66. 00   06600   PHYSI CAL THERAPY	0	0	0 461	2, 149 420	0	65. 00 66. 00
67. 00   06700   OCCUPATI ONAL THERAPY	0	0	401 0	420	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0	0	o	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	1, 474	7, 712	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73. 00 O7300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	U	0	3, 952	0	73. 00
88. 00   08800   RURAL HEALTH CLINIC	0	0	0	O	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	Ö	0	o	0	89. 00
90. 00   09000   CLI NI C	0	0	0	0	0	90.00
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	0	0	0	21, 259	0	90. 01
90. 02   09002   JAY FAMILY MEDICINE	0	0	0	33, 281	0	90. 02
91. 00   09100   EMERGENCY 92. 00   09200   0BSERVATI ON BEDS (NON-DI STINCT PART)	0	0	9, 580	17, 496	0	91.00
92.00   09200   OBSERVATION BEDS (NON-DISTINCT PART) 93.00   04040   OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	92. 00 93. 00
OTHER REIMBURSABLE COST CENTERS	0	0	0	O <sub>I</sub>		73.00
99. 10 09910 CORF	0	0	0	0	0	99. 10
SPECIAL PURPOSE COST CENTERS						
106. 00 10600 HEART ACQUI SI TI ON	0	0	0	0		106.00
109. 00 10900 PANCREAS ACQUISITION	0	0	0	0		109.00
110. 00 11000  I NTESTI NAL ACQUI SI TI ON 111. 00 11100  I SLET ACQUI SI TI ON	0	0	0	0	0	110. 00 111. 00
113. 00 11300   NTEREST EXPENSE	0	Ü	U	U	U	111.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	25, 161	0	70, 747	260, 042	287, 502	
NONREI MBURSABLE COST CENTERS				===, = :=		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	3, 490		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		193.00
194. 00 07950 M0B 194. 01 07951 P0B	0	0	0	0		194. 00 194. 01
194. 01 07951 P0B 194. 02 07952 WEST JAY CLINIC		309	0	0		194. 01 194. 02
194. 03 07953  CONVENTENT CARE		0	0	6, 221		194. 02
194. 04 07954 OTHER NONREI MBURSABLE COST CENTERS	0	o	Ō	0		194. 04
194.05 07955 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194. 05
194. 06 07956 TRI COUNTY	22, 785		0	16, 471		194.06
194. 07 07957 H0SPI TALI ST	0	0	0	0	0	194. 07

Health Financial Systems

OST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1320
Period:
From 10/01/2017
To 02/28/2018
Part I
Date/Time Prepared:
7/30/2018 12: 58 pm

						1/30/2018 12:	og bill
	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. 08 07958	FAMILY FIRST HEALTH	0	0	0	14, 899	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	0	201.00
202. 00	TOTAL (sum lines 118 through 201)	47, 946	309	70, 747	301, 123	287, 502	202.00

Provider CCN: 15-1320

Cost Contor Description CAFFEDIA NUBBLING CENTRAL	7/30/2018 12: 58 pm   MEDICAL   Subtotal
Cost Center Description CAFETERIA NURSING CENTRAL	
ADMI NI STRATI 0 SERVI CES N SUPPLY	& RECORDS & LI BRARY
11. 00 13. 00 14. 00	16.00 24.00
GENERAL SERVICE COST CENTERS	
2. 00   00200 NEW CAP REL COSTS-MVBLE EQUIP	2.00
2. 01   00201   NEW CAP REL COSTS-MVBLE EQUI P MOB	2.01
2. 02   00202  NEW CAP REL COSTS-MVBLE EQUI P-P0B 2. 03   00203  NEW CAP REL COSTS-MVBLE EQUI P- WJ	2.02 2.03
4.00 OO400 EMPLOYEE BENEFITS DEPARTMENT	4.00
5. 00   00500   ADMINISTRATIVE & GENERAL	5.00
7. 00   00700   OPERATI ON OF PLANT	7.00
7. 01   00701   0PERATI ON OF PLANT-MOB 7. 02   00702   0PERATI ON OF PLANT-POB	7. 01
7. 02   00702   OPERATION OF PLANT-POB 7. 03   00703   OPERATION OF PLANT-WJ	7.02
8. 00   00800 LAUNDRY & LINEN SERVICE	8.00
9. 00   00900   HOUSEKEEPI NG	9.00
10. 00   01000   DI ETARY	10.00
11. 00   01100   CAFETERI A	11.00
	958 14.00
16.00 01600 MEDI CAL RECORDS & LI BRARY 7, 540 0	111 279, 237 16. 00
INPATIENT ROUTINE SERVICE COST CENTERS	
	675 15, 676 1, 817, 885 30. 00
31. 00   03100   I NTENSI VE CARE UNI T	0 0 0 31.00 0 0 33.00
	290 2, 871 909, 944 40. 00
41. 00   04100   SUBPROVI DER -   I RF   0   0	0 0 0 41.00
42. 00   04200   SUBPROVI DER   0   0	0 0 42.00
43. 00   04300  NURSERY   1, 447   16, 104	0 595 123, 931 43. 00
ANCI LLARY SERVI CE COST CENTERS  50. 00   05000   0PERATI NG ROOM   11,898   132,379   23,	352 42, 258 1, 259, 071 50. 00
52. 00   05200  DELIVERY ROOM & LABOR ROOM 147 1, 638	0 813 25, 626 52.00
53. 00   05300   ANESTHESI OLOGY   0   0	0 0 53.00
	837 86, 438 1, 131, 475 54. 00
57. 00   05700   CT SCAN	0 0 0 57.00 0 0 58.00
59. 00   05900   CARDI AC   CATHETERI ZATI ON   0   0	0 0 0 59.00
	929 61, 331 1, 055, 895 60. 00
60. 01   06001   BLOOD LABORATORY   0   0	0 0 60.01
	472 2, 747 607, 432 65. 00
66. 00   06600  PHYSI CAL THERAPY	176 8, 618 350, 161 66. 00 0 0 67. 00
68. 00   06800   SPEECH PATHOLOGY   0   0	0 0 68.00
	873 6, 991 274, 322 69. 00
71.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0	0 0 71.00
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS 0 0 0 73. 00   07300   DRUGS CHARGED TO PATIENTS 5. 103 0	0 0 72.00
73. 00   07300   DRUGS CHARGED TO PATIENTS   5, 103   0	<u>495</u> <u>17, 215</u> <u>1, 133, 465</u> 73. 00
88. OO   OBBOO  RURAL HEALTH CLINIC   O  O	0 0 0 88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0	0 0 89.00
	198 0 14, 498 90.00
	923 3, 904 482, 637 90. 01 078 2, 766 699, 312 90. 02
	454 26, 838 1, 184, 964 91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	92.00
93.00 04040 OTHER OUTPATIENT SERVICE COST CENTER 0 0	0 176 12, 248 93. 00
OTHER REIMBURSABLE COST CENTERS	0 0 10
99. 10   09910   CORF   0   0   SPECI AL PURPOSE COST CENTERS	0 0 99.10
106. 00 10600 HEART ACQUISITION 0 0	0 0 106.00
109. 00 10900 PANCREAS ACQUISITION 0 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 0 111.00
113.00 11300 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 120,170 709,572 76,	863 279, 237 11, 082, 866 118. 00
NONREI MBURSABLE COST CENTERS	277, 237 11, 002, 000 110. 00
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0	0 0 24, 688 190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0	0 0 192.00
193. 00 19300 NONPALD WORKERS 0 0	0 0 193.00
194. 00 07950 MOB 194. 01 07951 POB 0 0	0 0 0 194.00 0 0 0 194.01
194. 0107931 POB	85 0 75, 159 194. 02
194. 03 07953 CONVENI ENT CARE 0 0	318 0 135, 064 194. 03
194. 04 07954 OTHER NONREI MBURSABLE COST CENTERS 0 0	0 0 194.04
194. 05 07955 OTHER NONREIMBURSABLE COST CENTERS 0 0 194. 06 07956 TRI COUNTY 0 1,	0 0 0 194.05 344 0 857,573 194.06
174. 00 0/730 1/1 000 111   0  0  1,	344  0  857, 573   194. 06

Heal th Financial Systems

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1320
Provider CCN: 15-132

					0 02/20/2010	7/30/2018 12:	
	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	C	0	317, 395	194.07
194. 08 07958	FAMILY FIRST HEALTH	0	0	5, 348	0	751, 880	194. 08
194. 09 07959	MERIDIAN HEALTH CONVENIENT CARE	0	0	C	0	0	194.09
200. 00	Cross Foot Adjustments					0	200.00
201. 00	Negative Cost Centers	0	0	C	0	0	201.00
202. 00	TOTAL (sum lines 118 through 201)	120, 170	709, 572	83, 958	279, 237	13, 244, 625	202.00

Health Financial Systems

JAY COUNTY HOSPITAL

In Lieu of Form CMS-2552-10

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1320 | Period: | Worksheet B

From 10/01/2017 Part I Date/Time Prepared: 02/28/2018 7/30/2018 12:58 pm Cost Center Description Intern & Total Resi dents Cost & Post Stepdown Adjustments 25. 00 26.00 GENERAL SERVICE COST CENTERS 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00201 NEW CAP REL COSTS-MVBLE EQUIP MOB 2.01 2 01 2.02 00202 NEW CAP REL COSTS-MVBLE EQUIP-POB 2.02 00203 NEW CAP REL COSTS-MVBLE EQUIP- WJ 2.03 2.03 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 7.00 00700 OPERATION OF PLANT 7.00 7.01 00701 OPERATION OF PLANT-MOB 7.01 00702 OPERATION OF PLANT-POB 7.02 7.02 00703 OPERATION OF PLANT-WJ 7.03 7.03 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9.00 9.00 01000 DI ETARY 10.00 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14 00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 1, 817, 885 30.00 0 03100 INTENSIVE CARE UNIT 31.00 31.00 33.00 03300 BURN INTENSIVE CARE UNIT 0 33.00 0 04000 SUBPROVI DER - I PF 40.00 909, 944 40.00 41 00 04100 SUBPROVI DER - I RF 41 00 C 04200 SUBPROVI DER 0 42.00 42.00 43.00 04300 NURSERY 123, 931 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 0 1, 259, 071 50.00 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 25, 626 52.00 05300 ANESTHESI OLOGY 0 53.00 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 1, 131, 475 54.00 05700 CT SCAN 57 00 57.00 0 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 0 58.00 05900 CARDIAC CATHETERIZATION 59.00 59.00 60.00 06000 LABORATORY 00000 1, 055, 895 60.00 06001 BLOOD LABORATORY 60.01 60.01 65.00 06500 RESPIRATORY THERAPY 607, 432 65.00 66.00 06600 PHYSI CAL THERAPY 350, 161 66.00 06700 OCCUPATI ONAL THERAPY 67.00 67.00 C 06800 SPEECH PATHOLOGY 68.00 Λ 68.00 69.00 06900 ELECTROCARDI OLOGY 0 274, 322 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 1, 133, 465 73.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88.00 00 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 r 89 00 90.00 09000 CLI NI C 0 14, 498 90.00 09001 FAMILY PRACTICE OF JAY COUNTY 90. 01 0 0 482, 637 90.01 09002 JAY FAMILY MEDICINE 90.02 699, 312 90.02 91.00 09100 EMERGENCY 1, 184, 964 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 04040 OTHER OUTPATIENT SERVICE COST CENTER 12, 248 93.00 93.00 OTHER REIMBURSABLE COST CENTERS 0 99.10 09910 CORF 0 99.10 SPECIAL PURPOSE COST CENTERS 106. 00 10600 HEART ACQUISITION 0 106.00 0 109.00 10900 PANCREAS ACQUISITION 0 0 109.00 110.00 11000 INTESTINAL ACQUISITION 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 0 111.00 113. 00 11300 INTEREST EXPENSE 113 00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 0 11, 082, 866 118.00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 24, 688 190.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 192 00 C 193. 00 19300 NONPALD WORKERS 0 0 193.00 194. 00 07950 MOB 0 0 0 194.00 194. 01 07951 POB 194. 01 Ω 194.02 07952 WEST JAY CLINIC 75, 159 194.02 194. 03 07953 CONVENIENT CARE 194.03 135, 064 194. 04 07954 OTHER NONREI MBURSABLE COST CENTERS 194.04

Health Financial Systems	JAY COUNTY H	HOSPI TAL		In Lieu of Form CMS-2552-10		
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-1320		Peri od:	Worksheet B	
				From 10/01/2017 To 02/28/2018	Part I Date/Time Prepared:	
				10 02/20/2018	7/30/2018 12:58 pm	
Cost Center Description	Intern &	Total				
	Resi dents					
	Cost & Post					
	Stepdown					
	Adjustments					
	25. 00	26. 00				
194. 05 07955 OTHER NONREIMBURSABLE COST CENTERS	0	0			194. 05	
194.06 07956 TRI COUNTY	0	857, 573			194. 06	
194. 07 07957 HOSPI TALI ST	0	317, 395			194. 07	
194.08 07958 FAMILY FIRST HEALTH	0	751, 880			194. 08	
194. 09 07959 MERIDIAN HEALTH CONVENIENT CARE	o	0			194. 09	
200.00 Cross Foot Adjustments	o	0			200.00	
201.00 Negative Cost Centers	O	0			201.00	
202.00 TOTAL (sum lines 118 through 201)	0	13, 244, 625			202.00	

Provider CCN: 15-1320

				CARLTAL DEL	ATED COSTS	7/30/2018 12:	
				CAPI TAL REL	ATED COSTS		
	Cost Center Description	Di rectly Assi gned New Capi tal	NEW MVBLE EQUIP	NEW MVBLE EQUIP MOB	NEW MVBLE EQUI P-POB	NEW MVBLE EQUIP- WJ	
		Related Costs 0	2. 00	2. 01	2. 02	2. 03	
	GENERAL SERVICE COST CENTERS		2.00	2.0.	2. 02	2. 00	
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2. 01 2. 02	00201 NEW CAP REL COSTS-MVBLE EQUIP MOB 00202 NEW CAP REL COSTS-MVBLE EQUIP-POB						2. 01 2. 02
2. 03	00203 NEW CAP REL COSTS-MVBLE EQUIP- WJ						2. 03
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	0	o	C	
5.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	0	80, 153		3, 531	C	
7. 00 7. 01	00700 OPERATION OF PLANT	0	48, 162 0	1	2, 548 0	C	1
7. 02	00702 OPERATION OF PLANT-POB	0	0		Ö	C	1
7. 03	00703 OPERATION OF PLANT-WJ	0	0	0	0	C	
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	0	4, 351 4, 859	0	0	C	
10.00	01000 DI ETARY		20, 366		ol ol	C	1
11. 00	01100 CAFETERI A	0	20, 092		ō	C	1
13.00	01300 NURSING ADMINISTRATION	0	16, 299		0	C	
14. 00 16. 00	01400 CENTRAL SERVICES & SUPPLY 01600 MEDICAL RECORDS & LIBRARY	0	12, 300 13, 884		0 0	C	
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	13, 004	<u> </u>			10.00
30.00	03000 ADULTS & PEDIATRICS	0	116, 524		0	C	
31.00	03100   NTENSI VE CARE UNI T	0	0		0	C	1
33. 00 40. 00	03300 BURN INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	0	0 44, 916	0	0	C	
41. 00	04100 SUBPROVI DER – I RF	0	0	Ö	o	C	
42.00	04200 SUBPROVI DER	0	0	_	o	C	1
43. 00	04300 NURSERY	0	10, 100	0	0	C	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS  05000 OPERATING ROOM	0	52, 895	O	19, 103	C	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	1, 242		0	C	1
53.00	05300 ANESTHESI OLOGY	0	0		0	C	
54. 00 57. 00	05400 RADI OLOGY-DI AGNOSTI C 05700 CT SCAN	0	61, 293	0	0	C	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0		0	C	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	ō	C	1
60.00	06000 LABORATORY	0	25, 000		0	C	
60. 01 65. 00	06001 BLOOD LABORATORY 06500 RESPI RATORY THERAPY	0	0 5, 456	_	ol ol	C	
66. 00	06600 PHYSI CAL THERAPY		1, 066		Ö	C	1
67.00	06700 OCCUPATI ONAL THERAPY	0	0	1	o	C	
68. 00	06800 SPEECH PATHOLOGY	0	10.574	0	0	C	
69. 00 71. 00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATIENTS		19, 574 0	1	0	C	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		Ö	C	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	10, 031	0	0	C	73. 00
88. 00	OUTPATIENT SERVICE COST CENTERS  08800 RURAL HEALTH CLINIC		0		ام	C	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0	0	o	C	1
	09000 CLI NI C	0	0	0	О	C	1
90. 01	09001 FAMILY PRACTICE OF JAY COUNTY	0	04.475	3, 984	0	C	
	09002 JAY FAMILY MEDICINE 09100 EMERGENCY	0	84, 475 44, 408		0	C	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		44, 400		Ĭ	C	92.00
93. 00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	C	93. 00
00 10	OTHER REIMBURSABLE COST CENTERS  09910 CORF	O	0	O	ol	C	99. 10
99. 10	SPECIAL PURPOSE COST CENTERS	J 01	0	] 0			79.10
	10600 HEART ACQUISITION	0	0	0	0		106. 00
	10900 PANCREAS ACQUISITION	0	0	0	0		109.00
	11000   INTESTINAL ACQUISITION   11100   ISLET ACQUISITION	0	0	0	0		110.00
	11300 INTEREST EXPENSE		O		Ĭ		113.00
118.00	9 /	0	697, 446	5, 880	25, 182	C	118. 00
100.00	NONREI MBURSABLE COST CENTERS		0.050		21		1100 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES		8, 858 0	0	0		190. 00 192. 00
	19300 NONPALD WORKERS		0		Ö		193. 00
	07950 MOB	0	0	0	o		194. 00
	07951 POB 207952 WEST JAY CLINIC	0	0	0	0 0		194. 01 194. 02
	3 07952  WEST JAY CLINIC		15, 790		0		194. 02
	i i i i i i i i i i i i i i i i i i i	, 9	-770	٠	٩١		

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS JAY COUNTY HOSPITAL Provider CCN: 15-1320

					7/30/2018 12:	58 pm_
			CAPI TAL REI	_ATED COSTS		
Cost Center Description	Di rectly	NEW MVBLE	NEW MVBLE	NEW MVBLE	NEW MVBLE	
	Assigned New	EQUI P	EQUIP MOB	EQUI P-POB	EQUIP- WJ	
	Capi tal					
	Related Costs					
	0	2. 00	2. 01	2. 02	2. 03	
194. 04 07954 OTHER NONREI MBURSABLE COST CENTERS	0	0	0	0	0	194. 04
194.05 07955 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194. 05
194.06 07956 TRI COUNTY	0	0	0	17, 297	0	194. 06
194. 07 07957 HOSPI TALI ST	0	0	0	0	0	194. 07
194.08 07958 FAMILY FIRST HEALTH	0	37, 818	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	759, 912	5, 880	42, 479	0	202. 00

Provider CCN: 15-1320

				'	o 02/28/2018	Date/lime Pre 7/30/2018 12:	
	Cost Center Description	Subtotal	EMPLOYEE	ADMI NI STRATI V	OPERATION OF	OPERATION OF	
			BENEFITS DEPARTMENT	E & GENERAL	PLANT	PLANT-MOB	
		2A	4. 00	5. 00	7. 00	7. 01	
	GENERAL SERVICE COST CENTERS						
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2. 01 2. 02	OO201 NEW CAP REL COSTS-MVBLE EQUIP MOB   OO202 NEW CAP REL COSTS-MVBLE EQUIP-POB						2. 01 2. 02
2. 03	00203 NEW CAP REL COSTS-MVBLE EQUIP- WJ						2. 02
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0				4.00
5.00	00500 ADMINISTRATIVE & GENERAL	84, 717	0				5. 00
7. 00 7. 01	OO7OO   OPERATION OF PLANT   OO7O1   OPERATION OF PLANT-MOB	51, 573	0	.,	56, 223 0	171	7. 00 7. 01
7. 01	00701 OPERATION OF PLANT-MOB	0	0	1	0	1/1	7.01
7. 03	00703 OPERATION OF PLANT-WJ	o	0	2	0	Ö	7. 03
8.00	00800 LAUNDRY & LINEN SERVICE	4, 351	0			0	8. 00
9.00	00900 HOUSEKEEPI NG	4, 859	0	.,		0	9.00
10. 00 11. 00	01000 DI ETARY   01100 CAFETERI A	20, 366 20, 092	0	.,		0	10.00 11.00
13. 00	01300 NURSING ADMINISTRATION	16, 299	0	1		0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	12, 300	0	1	1, 095	0	14.00
16.00	01600 MEDICAL RECORDS & LIBRARY	13, 884	0	1, 600	1, 236	0	16. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	114 504	0	7 020	10 271	0	20.00
30. 00 31. 00	03100 INTENSIVE CARE UNIT	116, 524 0	0		10, 371	0	30. 00 31. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	o	0	Ö	0	ő	33.00
40.00	04000 SUBPROVI DER - I PF	44, 916	0	3, 876	3, 998	0	40.00
41. 00	04100 SUBPROVI DER - I RF	0	0		0	0	41.00
42. 00 43. 00	04200 SUBPROVI DER 04300 NURSERY	10, 100	0		899	0	42. 00 43. 00
43.00	ANCI LLARY SERVI CE COST CENTERS	10, 100		307	077	0	43.00
50.00	05000 OPERATING ROOM	71, 998	0	5, 864	4, 709	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 242	0		111	0	52.00
53. 00 54. 00	05300   ANESTHESI OLOGY   05400   RADI OLOGY-DI AGNOSTI C	0 61, 293	0	_	0	0	53. 00 54. 00
57. 00	05700 CT SCAN	01, 293	0	1	5, 456 0	0	57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	o	0		0	ő	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00
60.00	06000 LABORATORY	25, 000	0	5, 929		0	60.00
60. 01 65. 00	06001 BL00D LABORATORY 06500 RESPI RATORY THERAPY	5, 456	0	3, 811	0 486	0	60. 01 65. 00
66. 00	06600 PHYSI CAL THERAPY	1, 066	0	1		0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	1	0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0	0		0	0	68. 00
69. 00 71. 00	06900  ELECTROCARDI OLOGY   07100  MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	19, 574 0	0		1, 742	0	69. 00 71. 00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	10, 031	0		893	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	0	0		-	0	
	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0	0	_ ~	0	0	
	09001 FAMILY PRACTICE OF JAY COUNTY	3, 984	0		0	171	90. 01
	09002 JAY FAMILY MEDICINE	84, 475	0	3, 582	7, 520	0	
	09100 EMERGENCY	44, 408	0	5, 691	3, 953	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART) 04040 OTHER OUTPATIENT SERVICE COST CENTER	0 0	0	77	0	0	92. 00 93. 00
73.00	OTHER REIMBURSABLE COST CENTERS	<u> </u>		,,	J	0	73.00
99. 10	09910 CORF	0	0	0	0	0	99. 10
	SPECIAL PURPOSE COST CENTERS			1	_		
	10600 HEART ACQUISITION 10900 PANCREAS ACQUISITION	0	0		0		106. 00 109. 00
	11000 INTESTINAL ACQUISITION	0	0		0		110.00
	11100   SLET ACQUISITION	Ö	0	Ö	0		111.00
	11300 I NTEREST EXPENSE						113.00
118.00	, , , , , , , , , , , , , , , , , , ,	728, 508	0	71, 806	50, 662	171	118. 00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	8, 858	0	70	789	0	190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0, 030	0				192.00
	19300 NONPALD WORKERS	O	0	Ō	0		193. 00
	07950 MOB	0	0	0	0		194.00
	07951 P0B	0	0	0	0		194. 01
	07952 WEST JAY CLINIC 07953 CONVENIENT CARE	15, 790	0	478 706			194. 02 194. 03
	07954 OTHER NONREIMBURSABLE COST CENTERS	13, 770	0	, 00	0		194. 04
194. 05	07955 OTHER NONREIMBURSABLE COST CENTERS	0	0	_	0		194. 05
194.06	07956 TRI COUNTY	17, 297	0	5, 226	0	0	194. 06

Health Financial Systems	JAY COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 15-1320	Period: Worksheet B From 10/01/2017 Part II
		To 02/28/2018 Date/Time Prenared:

					7/30/2018 12:	58 pm
Cost Center Description	Subtotal	EMPLOYEE	ADMI NI STRATI V	OPERATION OF	OPERATION OF	
		BENEFITS	E & GENERAL	PLANT	PLANT-MOB	
		DEPARTMENT				
	2A	4.00	5. 00	7. 00	7. 01	
194. 07 07957 HOSPI TALI ST	0	0	2, 030	0	0	194. 07
194.08 07958 FAMILY FIRST HEALTH	37, 818	0	4, 401	3, 366	0	194. 08
194. 09 07959 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)	808, 271	0	84, 717	56, 223	171	202. 00

Provider CCN: 15-1320

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 10/01/2017 Part II
To 02/28/2018 Date/Time Prepared: 7/30/2018 12:58 pm

					0 02, 20, 20.0	7/30/2018 12:	
	Cost Center Description	OPERATION OF	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		PLANT-POB 7. 02	PLANT-WJ 7. 03	8.00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS	7.02	7.05	0.00	7. 00	10.00	
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
	00201 NEW CAP REL COSTS-MVBLE EQUIP MOB						2. 01
1	00202 NEW CAP REL COSTS-MVBLE EQUIP-POB						2. 02
1	00203 NEW CAP REL COSTS-MVBLE EQUIP- WJ						2.03
1	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	00500 ADMINI STRATI VE & GENERAL						5.00
1	00700 OPERATION OF PLANT						7. 00 7. 01
1	00701 OPERATION OF PLANT-MOB 00702 OPERATION OF PLANT-POB	307					7.01
1	00703 OPERATION OF PLANT-WJ	0	2				7. 02
1	00800 LAUNDRY & LINEN SERVICE		0	5, 158			8.00
	00900 HOUSEKEEPI NG	0	0		l .		9.00
10.00	01000 DI ETARY	o	0	161	207	24, 171	10.00
1	01100 CAFETERI A	0	0	0	204	0	11.00
	01300 NURSING ADMINISTRATION	0	0	0	165	0	13.00
1	01400 CENTRAL SERVICES & SUPPLY	0	0	0	125	0	14.00
	01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	141	0	16. 00
	03000 ADULTS & PEDIATRICS	l ol	0	2, 365	1, 180	16, 795	30.00
1	03100 INTENSIVE CARE UNIT		0		0	0,775	31.00
1	03300 BURN INTENSIVE CARE UNIT	o	0		o	0	33.00
1	04000 SUBPROVI DER - I PF	o	0	128	456	7, 376	40.00
41.00	04100 SUBPROVI DER - I RF	o	0	0	0	0	41.00
42. 00	04200 SUBPROVI DER	0	0	0	0	0	42.00
	04300 NURSERY	0	0	93	102	0	43.00
	ANCILLARY SERVICE COST CENTERS				4 005		
	05000 OPERATING ROOM	161	0		1, 005	0	
	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0	0		13	0	52. 00 53. 00
1	05400 RADI OLOGY-DI AGNOSTI C		0		_	0	54.00
1	05700 CT SCAN		0	0	022	0	57.00
1	05800 MAGNETIC RESONANCE IMAGING (MRI)		0	0	Ö	0	58.00
	05900 CARDI AC CATHETERI ZATI ON	Ö	0	Ö	O	0	59.00
1	06000 LABORATORY	o	0	0	254	0	60.00
60. 01	06001 BLOOD LABORATORY	o	0	0	0	0	60. 01
65. 00	06500 RESPI RATORY THERAPY	0	0	0	55	0	65. 00
1	06600 PHYSI CAL THERAPY	0	0		11	0	66.00
1	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67.00
1	06800 SPEECH PATHOLOGY	0	0	0	100	0	68.00
1	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	107 0	199	0	69. 00 71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS		0		0	0	72.00
1	07300 DRUGS CHARGED TO PATIENTS		0		102	0	73.00
1	OUTPATIENT SERVICE COST CENTERS	<u> </u>			102		70.00
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
	09000 CLI NI C	0	0	0		0	
	09001 FAMILY PRACTICE OF JAY COUNTY	0	0	0	547	0	
1	09002 JAY FAMILY MEDICINE	0	0	0	857	0	90.02
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	698	450	0	91.00
	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	92. 00 93. 00
	OTHER REIMBURSABLE COST CENTERS	<u> </u>	0	0	<u> </u>	0	73.00
	09910 CORF	0	0	0	0	0	99. 10
	SPECIAL PURPOSE COST CENTERS	-1			- 1		
106.00	10600 HEART ACQUISITION	0	0	0	0	0	106. 00
	10900 PANCREAS ACQUISITION	0	0	0	0		109. 00
1	11000 INTESTINAL ACQUISITION	0	0	0	0		110.00
	11100   SLET ACQUISITION	0	0	0	0	0	111. 00
	11300 INTEREST EXPENSE			- 450		0.4.74	113.00
118. 00	1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	161	0	5, 158	6, 695	24, 171	118.00
	NONREIMBURSABLE COST CENTERS  19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	0	0	90	^	190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES		0		l .		192.00
	19300 NONPAI D WORKERS		0	0	o		193. 00
	07950 MOB	l ol	0	l o	o		194.00
	07951 P0B	0	0	Ö	o		194. 01
	07952 WEST JAY CLINIC	0	2	0	o		194. 02
	07953 CONVENIENT CARE	0	0	0	160		194. 03
	07954 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194. 04
	07955 OTHER NONREIMBURSABLE COST CENTERS	0	0	1	0		194. 05
	07956 TRI COUNTY 07957 HOSPI TALI ST	146	0	1			194. 06 194. 07
	U / 7U / HUJET I MEL J I	. 01	U	1 0	0	. ()	1174. U/

Heal th Financial Systems

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1320
Period:
From 10/01/2017
To 02/28/2018
Part II
To 02/28/2018
Part II
To 02/28/2018
Part II
To 02/28/2018
To 03/2018
To 7/30/2018
To 7/30/2018

						//30/2018 12:	58 pm
	Cost Center Description	OPERATION OF	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		PLANT-POB	PLANT-WJ	LINEN SERVICE			
		7. 02	7. 03	8. 00	9. 00	10.00	
194. 08 07958	FAMILY FIRST HEALTH	0	0	0	384	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	0	201.00
202. 00	TOTAL (sum lines 118 through 201)	307	2	5, 158	7, 753	24, 171	202.00

Provider CCN: 15-1320

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 10/01/2017 Part II
To 02/28/2018 Date/Time Prepared: 7/30/2018 12:58 pm

				02/28/2018	7/30/2018 12:	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	MEDI CAL	Subtotal	
		ADMINISTRATIO N	SERVICES & SUPPLY	RECORDS & LI BRARY		
	11. 00	13. 00	14. 00	16. 00	24. 00	
GENERAL SERVICE COST CENTERS	111.00	10.00		10.00	2 00	
2.00 O0200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2. 01   00201 NEW CAP REL COSTS-MVBLE EQUIP MOB						2. 01
2. 02   00202 NEW CAP REL COSTS-MVBLE EQUI P-POB						2.02
2. 03   00203   NEW CAP REL COSTS-MVBLE EQUI P- WJ						2.03
4. 00   00400   EMPLOYEE BENEFITS DEPARTMENT 5. 00   00500   ADMINISTRATIVE & GENERAL						4. 00 5. 00
7.00 00700 OPERATION OF PLANT						7.00
7. 01   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 00800 LAUNDRY & LINEN SERVICE						8.00
9. 00   00900   HOUSEKEEPI NG						9. 00
10. 00   01000   DI ETARY						10.00
11. 00   01100   CAFETERI A	22, 655	0.4 5.47				11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	2, 334	24, 547	14 2/2			13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	339	0	14, 263	10 201		14.00
16. 00 O1600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	1, 421	0	19	18, 301		16.00
30. 00 03000 ADULTS & PEDIATRICS	4, 387	8, 954	1, 304	1, 027	169, 945	30.00
31. 00 03100 INTENSIVE CARE UNIT	0	0, 751	0	0	0	31.00
33.00 03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
40. 00   04000   SUBPROVI DER -   I PF	2, 206	4, 504	49	188	67, 697	
41. 00   04100   SUBPROVI DER -   RF	0	0	0	0	0	41.00
42. 00   04200   SUBPROVI DER	0	0	0	0	0	42.00
43. 00   04300   NURSERY	273	557	0	39	12, 632	43.00
ANCILLARY SERVICE COST CENTERS	2 242	4 500	2.0//	2.7/0	07.021	 
50. 00   05000   OPERATING ROOM	2, 243	4, 580	3, 966 0	2, 768	97, 831	50.00
52.00   05200   DELIVERY ROOM & LABOR ROOM   53.00   05300   ANESTHESIOLOGY	28 0	57 0	0	53	1, 639 0	52. 00 53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	2, 084	0	1, 161	5, 670	82, 624	54.00
57. 00   05700 CT SCAN	2,004	0	1, 101	3, 0, 0	02, 024	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	Ö	0	o	0	58.00
59. 00   05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59.00
60. 00   06000   LABORATORY	2, 451	0	2, 706	4, 018	42, 583	60.00
60. 01   06001   BLOOD LABORATORY	0	0	0	0	0	60. 01
65. 00 06500 RESPIRATORY THERAPY	0	0	80	180	10, 068	65.00
66. 00   06600   PHYSI CAL THERAPY	0	0	30	565	3, 971	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	1 020	0	0	0	0	68.00
69. 00   06900   ELECTROCARDI OLOGY 71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	1, 039 0	0	148 0	458	24, 733 0	69. 00 71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	962	0	84	1, 128	20, 205	73.00
OUTPATIENT SERVICE COST CENTERS	762	<u> </u>	01	1, 120	20, 200	70.00
88. 00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00
90. 00   09000   CLI NI C	0	0	34	0	125	
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	0	0	1, 686	256	9, 336	90. 01
90. 02   09002   JAY FAMILY MEDICINE	0	0	1, 033	181	97, 648	1
91. 00 09100 EMERGENCY	2, 888	5, 895	757	1, 758	66, 498	
92.00   09200   OBSERVATION BEDS (NON-DISTINCT PART) 93.00   04040   OTHER OUTPATIENT SERVICE COST CENTER	0		0	10	00	92.00
93. 00 O4040 OTHER OUTPATIENT SERVICE COST CENTER OTHER REIMBURSABLE COST CENTERS	U	0	0	12	89	93.00
99. 10 09910 CORF	0	0	0	0	0	99. 10
SPECIAL PURPOSE COST CENTERS	0		o l	<u> </u>		77. 10
106. 00 10600 HEART ACQUISITION	0	0	0	O	0	106.00
109. 00 10900 PANCREAS ACQUISITION	0	0	0	0		109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100 I SLET ACQUISITION	0	0	0	0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	22, 655	24, 547	13, 057	18, 301	707, 624	118. 00
NONREI MBURSABLE COST CENTERS			-	اه	0.007	
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
193. 00 19300 NONPAI D WORKERS 194. 00 07950 MOB	0	0	0	0		193. 00 194. 00
194. 01 07950 MOB 194. 01 07951 POB	0	0	0	0		194.00
194. 02 07952 WEST JAY CLINIC	0	n	15	0		194. 01
194. 03 07953 CONVENI ENT CARE	0	0	54	ol		194. 02
194. 04 07954 OTHER NONREI MBURSABLE COST CENTERS	0	ő	0	ő		194. 04
194.05 07955 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	o	0	194. 05
194. 06 07956 TRI COUNTY	0	0	228	0	23, 321	194. 06
	<u>-</u>					

Health Financial Systems

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1320
Pro

					7/30/2018 12:	58 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	2, 030	194. 07
194.08 07958 FAMILY FIRST HEALTH	0	0	909	0	46, 878	194. 08
194. 09 07959 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)	22, 655	24, 547	14, 263	18, 301	808, 271	202. 00

Health FinancialSystemsJAY COUNTY HOSPITALIn Lieu of Form CMS-2552-10ALLOCATION OF CAPITALRELATED COSTSProvider CCN: 15-1320Period:Worksheet B

From 10/01/2017 Part II Date/Time Prepared: 02/28/2018 7/30/2018 12:58 pm Cost Center Description Intern & Total Resi dents Cost & Post Stepdown Adjustments 25. 00 26.00 GENERAL SERVICE COST CENTERS 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00201 NEW CAP REL COSTS-MVBLE EQUIP MOB 2.01 2 01 2.02 00202 NEW CAP REL COSTS-MVBLE EQUIP-POB 2.02 00203 NEW CAP REL COSTS-MVBLE EQUIP- WJ 2.03 2.03 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 7.00 00700 OPERATION OF PLANT 7.00 7.01 00701 OPERATION OF PLANT-MOB 7.01 00702 OPERATION OF PLANT-POB 7.02 7.02 00703 OPERATION OF PLANT-WJ 7.03 7.03 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9.00 9.00 01000 DI ETARY 10.00 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14 00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 169, 945 30.00 0 03100 INTENSIVE CARE UNIT 31.00 31.00 33.00 03300 BURN INTENSIVE CARE UNIT 0 33.00 04000 SUBPROVI DER - I PF 40.00 0 0 67, 697 40.00 41 00 04100 SUBPROVI DER - I RF 41 00 C 04200 SUBPROVI DER 42.00 42.00 43.00 04300 NURSERY 12,632 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 0 97, 831 50.00 0 1, 639 52.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 53.00 05300 ANESTHESI OLOGY 53.00 0 0 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 82.624 54.00 05700 CT SCAN 57 00 57.00 0 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 0 58.00 05900 CARDIAC CATHETERIZATION 59.00 59.00 60.00 06000 LABORATORY 00000 42, 583 60.00 06001 BLOOD LABORATORY 60.01 60.01 65.00 06500 RESPIRATORY THERAPY 10,068 65.00 66.00 06600 PHYSI CAL THERAPY 3, 971 66.00 06700 OCCUPATI ONAL THERAPY 67.00 67.00 C 06800 SPEECH PATHOLOGY 68.00 r 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 24, 733 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 20, 205 73.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 0 88.00 88.00 0 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 r 89 00 90.00 09000 CLI NI C 0 90.00 125 09001 FAMILY PRACTICE OF JAY COUNTY 90. 01 0 0 9, 336 90.01 09002 JAY FAMILY MEDICINE 97, 648 90.02 90.02 91.00 09100 EMERGENCY 66, 498 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 04040 OTHER OUTPATIENT SERVICE COST CENTER 89 93.00 93.00 OTHER REIMBURSABLE COST CENTERS 0 99.10 09910 CORF 0 99.10 SPECIAL PURPOSE COST CENTERS 106. 00 10600 HEART ACQUISITION 0 106.00 0 109.00 10900 PANCREAS ACQUISITION 0 0 109.00 110.00 11000 INTESTINAL ACQUISITION 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 0 111.00 113. 00 11300 INTEREST EXPENSE 113 00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 0 707, 624 118.00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 9, 807 190.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 192 00 C 193. 00 19300 NONPALD WORKERS 0 0 193.00 194. 00 07950 MOB 0 0 0 194.00 194. 01 07951 POB 194. 01 Ω 194.02 07952 WEST JAY CLINIC 495 194.02 194. 03 07953 CONVENIENT CARE 194.03 18, 116 194. 04 07954 OTHER NONREI MBURSABLE COST CENTERS 194.04

Health Financial Systems	JAY COUNTY H	HOSPI TAL		In Lieu of Form CMS-2552-10		
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CC	CN: 15-1320	Peri od:	Worksheet B	
				From 10/01/2017 To 02/28/2018	Part II Date/Time Prepared:	
				10 02/20/2018	7/30/2018 12:58 pm	
Cost Center Description	Intern &	Total				
	Resi dents					
	Cost & Post					
	Stepdown					
	Adjustments					
	25. 00	26. 00				
194. 05 07955 OTHER NONREIMBURSABLE COST CENTERS	0	0			194. 05	
194.06 07956 TRI COUNTY	0	23, 321			194. 06	
194. 07 07957 HOSPI TALI ST	0	2, 030			194. 07	
194.08 07958 FAMILY FIRST HEALTH	o	46, 878			194. 08	
194. 09 07959 MERIDIAN HEALTH CONVENIENT CARE	o	o			194. 09	
200.00 Cross Foot Adjustments	o	o			200. 00	
201.00 Negative Cost Centers	0	O			201. 00	
202.00 TOTAL (sum lines 118 through 201)	0	808, 271			202. 00	

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

				Ic	02/28/2018	Date/lime Pre 7/30/2018 12:	
			CAPI TAL REI	_ATED COSTS			
	Cost Center Description	NEW MVBLE EQUIP (SQUARE FEET)	NEW MVBLE EQUIP MOB (SQUARE FEET)	NEW MVBLE EQUIP-POB (SQUARE FEET)	NEW MVBLE EQUIP- WJ (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
		2. 00	2. 01	2. 02	2. 03	4. 00	
	GENERAL SERVICE COST CENTERS			T			
2. 00 2. 01 2. 02 2. 03 4. 00 5. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP 00201 NEW CAP REL COSTS-MVBLE EQUIP MOB 00202 NEW CAP REL COSTS-MVBLE EQUIP-POB 00203 NEW CAP REL COSTS-MVBLE EQUIP- WJ 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	77, 723 0 0 0 0 0 0 8, 198	8, 146 0 0 0 1, 431	10, 501 0 0	3, 300 0 0	7, 428, 394 842, 721	2. 00 2. 01 2. 02 2. 03 4. 00 5. 00
7. 00 7. 01 7. 02 7. 03	00700 OPERATION OF PLANT 00701 OPERATION OF PLANT-MOB 00702 OPERATION OF PLANT-POB 00703 OPERATION OF PLANT-WJ	4, 926 0 0 0	1, 196 0 0	630 0	0 0 0 0	114, 762 300 329 201	7. 00 7. 01 7. 02 7. 03
8. 00 9. 00 10. 00 11. 00 13. 00	O0800 LAUNDRY & LINEN SERVICE O0900 HOUSEKEEPING O1000 DIETARY O1100 CAFETERIA O1300 NURSING ADMINISTRATION	445 497 2, 083 2, 055 1, 667	0 0 0 0	0 0 0	0 0 0 0	22, 269 158, 765 85, 738 59, 602 427, 279	11. 00
14. 00 16. 00 30. 00	01400 CENTRAL SERVI CES & SUPPLY 01600 MEDI CAL RECORDS & LI BRARY I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	1, 258 1, 420 11, 918	0	0	0 0 0	27, 752 142, 461 567, 707	14. 00 16. 00 30. 00
31. 00 33. 00 40. 00 41. 00 42. 00	03100 I NTENSI VE CARE UNI T 03300 BURN I NTENSI VE CARE UNI T 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 04200 SUBPROVI DER	0 0 4, 594 0 0	0 0 0 0	0 0 0	0 0 0 0	0 0 314, 142 0 0	31.00 33.00 40.00 41.00 42.00
43. 00	04300 NURSERY	1, 033	0	0	0	42, 954	43.00
50. 00 52. 00 53. 00	ANCILLARY SERVICE COST CENTERS  05000 OPERATING ROOM  05200 DELIVERY ROOM & LABOR ROOM  05300 ANESTHESIOLOGY	5, 410 127	0		0	336, 369 11, 546 0	50. 00 52. 00 53. 00
54. 00 57. 00 58. 00	05400 RABIOLOGY-DIAGNOSTIC 05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	6, 269 0	0	0 0	0	331, 070 0 0	
59. 00 60. 00 60. 01	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 BLOOD LABORATORY	0 2, 557 0	0	0 0 0	0	0 252, 819 0	59. 00 60. 00 60. 01
65. 00 66. 00 67. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	558 109 0	0 0 0	0 0 0	0 0 0	0 0 0	65. 00 66. 00 67. 00
	06800  SPEECH PATHOLOGY   06900  ELECTROCARDI OLOGY   07100  MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0 2, 002 0	0 0 0	0 0	0 0 0	0 79, 055 0	71. 00
73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 0UTPATIENT SERVICE COST CENTERS	1, 026	0	0 0	0 0	,	73. 00
89. 00 90. 00 90. 01 90. 02	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09001 FAMILY PRACTICE OF JAY COUNTY 09002 JAY FAMILY MEDICINE 09100 EMERGENCY	0 0 0 0 8, 640 4, 542	0 0 0 5, 519 0 0	0	0 0 0 0 0	0 0 116 684, 208 764, 978 933, 457	89. 00 90. 00 90. 01 90. 02
93. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) 04040 OTHER OUTPATIENT SERVICE COST CENTER OTHER REIMBURSABLE COST CENTERS	0	0	0	0	881	92.00 93.00
99. 10	09910 CORF	0	0	0	0	0	99. 10
	SPECIAL PURPOSE COST CENTERS 10600 HEART ACQUISITION 10900 PANCREAS ACQUISITION	0	0	0	0		106. 00 109. 00
110. 00 111. 00	11000 INTESTINAL ACQUISITION 11100 ISLET ACQUISITION 11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	71, 334	0 0 8, 146	0	0 0	0	110. 00 111. 00 113. 00
192.00	NONREIMBURSABLE COST CENTERS   19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN   19200 PHYSICIANS' PRIVATE OFFICES   19300 NONPAID WORKERS	906 0 0	0 0	0 0	0	0	190. 00 192. 00 193. 00
194. 00 194. 01	07950   MOB	0 0	0 0	0 0	0 0 3, 300	0	194. 00 194. 01

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS JAY COUNTY HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-1320

Peri od: Worksheet B-1 From 10/01/2017 To 02/28/2018 Date/Time Prepared:

					7/30/2018 12:	58 pm
		CAPI TAL REI	LATED COSTS			
Cost Center Description	NEW MVBLE	NEW MVBLE	NEW MVBLE	NEW MVBLE	EMPLOYEE	
	EQUI P	EQUIP MOB	EQUI P-POB	EQUIP- WJ	BENEFITS	
	(SQUARE	(SQUARE	(SQUARE	(SQUARE	DEPARTMENT	
	FEET)	FEET)	FEET)	FEET)	(GROSS	
	2.00	2.01	2.02	2.02	SALARI ES)	
194. 03 07953  CONVENI ENT CARE	2.00	2. 01	2. 02	2. 03	4. 00	104 00
	1, 615	0	0	0	126, 845	194. 03
194. 04 07954 OTHER NONREIMBURSABLE COST CENTERS 194. 05 07955 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194. 04
194.06 07956 TRI COUNTY	0	0	4, 276	0	109, 360	
194. 06 07956  TRI COUNTY 194. 07 07957  HOSPI TALI ST	0	0	4,270	0	179, 481	
194. 08 07 958 FAMILY FIRST HEALTH	2 040	0	0	0	377, 422	
194. 09 07939 MERI DI AN HEALTH CONVENI ENT CARE	3, 868	0	0	0		194. 06
200.00 Cross Foot Adjustments	0	U	٥	U	U	200.00
201.00 Negative Cost Centers						200.00
202.00 Cost to be allocated (per Wkst. B,	759, 912	5, 880	42, 479	0	1, 787, 223	
Part I)	759, 912	3, 000	42,479	U	1, 707, 223	202.00
203.00 Unit cost multiplier (Wkst. B, Part I	9, 777183	0. 721827	4. 045234	0. 000000	0. 240593	303 00
204.00 Cost to be allocated (per Wkst. B,	7. 777103	0.721027	4.043234	0.000000		204.00
Part II)					0	204.00
205.00 Unit cost multiplier (Wkst. B, Part					0. 000000	205 00
II)					0.00000	200.00
206.00 NAHE adjustment amount to be allocated	d					206. 00
(per Wkst. B-2)						200.00
207.00 NAHE unit cost multiplier (Wkst. D,						207.00
Parts III and IV)						
	•			· ·		-

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS JAY COUNTY HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-1320 

			Ť	o 02/28/2018	Date/Time Pre 7/30/2018 12:	pared: 58 pm
Cost Center Description		ADMI NI STRATI V	OPERATION OF	OPERATION OF	OPERATION OF	<u> </u>
	n	E & GENERAL (ACCUM.	PLANT (SQUARE	PLANT-MOB (SQUARE	PLANT-POB (SQUARE	
		COST)	FEET)	FEET)	FEET)	
GENERAL SERVICE COST CENTERS	5A	5.00	7.00	7. 01	7. 02	
2. 00 00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2. 01 00201 NEW CAP REL COSTS-MVBLE EQUIP MOB						2. 01
2. 02   00202 NEW CAP REL COSTS-MVBLE EQUI P-POB 2. 03   00203 NEW CAP REL COSTS-MVBLE EQUI P- WJ						2. 02 2. 03
4. 00   00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMINISTRATIVE & GENERAL	-2, 580, 417	10, 664, 208				5.00
7. 00 00700 OPERATION OF PLANT	0	,	1			7.00
7. 01   00701   OPERATION OF PLANT-MOB 7. 02   00702   OPERATION OF PLANT-POB	0	21, 467 38, 605		5, 519	8, 998	7. 01 7. 02
7. 03   00703   OPERATION OF PLANT-WJ		249	1	0	0, 770	7.02
8.00 00800 LAUNDRY & LINEN SERVICE	0	52, 931	1	0	0	8. 00
9. 00   00900   HOUSEKEEPI NG	0	231, 055		0	0	9.00
10. 00   01000   DI ETARY 11. 00   01100   CAFETERI A	0	204, 372 71, 762	1		0	10.00 11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	0		1	0	0	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0				0	14.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	201, 402	1, 420	0	0	16. 00
30. 00   03000   ADULTS & PEDIATRICS	1 0	885, 831	11, 918	0	0	30.00
31. 00   03100   NTENSI VE CARE UNI T	0			0	0	31.00
33.00 03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33. 00
40. 00   04000   SUBPROVI DER -   PF	0		4, 594	0	0	40.00
41. 00   04100   SUBPROVI DER -   I RF 42. 00   04200   SUBPROVI DER		1	0	0	0	41. 00 42. 00
43. 00 04300 NURSERY	0	-	1, 033	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00   05000   0PERATING ROOM 52.00   05200   DELIVERY ROOM & LABOR ROOM	0		1	0	4, 722 0	50. 00 52. 00
53. 00   05200   DELI VERY ROOM & LABOR ROOM   53. 00   05300   ANESTHESI OLOGY			127	0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	1	1	_	0	54.00
57. 00 05700 CT SCAN	0	0	0	0	0	57.00
58. 00   05800   MAGNETIC RESONANCE I MAGING (MRI) 59. 00   05900   CARDIAC CATHETERIZATION	0	0	0	0	0	58. 00 59. 00
60. 00   06000   LABORATORY		746, 400	2, 557	0	0	60.00
60. 01 06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
65. 00 06500 RESPI RATORY THERAPY	0	479, 709	1		0	65.00
66. 00   06600   PHYSI CAL THERAPY 67. 00   06700   OCCUPATI ONAL THERAPY	0	273, 162	109	0	0	66. 00 67. 00
68. 00   06800   SPEECH PATHOLOGY			0	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	184, 569	2, 002	0	0	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS 73. 00   07300   DRUGS CHARGED TO PATIENTS	0	0 881, 787	1, 026	0	0	72. 00 73. 00
OUTPATIENT SERVICE COST CENTERS		001,707	1,020	<u> </u>	0	73.00
88. 00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	1	0	0	0	89.00
90.00   09000   CLINIC 90.01   09001   FAMILY PRACTICE OF JAY COUNTY	0	11, 514 338, 889		0 5, 519	0	90. 00 90. 01
90. 02 09002 JAY FAMILY MEDICINE		450, 855	1		0	90.02
91. 00 09100 EMERGENCY	0	716, 403			0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0.700				92.00
93. 00   04040 OTHER OUTPATIENT SERVICE COST CENTER OTHER REIMBURSABLE COST CENTERS	0	9, 720	0	0	0	93.00
99. 10 09910 CORF	0	0	0	0	0	99. 10
SPECIAL PURPOSE COST CENTERS		-				
106. 00 10600 HEART ACQUISITION	0	0	0	0		106.00
109. 00 10900  PANCREAS ACQUISITION 110. 00 11000  INTESTINAL ACQUISITION	0	0	0	0		109. 00 110. 00
111. 00 11100   SLET ACQUISITION			0	0		111.00
113.00 11300 I NTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-2, 580, 417	9, 038, 899	58, 210	5, 519	4, 722	118. 00
NONREI MBURSABLE COST CENTERS  190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	1 0	8, 858	906	0	0	190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES			0	0		192.00
193.00 19300 NONPALD WORKERS	0	0	0	0		193. 00
194. 00 07950 MOB	0	0	0	0		194.00
194. 01 07951 POB 194. 02 07952 WEST JAY CLINIC		0 60, 199	0	0		194. 01 194. 02
194. 03 07953  CONVENI ENT CARE		88, 850	1			194. 02
194.04 07954 OTHER NONREIMBURSABLE 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

OST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-1320
Prov

				19	0 02/28/2018	7/30/2018 12:	
	Cost Center Description	Reconciliatio	ADMI NI STRATI V	OPERATION OF	OPERATION OF	OPERATION OF	Jo pili
	oost center bescription	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	657, 804	0	0	4, 276	194. 06
194. 07 07957	HOSPI TALI ST	0	255, 558	0	0	0	194. 07
194. 08 07958	FAMILY FIRST HEALTH	0	554, 040	3, 868	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,		2, 580, 417	727, 027	26, 661	47, 946	202.00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)		0. 241970	11. 254462	4. 830766	5. 328517	203. 00
204.00	Cost to be allocated (per Wkst. B,		84, 717	56, 223	171	307	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part		0. 007944	0. 870339	0. 030984	0. 034119	205. 00
	[11]						
206. 00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

	Financial Systems	JAY COUNTY				u of Form CMS-2	
COST A	LLOCATION - STATISTICAL BASIS		Provi der C	F	Period: From 10/01/2017 Fo 02/28/2018	Worksheet B-1 Date/Time Pre	
					. 02/20/2010	7/30/2018 12:	
	Cost Center Description	OPERATION OF PLANT-WJ (SQUARE	LAUNDRY & LINEN SERVICE (POUNDS OF	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (MEALS SERVED)	CAFETERI A (FTE' S)	
		FEET) 7. 03	LAUNDRY) 8. 00	9. 00	10.00	11. 00	
	GENERAL SERVICE COST CENTERS	7.00	0.00	7.00	10.00	11.00	
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 2. 03	OO202   NEW CAP REL COSTS-MVBLE EQUIP-POB   OO203   NEW CAP REL COSTS-MVBLE EQUIP- WJ						2. 02 2. 03
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00	00500 ADMINI STRATI VE & GENERAL						5. 00
7. 00	00700 OPERATION OF PLANT						7. 00
7. 01	00701 OPERATION OF PLANT-MOB						7.01
7. 02 7. 03	00702 OPERATION OF PLANT-POB 00703 OPERATION OF PLANT-WJ	3, 300					7. 02 7. 03
8. 00	00800 LAUNDRY & LINEN SERVICE	0,000	46, 080				8.00
9. 00	00900 HOUSEKEEPI NG	0	5, 580				9. 00
10.00	01000 DI ETARY	0	1, 440			14 (05	10.00
11. 00 13. 00	O1100   CAFETERI A   O1300   NURSI NG   ADMI NI STRATI ON	0	)   0	2, 055 1, 66		14, 695 1, 514	
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	0	1		220	
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0			922	16. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		24 425	11 010	11 000	2.045	1 20 00
30. 00 31. 00	03000   ADULTS & PEDIATRICS   03100   INTENSIVE CARE UNIT	0	21, 125 0	11, 918		2, 845 0	30.00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0			0	33.00
40.00	04000 SUBPROVI DER - I PF	0	1, 140	4, 594	4, 874	1, 431	40. 00
41.00	04100 SUBPROVI DER – I RF	0	0	)	0	0	
42. 00 43. 00	04200 SUBPROVI DER 04300 NURSERY	0 0	0 835	1	1	0 177	42. 00 43. 00
43.00	ANCI LLARY SERVI CE COST CENTERS		033	1,000	<u> </u>	177	43.00
50.00	05000 OPERATING ROOM	0	4, 800			1, 455	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	127		18	1
53. 00 54. 00	05300  ANESTHESI OLOGY   05400  RADI OLOGY-DI AGNOSTI C	0	3, 660	6, 26	1	0 1, 352	
57. 00	05700 CT SCAN	0	0,000	) 0, 20,	.	0	1
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	) (	o o	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	) (	-	1 500	
60. 00 60. 01	06000  LABORATORY  06001  BLOOD LABORATORY	0	)   0	2, 557	1	1, 590 0	60.00
65. 00	06500 RESPI RATORY THERAPY	0	0	558	-	Ö	65.00
66. 00	06600 PHYSI CAL THERAPY	0	300	1	1	0	66.00
67. 00 68. 00	06700 OCCUPATIONAL THERAPY	0	0			0	67. 00 68. 00
69.00	06800   SPEECH   PATHOLOGY   06900   ELECTROCARDI OLOGY	0	960	2,002		674	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1	1	0	
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	1	0	0	
/3.00	07300 DRUGS CHARGED TO PATLENTS OUTPATLENT SERVICE COST CENTERS	0	0	1, 026	5 0	624	73.00
88. 00	08800 RURAL HEALTH CLINIC	0	0	) (	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	) (	o	0	89. 00
	09000 CLINIC	0	0	(	0	0	
90. 01 90. 02	09001 FAMILY PRACTICE OF JAY COUNTY 09002 JAY FAMILY MEDICINE	0	)   0	5, 519 8, 640		0	
91. 00	09100 EMERGENCY	0	6, 240			1, 873	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93. 00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	) (	0	0	93.00
99 10	OTHER REIMBURSABLE COST CENTERS 09910 CORF	0	0		o	0	99. 10
77. 10	SPECIAL PURPOSE COST CENTERS			1	<u> </u>	J	77.10
	10600 HEART ACQUISITION	0	0	) (			106. 00
	10900 PANCREAS ACQUISITION	0	0		0		109.00
	11000 INTESTINAL ACQUISITION  11100 ISLET ACQUISITION	0	)   0				110. 00 111. 00
	11300   NTEREST EXPENSE			1		Ü	113.00
118.00		0	46, 080	67, 509	15, 973	14, 695	118. 00
100 00	NONREIMBURSABLE COST CENTERS   19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1 0	0	906	si ol	0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	) 700			192.00
193.00	19300 NONPALD WORKERS	0	0		o	0	193. 00
	07950 M0B	0	0		0		194.00
	07951 POB 07952 WEST JAY CLINIC	3, 300	0		ا م		194. 01 194. 02
194. 03	07953 CONVENI ENT CARE	3, 300	0	1, 615			194. 02
194. 04	07954 OTHER NONREIMBURSABLE COST CENTERS	0	0	)	0	0	194. 04
194. 05	07955 OTHER NONREIMBURSABLE COST CENTERS	0	0	)  (	0	0	194. 05

Health Financial Systems	JAY COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provider CCN: 15-1320	Period: Worksheet B-1 From 10/01/2017

				T	02/28/2018	Date/Time Pre 7/30/2018 12:	
	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, 276	0	0	194.06
194. 07 07957	HOSPI TALI ST	0	0	0	0	0	194. 07
194. 08 07958	FAMILY FIRST HEALTH	0	0	3, 868	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,	309	70, 747	301, 123	287, 502	120, 170	202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 093636	1. 535308	3. 851958	17. 999249	8. 177611	203. 00
204. 00	Cost to be allocated (per Wkst. B,	2	5, 158	7, 753	24, 171	22, 655	204.00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000606	0. 111936	0. 099176	1. 513241	1. 541681	205.00
	[1]						
206. 00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						[

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS | Peri od: | Worksheet B-1 | From 10/01/2017 | To 02/28/2018 | Date/Time Prepared: Provider CCN: 15-1320

				Ť	To 02/28/2018 Date/Time I 7/30/2018	
	Cost Center Description	NURSI NG	CENTRAL	MEDI CAL	77 007 2010	12.00 p
		ADMI NI STRATI O N	SERVICES & SUPPLY	RECORDS & LI BRARY		
		(DI RECT	(SUPPLY COST)	(GROSS		
		NRSI NG FTE)	14.00	CHARGES)	4	
	GENERAL SERVICE COST CENTERS	13. 00	14. 00	16. 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 2. 03	OO2O2   NEW CAP REL COSTS-MVBLE EQUIP-POB   OO2O3   NEW CAP REL COSTS-MVBLE EQUIP- WJ					2. 02 2. 03
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500 ADMINISTRATIVE & GENERAL					5.00
7. 00 7. 01	OO7OO  OPERATION OF PLANT  OO7O1  OPERATION OF PLANT-MOB					7. 00 7. 01
7. 01	00702 OPERATION OF PLANT-NOB					7.01
7. 03	00703 OPERATION OF PLANT-WJ					7. 03
8.00	00800 LAUNDRY & LI NEN SERVI CE					8.00
9. 00 10. 00	00900  HOUSEKEEPI NG  01000  DI ETARY					9. 00 10. 00
11. 00	01100 CAFETERI A					11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	7, 799				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	720, 135			14.00
16. 00	O1600   MEDICAL RECORDS & LIBRARY     INPATIENT ROUTINE SERVICE COST CENTERS	0	956	36, 957, 230	)	16.00
30.00	03000 ADULTS & PEDIATRICS	2, 845	65, 830	2, 074, 587	·	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	0	C	)	31.00
33. 00 40. 00	03300   BURN INTENSIVE CARE UNIT   04000   SUBPROVIDER - IPF	0 1, 431	2, 489	379, 920	)	33. 00 40. 00
41. 00	04100 SUBPROVI DER - I RF	0	2, 407	377, 720		41.00
42.00	04200 SUBPROVI DER	0	0	С		42. 00
43. 00	04300 NURSERY	177	0	78, 743	<u> </u>	43.00
50. 00	ANCILLARY SERVICE COST CENTERS    O5000   OPERATING ROOM	1, 455	200, 280	5, 592, 581		50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	18		107, 584		52.00
53.00	05300 ANESTHESI OLOGY	0	1	0		53.00
54. 00 57. 00	05400   RADI OLOGY-DI AGNOSTI C   05700   CT   SCAN	0	58, 640	11, 441, 333	) )	54. 00 57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	Ö			58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	o	C	)	59. 00
60.00	06000 LABORATORY	0	136, 630	8, 116, 885		60.00
60. 01 65. 00	06001   BLOOD LABORATORY   06500   RESPI RATORY THERAPY	0	4, 045	363, 573		60. 01 65. 00
66. 00	06600 PHYSI CAL THERAPY	0	1, 511	1, 140, 509		66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	C		67.00
68. 00 69. 00	O6800  SPEECH PATHOLOGY   O6900  ELECTROCARDI OLOGY	0	7, 489	925, 223	) 2	68. 00 69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7,487	725, 225		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	o	C		72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	4, 247	2, 278, 281		73.00
88. 00	OUTPATIENT SERVICE COST CENTERS  O8800 RURAL HEALTH CLINIC	0	O	C		88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	С		89. 00
	09000 CLINIC	0	1, 697	C 51/ /0/	)	90.00
	09001 FAMILY PRACTICE OF JAY COUNTY 09002 JAY FAMILY MEDICINE	0	85, 117 52, 137			90. 01 90. 02
	09100 EMERGENCY	1, 873				91.00
	1 1					92.00
93.00	O4040  OTHER OUTPATIENT SERVICE COST CENTER   OTHER REIMBURSABLE COST CENTERS	0	0	23, 298	<u>}</u>	93. 00
99. 10	09910 CORF	0	0	С		99. 10
	SPECIAL PURPOSE COST CENTERS	I				
	10600 HEART ACQUISITION  10900 PANCREAS ACQUISITION	0	0	C		106. 00 109. 00
	11000   NTESTINAL ACQUISITION		0		)	1109.00
111.00	11100 ISLET ACQUISITION	0	0	C		111.00
	11300 I NTEREST EXPENSE	7 700	/F0 07F	0, 057 000		113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)   NONREIMBURSABLE COST CENTERS	7, 799	659, 275	36, 957, 230	J	118. 00
190. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	С		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	C		192. 00
193.00	19300 NONPAID WORKERS  07950 MOB	0	0	C		193. 00 194. 00
	07950 MOB  07951 POB	0			<u>'</u>	194.00
194. 02	07952 WEST JAY CLINIC	0	733	, c		194. 02
194.03	07953 CONVENIENT CARE	0	2, 727	C		194. 03
194. 04	07954 OTHER NONREIMBURSABLE COST CENTERS	0	0	<u> </u>	<u>"1</u>	194. 04

Health Financial Systems

OST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-1320
Prov

Date/Time Prepared: 7/30/2018 12:58 pm Cost Center Description NURSI NG CENTRAL MEDI CAL ADMI NI STRATI O SERVICES & RECORDS & SUPPLY LI BRARY Ν (DI RECT (SUPPLY COST) (GROSS NRSING FTE) CHARGES) 13. 00 14.00 16.00 194. 05 07955 OTHER NONREI MBURSABLE COST CENTERS 194. 05 194. 06 07956 TRI COUNTY 194. 07 07957 HOSPI TALI ST 0 11, 527 0 0 0 194.06 194. 07 194.08 07958 FAMILY FIRST HEALTH 0 45, 873 194. 08 194. 09 07959 MERI DI AN HEALTH CONVENI ENT CARE 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, 709, 572 83, 958 279, 237 202.00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 90. 982434 0.116586 0.007556 203.00 Cost to be allocated (per Wkst. B, 204.00 204.00 24, 547 14, 263 18, 301 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 3. 147455 0.019806 0.000495 205.00 11)

206.00

207.00

206.00

207.00

NAHE adjustment amount to be allocated

NAHE unit cost multiplier (Wkst. D,

(per Wkst. B-2)

Parts III and IV)

From 10/01/2017 Part I Date/Time Prepared: 02/28/2018 7/30/2018 12:58 pm Title XVIII Hospi tal Cost Costs Total Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Di sal I owance (from Wkst. Adj B, Part I, col. 26) 1. 00 2.00 3.00 4.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 1, 817, 885 1, 817, 885 1, 817, 885 30.00 03100 INTENSIVE CARE UNIT 0 31.00 31.00 33.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 33.00 0 04000 SUBPROVI DER - I PF 909, 944 0 909, 944 40 00 909, 944 40 00 41.00 04100 SUBPROVI DER - I RF 0 0 41.00 0 42.00 04200 SUBPROVI DER 0 0 42.00 04300 NURSERY 123, 931 123, 931 123, 931 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1, 259, 071 1, 259, 071 0 1, 259, 071 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 25, 626 25, 626 o 25, 626 52.00 05300 ANESTHESI OLOGY 0 53.00 53.00 0 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 131, 475 1, 131, 475 1, 131, 475 54.00 05700 CT SCAN 0 57.00 57.00 0 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 0 0 0 58.00 0 05900 CARDI AC CATHETERI ZATI ON 59 00  $\cap$ Ω 59 00 60.00 06000 LABORATORY 1, 055, 895 1, 055, 895 1, 055, 895 60.00 06001 BLOOD LABORATORY 60.01 0 0 60.01 06500 RESPIRATORY THERAPY 607, 432 607, 432 607, 432 65.00 65.00 06600 PHYSI CAL THERAPY 66.00 350, 161 350, 161 350, 161 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 67.00 06800 SPEECH PATHOLOGY 0 68.00 68.00 C 0 0 69 00 06900 ELECTROCARDI OLOGY 274 322 274 322 274, 322 69 00 |07100| MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 1, 133, 465 1, 133, 465 73.00 07300 DRUGS CHARGED TO PATIENTS 1, 133, 465 73.00 OUTPATIENT SERVICE COST CENTERS 88 00 08800 RURAL HEALTH CLINIC 0 0 0 0 88 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 0 0 0 89.00 0 90 00 09000 CLINIC 14, 498 14 498 14 498 90 00 09001 FAMILY PRACTICE OF JAY COUNTY 90.01 482, 637 482, 637 482, 637 90.01 90.02 09002 JAY FAMILY MEDICINE 699, 312 699, 312 0 699, 312 90.02 0 91.00 09100 EMERGENCY 1, 184, 964 1, 184, 964 1, 184, 964 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 192, 252 192, 252 92 00 92 00 192, 252 04040 OTHER OUTPATIENT SERVICE COST CENTER 93.00 12, 248 12, 248 12, 248 93.00 OTHER REIMBURSABLE COST CENTERS 99.10 09910 CORF 0 0 0 99.10 SPECIAL PURPOSE COST CENTERS 106.00 10600 HEART ACQUISITION 0 0 106.00 109.00 10900 PANCREAS ACQUISITION 0 0 0 109.00 110.00 11000 INTESTINAL ACQUISITION 0 110.00 0 0 111.00 11100 I SLET ACQUISITION 0 O 0 111 00 113. 00 11300 INTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 11, 275, 118 0 11, 275, 118 0 11, 275, 118 200. 00 201.00 Less Observation Beds 192, 252 201. 00 192, 252 192, 252

11, 082, 866

11, 082, 866

11, 082, 866 202. 00

202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-1320 Peri od: Worksheet C From 10/01/2017 Part I Date/Time Prepared: 02/28/2018 7/30/2018 12:58 pm Title XVIII Hospi tal Cost Charges Total (col. 6 Cost or Other TEFRA Cost Center Description Inpati ent Outpati ent I npati ent + col. 7) Ratio Ratio 6. 00 7.00 8.00 9.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 1, 916, 521 30.00 03000 ADULTS & PEDIATRICS 1, 916, 521 30.00 31.00 03100 INTENSIVE CARE UNIT 31.00 03300 BURN INTENSIVE CARE UNIT 33.00 33.00 40.00 04000 SUBPROVI DER - I PF 379, 920 379.920 40.00 04100 SUBPROVI DER - I RF 41.00 0 0 41.00 42.00 04200 SUBPROVI DER 42.00 43.00 04300 NURSERY 78, 743 78, 743 43 00 ANCILLARY SERVICE COST CENTERS 50 00 0.000000 50.00 05000 OPERATING ROOM 766, 215 4, 826, 366 5, 592, 581 0 225132 52.00 05200 DELIVERY ROOM & LABOR ROOM 107, 584 107, 584 0.238195 0.000000 52.00 53.00 05300 ANESTHESI OLOGY 0.000000 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.098894 0.000000 575, 688 10, 865, 645 11, 441, 333 54.00 57.00 05700 CT SCAN 0 0 0.000000 0.000000 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.000000 58.00 0 0 0.000000 05900 CARDI AC CATHETERI ZATI ON 0.000000 0.000000 59.00 59.00 0 06000 LABORATORY 60.00 983, 893 7, 132, 992 8, 116, 885 0.130086 0.000000 60 00 06001 BLOOD LABORATORY 0.000000 0.000000 60.01 60.01 06500 RESPIRATORY THERAPY 65.00 234, 628 128, 945 363, 573 1.670729 0.000000 65.00 06600 PHYSI CAL THERAPY 935, 378 0.307022 66.00 205, 131 1, 140, 509 0.000000 66,00 67.00 06700 OCCUPATI ONAL THERAPY 0.000000 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 0.000000 68.00 06900 ELECTROCARDI OLOGY 60, 404 864, 819 925, 223 0. 296493 0.000000 69.00 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71 00  $\cap$ 0.000000 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 0. 497509 73.00 572, 222 1, 706, 059 2, 278, 281 0.000000 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 89.00 90.00 09000 CLI NI C 0 0 0.000000 0.000000 90.00 90 01 09001 FAMILY PRACTICE OF JAY COUNTY 91 843 424, 851 516, 694 0 934087 0.000000 90 01 09002 JAY FAMILY MEDICINE 90.02 21, 595 344, 487 366, 082 1.910261 0.000000 90.02 91.00 09100 EMERGENCY 156, 440 3, 395, 497 3, 551, 937 0.333611 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 158, 066 158,066 1.216277 0.000000 92.00 04040 OTHER OUTPATIENT SERVICE COST CENTER 0 23, 298 <u>23,</u> 298 0.525710 0.000000 93.00 93.00 OTHER REIMBURSABLE COST CENTERS 99.10 0 0 99.10 09910 CORF 0 SPECIAL PURPOSE COST CENTERS 106. 00 10600 HEART ACQUISITION 0 C 0 106.00 109.00 10900 PANCREAS ACQUISITION 0 0 109.00 110.00 11000 INTESTINAL ACQUISITION 0 0 110.00 C 111.00 11100 | SLET ACQUISITION 0 0 111 00 113.00 11300 INTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 6, 150, 827 30, 806, 403 36, 957, 230 200.00

30, 806, 403

36, 957, 230

6, 150, 827

201.00

202.00

201.00

202.00

Less Observation Beds

Heal th Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1320
Provider CN: 15-132

7/30/2018 12:58 pm Title XVIII Hospi tal Cost PPS Inpatient Cost Center Description Ratio 11.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 31.00 03100 INTENSIVE CARE UNIT 31.00 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 04300 NURSERY 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 225132 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0. 238195 52.00 53. 00 05300 ANESTHESI OLOGY 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.098894 54.00 57.00 05700 CT SCAN 0. 000000 57.00 58.00 | 05800 | MAGNETIC RESONANCE I MAGING (MRI) 0.000000 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 59.00 60.00 06000 LABORATORY 0. 130086 60.00 06001 BLOOD LABORATORY 0. 000000 60.01 60.01 06500 RESPIRATORY THERAPY 65.00 1.670729 65.00 66.00 06600 PHYSI CAL THERAPY 0. 307022 66.00 06700 OCCUPATI ONAL THERAPY 0.000000 67.00 67.00 06800 SPEECH PATHOLOGY 0.000000 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 0. 296493 69.00 71.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0. 497509 73.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88.00 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 89.00 0.000000 90.00 09000 CLI NI C 90.00 09001 FAMILY PRACTICE OF JAY COUNTY 0. 934087 90.01 09002 JAY FAMILY MEDICINE 90.02 1. 910261 90.02 91.00 09100 EMERGENCY 91.00 0.333611 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 1. 216277 92.00 04040 OTHER OUTPATIENT SERVICE COST CENTER 93.00 0.525710 93.00 OTHER REIMBURSABLE COST CENTERS 99. 10 99.10 09910 CORF SPECIAL PURPOSE COST CENTERS 106. 00 10600 HEART ACQUISITION 106.00 109.00 10900 PANCREAS ACQUISITION 109.00 110.00 11000 INTESTINAL ACQUISITION 110.00 111.00 11100 I SLET ACQUISITION 111. 00 113. 00 11300 | INTEREST EXPENSE 113.00 Subtotal (see instructions) 200.00 200.00

201.00

202.00

201.00

202.00

Less Observation Beds

From 10/01/2017 Part I Date/Time Prepared: 02/28/2018 7/30/2018 12:58 pm Title XIX Hospi tal Cost Costs Total Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Di sal I owance (from Wkst. Adj B, Part I, col. 26) 1. 00 2.00 3.00 4.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 1, 817, 885 1, 817, 885 1, 817, 885 30.00 03100 INTENSIVE CARE UNIT 0 31.00 31.00 33.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 33.00 0 04000 SUBPROVI DER - I PF 909, 944 0 909, 944 40 00 909, 944 40 00 41.00 04100 SUBPROVI DER - I RF 0 0 41.00 0 42.00 04200 SUBPROVI DER 0 0 42.00 04300 NURSERY 123, 931 123, 931 123, 931 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1, 259, 071 1, 259, 071 0 1, 259, 071 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 25, 626 25, 626 o 25, 626 52.00 05300 ANESTHESI OLOGY 0 53.00 53.00 0 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 131, 475 1, 131, 475 1, 131, 475 54.00 05700 CT SCAN 0 57.00 57.00 0 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 0 0 0 58.00 0 05900 CARDI AC CATHETERI ZATI ON 59 00  $\cap$ Ω 59 00 60.00 06000 LABORATORY 1, 055, 895 1, 055, 895 1, 055, 895 60.00 06001 BLOOD LABORATORY 60.01 0 0 60.01 06500 RESPIRATORY THERAPY 607, 432 607, 432 607, 432 65.00 65.00 06600 PHYSI CAL THERAPY 66.00 350, 161 350, 161 350, 161 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 67.00 06800 SPEECH PATHOLOGY 0 68.00 68.00 C 0 0 69 00 06900 ELECTROCARDI OLOGY 274 322 274 322 274, 322 69 00 |07100| MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 1, 133, 465 1, 133, 465 73.00 07300 DRUGS CHARGED TO PATIENTS 1, 133, 465 73.00 OUTPATIENT SERVICE COST CENTERS 88 00 08800 RURAL HEALTH CLINIC 0 0 0 0 88 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 0 0 0 89.00 0 90 00 09000 CLINIC 14, 498 14 498 14 498 90 00 09001 FAMILY PRACTICE OF JAY COUNTY 90.01 482, 637 482, 637 482, 637 90.01 90.02 09002 JAY FAMILY MEDICINE 699, 312 699, 312 0 699, 312 90.02 0 91.00 09100 EMERGENCY 1, 184, 964 1, 184, 964 1, 184, 964 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 192, 252 192, 252 92 00 92 00 192, 252 04040 OTHER OUTPATIENT SERVICE COST CENTER 93.00 12, 248 12, 248 12, 248 93.00 OTHER REIMBURSABLE COST CENTERS 99.10 09910 CORF 0 0 0 99.10 SPECIAL PURPOSE COST CENTERS 106.00 10600 HEART ACQUISITION 0 0 106.00 109.00 10900 PANCREAS ACQUISITION 0 0 0 109.00 110.00 11000 INTESTINAL ACQUISITION 0 110.00 0 0 111.00 11100 I SLET ACQUISITION 0 O 0 111 00 113. 00 11300 INTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 11, 275, 118 0 11, 275, 118 0 11, 275, 118 200. 00 201.00 Less Observation Beds 192, 252 201. 00 192, 252 192, 252

11, 082, 866

11, 082, 866

11, 082, 866 202. 00

202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-1320 Peri od: Worksheet C From 10/01/2017 Part I Date/Time Prepared: 02/28/2018 7/30/2018 12:58 pm Title XIX Hospi tal Cost Charges Total (col. 6 Cost or Other TEFRA Cost Center Description Inpati ent Outpati ent I npati ent + col. 7) Ratio Ratio 6. 00 7.00 8.00 9.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 1, 916, 521 30.00 03000 ADULTS & PEDIATRICS 1, 916, 521 30.00 31.00 03100 INTENSIVE CARE UNIT 31.00 03300 BURN INTENSIVE CARE UNIT 33.00 33.00 40.00 04000 SUBPROVI DER - I PF 379, 920 379.920 40.00 04100 SUBPROVI DER - I RF 41.00 0 0 41.00 42.00 04200 SUBPROVI DER 42.00 43.00 04300 NURSERY 78, 743 78, 743 43 00 ANCILLARY SERVICE COST CENTERS 50 00 0.000000 50.00 05000 OPERATING ROOM 766, 215 4, 826, 366 5, 592, 581 0 225132 52.00 05200 DELIVERY ROOM & LABOR ROOM 107, 584 107, 584 0.238195 0.000000 52.00 53.00 05300 ANESTHESI OLOGY 0.000000 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.098894 0.000000 575, 688 10, 865, 645 11, 441, 333 54.00 57.00 05700 CT SCAN 0 0 0.000000 0.000000 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.000000 0 0 0.000000 58.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 0.000000 59.00 59.00 0 06000 LABORATORY 60.00 983, 893 7, 132, 992 8, 116, 885 0.130086 0.000000 60 00 06001 BLOOD LABORATORY 0.000000 0.000000 60.01 60.01 06500 RESPIRATORY THERAPY 65.00 234, 628 128, 945 363, 573 1.670729 0.000000 65.00 06600 PHYSI CAL THERAPY 935, 378 0.307022 66.00 205, 131 1, 140, 509 0.000000 66,00 67.00 06700 OCCUPATI ONAL THERAPY 0.000000 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 0.000000 68.00 06900 ELECTROCARDI OLOGY 60, 404 864, 819 925, 223 0. 296493 0.000000 69.00 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71 00  $\cap$ 0.000000 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 0. 497509 73.00 572, 222 1, 706, 059 2, 278, 281 0.000000 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.000000 0.000000 88.00 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0.000000 0.000000 89.00 0.000000 90.00 09000 CLI NI C 0 0 0.000000 90.00 90 01 09001 FAMILY PRACTICE OF JAY COUNTY 91 843 424, 851 516, 694 0 934087 0.000000 90 01 1. 910261 09002 JAY FAMILY MEDICINE 0.000000 90.02 21, 595 344, 487 366, 082 90.02 91.00 09100 EMERGENCY 156, 440 3, 395, 497 3, 551, 937 0.333611 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 158, 066 158,066 1.216277 0.000000 92.00 04040 OTHER OUTPATIENT SERVICE COST CENTER 0 23, 298 <u>23,</u> 298 0.525710 0.000000 93.00 93.00 OTHER REIMBURSABLE COST CENTERS 99. 10 0 0 99.10 09910 CORF 0 SPECIAL PURPOSE COST CENTERS

106. 00 10600 HEART ACQUISITION 0 C 0 106.00 109.00 10900 PANCREAS ACQUISITION 0 0 109.00 110.00 11000 INTESTINAL ACQUISITION 0 0 110.00 C 111.00 11100 | SLET ACQUISITION 0 0 111 00 113.00 11300 INTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 6, 150, 827 30, 806, 403 36, 957, 230 200.00 201.00 Less Observation Beds 201.00 30, 806, 403 202.00 6, 150, 827 36, 957, 230 Total (see instructions) 202.00

Heal th Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1320
Period: From 10/01/2017 To 02/28/2018 | Date/Time Prepared: 7/30/2018 12:58 pm

				7/30/2018 12: 58	8 pm
		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11. 00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00   03000   ADULTS & PEDIATRICS					30.00
31.00 03100 INTENSIVE CARE UNIT					31.00
33.00 03300 BURN INTENSIVE CARE UNIT					33.00
40. 00   04000   SUBPROVI DER - 1 PF					40.00
41. 00   04100   SUBPROVI DER -   I RF					41.00
42. 00   04200   SUBPROVI DER					42.00
43. 00   04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0. 000000				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
53. 00   05300   ANESTHESI OLOGY	0. 000000				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
57.00 05700 CT SCAN	0. 000000				57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000				59.00
60. 00 06000 LABORATORY	0. 000000			•	60.00
60. 01   06001   BLOOD   LABORATORY	0. 000000			•	60. 01
65. 00 06500 RESPIRATORY THERAPY	0. 000000				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000				67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000				69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000				72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73. 00
OUTPATIENT SERVICE COST CENTERS	0. 000000				70.00
88. 00 08800 RURAL HEALTH CLINIC	0. 000000				88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				89. 00
90. 00   09000   CLINIC	0. 000000			•	90.00
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY	0. 000000				90. 01
90. 02 09002 JAY FAMILY MEDICINE	0. 000000			•	90. 02
91. 00 09100 EMERGENCY	0. 000000			•	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			•	92.00
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTER	0. 000000			•	93.00
OTHER REIMBURSABLE COST CENTERS	0.00000				70.00
99. 10 09910 CORF					99. 10
SPECIAL PURPOSE COST CENTERS					,,,,,
106. 00 10600 HEART ACQUISITION				1	106. 00
109. 00 10900 PANCREAS ACQUISITION					109. 00
110. 00 11000   NTESTI NAL ACQUI SI TI ON	1			•	110.00
111. 00 11100   SLET ACQUISITION					111.00
113. 00 11300   NTEREST EXPENSE				•	113.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00
	1			<u> -</u>	

Health Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provi der Co		Peri od:	Worksheet D	
				From 10/01/2017 To 02/28/2018	Part II Date/Time Pre	narad:
				10 02/20/2010	7/30/2018 12:	рагец. 58 рм
		Title	XVIII	Hospi tal	Cost	
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)			
	col. 26)					
ANOLULARY OFRIVARE COOT OFFITERS	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	07.004	F F00 F04	0.04740	0 445 750	0.550	
50. 00 05000 OPERATING ROOM	97, 831		0.01749		2, 550	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	1, 639		0. 01523		0	52.00
53. 00   05300   ANESTHESI OLOGY 54. 00   05400   RADI OLOGY-DI AGNOSTI C	0 02 424	1	0. 00000 0. 00722		1 140	53. 00 54. 00
57. 00   05700 CT   SCAN	82, 624	11, 441, 333	0.00722		1, 149 0	57.00
58. 00   05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0. 00000		0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0. 00000		0	59.00
60. 00   06000   LABORATORY	42, 583	8, 116, 885	0. 00524		1, 669	60.00
60. 01   06001   BLOOD   LABORATORY	42, 303	0, 110, 003	0.00000		1, 007	60.01
65. 00 06500 RESPIRATORY THERAPY	10, 068	363, 573	0. 02769		2, 863	65.00
66. 00   06600   PHYSI CAL THERAPY	3, 971	1, 140, 509	0. 00348		264	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0, ,,,	0	0. 00000		0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	o	0. 00000		0	68.00
69. 00 06900 ELECTROCARDI OLOGY	24, 733	925, 223	0. 02673		1, 188	•
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.00000		0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.00000	0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	20, 205	2, 278, 281	0. 00886	9 178, 954	1, 587	73.00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0	0	0.00000	0 0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.00000	0 0	0	89. 00
90. 00  09000  CLI NI C	125		0.00000		0	90.00
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY	9, 336				0	90. 01
90.02 O9002 JAY FAMILY MEDICINE	97, 648		0. 26673		0	90. 02
91. 00   09100   EMERGENCY	66, 498		0. 01872		11	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	17, 973				0	92.00
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTER	89				0	93.00
200.00   Total (lines 50 through 199)	475, 323	34, 582, 046		1, 026, 277	11, 281	200. 00

| Peri od: | Worksheet D | From 10/01/2017 | Part IV | To | 02/28/2018 | Date/Time Prepared: Health Financial Systems

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-1320 THROUGH COSTS

				10 02/28/2018	7/30/2018 12:	
		Title	: XVIII	Hospi tal	Cost	<u> </u>
Cost Center Description	Non Physician	Nursi ng	Nursi ng		Allied Health	
	Anestheti st	School	School	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
ANOLLI ADV. CEDVILOE, COCT. CENTEDO	1. 00	2A	2. 00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS			1			
50. 00 05000 OPERATING ROOM	0	0		0	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0	0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0		0	0	54.00
57. 00 05700 CT SCAN	0	0		0	0	57.00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	0	58.00
59. 00   05900   CARDI AC CATHETERI ZATI ON 60. 00   06000   LABORATORY	0	0		0	0	59. 00 60. 00
60. 00   06000   LABORATORY 60. 01   06001   BLOOD   LABORATORY	0	0		0	0	60.00
65. 00 06500 RESPIRATORY THERAPY	0	0		0	0	65.00
66. 00   06600   PHYSI CAL THERAPY	0	0		0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0	0	67.00
68. 00   06800   SPEECH PATHOLOGY	0	0		0	0	68.00
69. 00   06900   SPEECT PATHOLOGY	0	0		0	0	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	ĺ	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	Ö	73.00
OUTPATIENT SERVICE COST CENTERS	ı			<u> </u>		70.00
88. 00 08800 RURAL HEALTH CLINIC	0	0		0 0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	Ö		o o	0	89. 00
90. 00  09000 CLI NI C	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			o	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

| Peri od: | Worksheet D | From 10/01/2017 | Part IV | To | 02/28/2018 | Date/Time Prepared: Health Financial Systems

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-1320 THROUGH COSTS

Title XVIII   Hospital   Cost
Medical Education   Cost   Cost (sum of col 1 through col.   Cost (sum of col 2, 3 and 4)   Cost (sum of col 2, 2) and (sum of col 2, 3) and (sum of col 3, 3) and (sum of col 2, 3) and (sum o
Education   Cost   4)   Cost   Sum of   Col. 2, 3 and   Col. 8)   Col. 7)
ANCILLARY SERVICE COST CENTERS   4.00   5.00   6.00   7.00   8.00
ANCILLARY SERVICE COST CENTERS
ANCI LLARY SERVICE COST CENTERS    ANCI LLARY SERVICE COST CENTERS
ANCI LLARY SERVI CE COST CENTERS
50. 00         05000   OFERATING ROOM         0         0         5, 592, 581   0.000000         50. 00           52. 00         05200   DELI VERY ROOM & LABOR ROOM         0         0         0         107, 584   0.000000   52. 00           53. 00   05300   ANESTHESI OLOGY         0         0         0         0         0.000000   52. 00           54. 00   05400   RADI OLOGY-DI AGNOSTI C         0         0         0         11, 441, 333   0.000000   54. 00           57. 00   05700   CT SCAN           0         0         0         0         0.000000   57. 00           58. 00   05800   MAGNETI C   RESONANCE   IMAGI NG (MRI )         0         0         0         0         0.000000   57. 00           59. 00   05900   CARDI AC   CATHETERI ZATI ON           0         0         0         0         0.000000   58. 00           60. 00   06000   LABORATORY           0         0         0         0         0         0.000000   60. 00           60. 01   06001   BLODD   LABORATORY           0         0         0         0         0         0.000000   60. 00           65. 00   06500   RESPI RATORY   THERAPY           0         0         0         0         0         0         0.000000   65. 00           67. 00   06600   SPECH PATHOLOGY           0         0
52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 107, 584 0.000000 52. 00 53. 00 05300 ANESTHESI OLOGY 0 0 0 0 0 0.000000 53. 00 0.000000 53. 00 0.000000 53. 00 0.000000 53. 00 0.000000 53. 00 0.000000 53. 00 0.000000 53. 00 0.000000 53. 00 0.000000 54. 00 0.000000 54. 00 0.000000 55. 00
53.00         05300         ANESTHESI OLOGY         0         0         0         0.000000         53.00           54.00         05400         RADI OLOGY-DI AGNOSTI C         0         0         0         11,441,333         0.000000         54.00           57.00         05700         CT SCAN         0         0         0         0.000000         57.00           58.00         05800         MAGNETI C RESONANCE I MAGI NG (MRI)         0         0         0         0.000000         58.00           59.00         05900         CARDI AC CATHETERI ZATI ON         0         0         0         0.000000         58.00           60.01         06000         LABORATORY         0         0         0         0.000000         60.00           60.01         06001         BLOOD LABORATORY         0         0         0         0.000000         60.00           65.00         06500         RESPI RATORY THERAPY         0         0         0         363,573         0.000000         65.00           66.00         06600         PHYSI CAL THERAPY         0         0         0         1,140,509         0.00000         66.00           67.00         06700         OCUPATI ONAL THERAPY
54. 00
57. 00
58. 00         05800 MAGNETI C RESONANCE I MAGI NG (MRI )         0         0         0         0.000000 58.00         58.00           59. 00         05900 CARDI AC CATHETERI ZATI ON         0         0         0         0.000000 59.00         59.00           60. 00         06000 LABORATORY         0         0         0         8, 116, 885         0.000000 60.00         60.00           60. 01         06001 BLOOD LABORATORY         0         0         0         0         0.000000 60.00         60.00           65. 00         06500 RESPI RATORY THERAPY         0         0         0         363, 573         0.000000 65.00         65.00           66. 00         06600 PHYSI CAL THERAPY         0         0         0         1,140,509         0.000000 65.00         66.00           67. 00         06700 OCCUPATI ONAL THERAPY         0         0         0         0.000000 67.00         68.00           68. 00         06800 SPEECH PATHOLOGY         0         0         0         0.000000 67.00         68.00           69. 00         06900 ELECTROCARDI OLOGY         0         0         0         0         0.000000 69.00           71. 00         07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS         0         0         0
59. 00         05900 CARDI AC CATHETERI ZATI ON         0         0         0         0.000000         59.00           60. 00         06000 LABORATORY         0         0         0         8, 116, 885         0.000000         60.00           60. 01         06001 BLOOD LABORATORY         0         0         0         0         0.000000         60.01           65. 00         06500 RESPI RATORY THERAPY         0         0         0         363, 573         0.000000         65.00           66. 00         06600 PHYSI CAL THERAPY         0         0         0         1, 140, 509         0.000000         65.00           67. 00         06700 OCCUPATI ONAL THERAPY         0         0         0         0.000000         65.00           68. 00         06800 SPEECH PATHOLOGY         0         0         0         0.000000         68.00           69. 00         06900 ELECTROCARDI OLOGY         0         0         0         0         0.000000         69.00           71. 00         07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS         0         0         0         0.000000         71.00           72. 00         07200 IMPL. DEV. CHARGED TO PATI ENTS         0         0         0         0.000000 <td< td=""></td<>
60. 00
60. 01
65. 00
66. 00   06600   PHYSI CAL THERAPY   0   0   0   1,140,509   0.000000   66. 00   67. 00   06700   0CCUPATI ONAL THERAPY   0   0   0   0   0.000000   67. 00   68. 00   06800   SPECH PATHOLOGY   0   0   0   0   0.000000   68. 00   69. 00   06900   ELECTROCARDI OLOGY   0   0   0   0   0.000000   69. 00   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000
67. 00
68. 00   06800   SPEECH PATHOLOGY   0   0   0   0   0   0   0   0   0
69. 00 06900 ELECTROCARDI OLOGY 0 0 925, 223 0. 000000 69. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0 0 0. 000000 71. 00 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0. 000000 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 2, 278, 281 0. 000000 73. 00 000000 73. 00 000000 73. 00 000000 73. 00 000000 73. 00 00000000 73. 00 0000000 73. 00 0000000 73. 00 0000000 73. 00 0000000 73. 00 0000000 73. 00 0000000 73. 00 0000000 73. 00 0000000 73. 00 0000000 73. 00 0000000 73. 00 0000000 73. 00 0000000 73. 00 00000000 73. 00 0000000 73. 00 0000000 73. 00 0000000 73. 00 00000000 73. 00 0000000 73. 00 0000000 73. 00 0000000 73. 00 0000000 73. 00 0000000 73. 00 0000000 73. 00 0000000 73. 00 0000000 73. 00 0000000 73. 00 0000000 73. 00 0000000 73. 00 0000000 73. 00 0000000 73. 00 0000000 73. 00 0000000 73. 00 0000000 73. 00 00000000 73. 00 0000000 73. 00 0000000 73. 00 0000000 73. 00 0000000 73. 00 0000000 73. 00 0000000 73. 00 0000000 73. 00 0000000 73. 00 0000000 73. 00 0000000 73. 00 0000000 73. 00 0000000 73. 00 0000000000
71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   0   0   0   0
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   0   0   0   0
73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   2, 278, 281   0.000000   73. 00   0000000   73. 00   0000000   73. 00   00000000   73. 00   00000000000000000000000000000000
OUTPATIENT SERVICE COST CENTERS           88.00         08800 RURAL HEALTH CLINIC         0         0         0         0.000000         88.00           89.00         08900 FEDERALLY QUALIFIED HEALTH CENTER         0         0         0         0.000000         89.00
89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER   0   0   0   0   0   0   0   0   0
90. 00   09000  CLI NI C   0   0   0   0   0. 000000   90. 00
90. 01   09001   FAMILY PRACTICE OF JAY COUNTY   0   0   516, 694   0.000000   90. 01
90. 02   09002   JAY FAMI LY MEDI CI NE 0 0 0 366, 082 0. 000000   90. 02
91. 00   09100  EMERGENCY   0   0   3, 551, 937   0. 000000   91. 00
92. 00   09200  0BSERVATI ON BEDS (NON-DISTINCT PART)   0   0   158, 066   0. 000000   92. 00
93. 00   04040  OTHER OUTPATIENT SERVICE COST CENTER   0   0   0   23, 298   0.000000   93. 00
200.00   Total (lines 50 through 199)   0   0   34,582,046     200.00

Health Financial Systems		JAY COUNTY HOSPITAL	In Lieu of Form CMS-2552-10			
	ADDODTIONMENT OF INDATIONATIONS	ANCLULARY SERVICE OTHER PASS   Provider CCN: 15 1220	Poriod: Workshoot D			

Period: From 10/01/2017 To 02/28/2018 Part IV THROUGH COSTS Date/Time Prepared: 7/30/2018 12:58 pm Title XVIII Hospi tal Cost Cost Center Description I npati ent Outpati ent Outpati ent I npati ent Outpati ent Ratio of Cost Program Program Program Program Pass-Through to Charges Charges Pass-Through Charges (col. 6 ÷ col. 7) Costs (col. 8 Costs (col. x col . 12) x col. 10) 9. 00 10.00 11. 00 12.00 ANCILLARY SERVICE COST CENTERS 50 00 0.000000 145, 759 50 00 05000 OPERATING ROOM 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 0 52.00 05300 ANESTHESI OLOGY 0.000000 0 53.00 53.00 0 0 0 0 0 0 0 0 0 0 05400 RADI OLOGY-DI AGNOSTI C 0.000000 0 54.00 159, 134 0 54.00 05700 CT SCAN 0.000000 57.00 r 0 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.000000 0 0 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 0 59.00 06000 LABORATORY 0 60. nn 0.000000 318, 241 0 60.00 06001 BLOOD LABORATORY 60.01 0.000000 0 60.01 65.00 06500 RESPIRATORY THERAPY 0.000000 103, 379 65.00 0 66.00 06600 PHYSI CAL THERAPY 0.000000 75, 789 0 66.00 06700 OCCUPATI ONAL THERAPY 0 0.000000 67.00 67.00 C 0 68.00 06800 SPEECH PATHOLOGY 0.000000 0 68.00 06900 ELECTROCARDI OLOGY 0 69.00 0.000000 44, 448 0 0 0 69.00 0 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 71.00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 178, 954 0 0 0 73.00 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 0 0 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 0 0 89.00 09000 CLI NI C 0.000000 0 90.00 90.00 0 0 0 0 0 90 01 09001 FAMILY PRACTICE OF JAY COUNTY 0.000000 0 Ω 90.01 0 09002 JAY FAMILY MEDICINE 0.000000 90.02 90.02 C 0 91. 00 09100 EMERGENCY 0.000000 573 0 91.00 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 92.00 0.000000 0 0

0.000000

1,026,277

0

93.00

0 200.00

Ω

93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTER

200.00

Total (lines 50 through 199)

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-1320 Peri od: Worksheet D From 10/01/2017 Part V 02/28/2018 Date/Time Prepared: 7/30/2018 12:58 pm Title XVIII Hospi tal Cost Charges Costs PPS PPS Services Cost Center Description Cost to Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, inst.) Subject To Subject To Ded. & Coins. Part I, col. Ded. & Coins. 9 (see inst.) (see inst.) 1.00 2.00 5.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 225132 1, 170, 665 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 0.238195 52.00 0 52.00 0 0 05300 ANESTHESI OLOGY 53.00 0.000000 0  $\cap$ 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.098894 0 3, 102, 401 0 0 0 0 54.00 57.00 05700 CT SCAN 0.000000 0 0 57.00 0 05800 MAGNETIC RESONANCE IMAGING (MRI) 58 00 0.000000 0 0 0 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 0 0 0 59.00 60.00 06000 LABORATORY 0.130086 2, 400, 095 0 0 0 0 60.00 06001 BLOOD LABORATORY 0.000000 0 0 60.01 60.01 0 06500 RESPIRATORY THERAPY 18, 470 65.00 1.670729 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.307022 297, 916 0 66.00 06700 OCCUPATI ONAL THERAPY 0.000000 67.00 0 0 0 0 67.00 06800 SPEECH PATHOLOGY 0.000000 0 68 00 0 0 68 00 69.00 06900 ELECTROCARDI OLOGY 0.296493 0 387, 653 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 0 0 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0.000000 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0.497509 723, 713 31, 354 Ω 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 0 89.00 90 00 09000 CLI NI C 0.000000 0 90 00 0 09001 FAMILY PRACTICE OF JAY COUNTY 90.01 0. 934087 66, 470 5, 979 0 90.01 09002 JAY FAMILY MEDICINE 1. 910261 47, 095 4, 235 0 90.02 90.02 09100 EMERGENCY 0. 333611 613, 750 91.00 91.00 0 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 1. 216277 130, 820 0 0 93.00 04040 OTHER OUTPATIENT SERVICE COST CENTER 0.525710 0 0 0 93.00 200.00 Subtotal (see instructions) 0 8, 959, 048 41.568 0 200.00 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges Net Charges (line 200 - line 201) 0 202.00 202.00 0 8, 959, 048 41, 568

Health Financial Systems	JAY COUNTY HOS	u of Form CMS-2552-10		
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1320	Peri od:	Worksheet D

From 10/01/2017 Part v To 02/28/2018 Date/Time Prepared: 7/30/2018 12:58 pm Titl<u>e XVIII</u> Hospi tal Cost Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 7. 00 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 263, 554 50.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 52.00 05300 ANESTHESI OLOGY 0 53.00 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 306, 809 0 54.00 57.00 05700 CT SCAN 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 0 0 58.00 05900 CARDI AC CATHETERI ZATI ON 59.00 0 59.00 60.00 06000 LABORATORY 312, 219 60.00 0 60.01 06001 BLOOD LABORATORY 60.01 06500 RESPIRATORY THERAPY 0 30, 858 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 91, 467 0 66.00 06700 OCCUPATI ONAL THERAPY 0 67.00 0 67.00 06800 SPEECH PATHOLOGY 0 68.00 68 00 69.00 06900 ELECTROCARDI OLOGY 114, 936 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 360, 054 15, 599 73.00 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0 0 89.00 90 00 09000 CLI NI C 90 00 0 0 09001 FAMILY PRACTICE OF JAY COUNTY 90.01 62, 089 5,585 90.01 90.02 09002 JAY FAMILY MEDICINE 89, 964 8,090 90.02 09100 EMERGENCY 91.00 204, 754 91.00 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 159, 113 92.00 0 93.00 04040 OTHER OUTPATIENT SERVICE COST CENTER C 93.00 200.00 Subtotal (see instructions) 1, 995, 817 29, 274 200.00 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges

1, 995, 817

29, 274

202.00

202.00

Net Charges (line 200 - line 201)

World Flooring Colors	IAV COUNTY	HOCDI TAI		1 . 12 .	. C. F OHC .	0550 40
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provi der CCN: 15-1320 Component CCN: 15-M320		Period: From 10/01/2017 To 02/28/2018	u of Form CMS-2552-10 Worksheet D Part II Date/Time Prepared: 7/30/2018 12:58 pm	
		Title	XVIII	Subprovi der - I PF	PPS	
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	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	97, 831		1		0	
52.00   05200   DELIVERY ROOM & LABOR ROOM	1, 639	107, 584			0	52.00
53. 00   05300   ANESTHESI OLOGY	0		0.0000		0	
54. 00   05400   RADI OLOGY-DI AGNOSTI C	82, 624	11, 441, 333			l e	
57. 00  05700 CT SCAN	0	0	0. 00000		0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0. 00000		0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0. 00000		0	59. 00
60. 00   06000   LABORATORY	42, 583				l	60.00
60. 01   06001   BL00D   LABORATORY	0	0	0.0000		0	60. 01
65. 00 06500 RESPIRATORY THERAPY	10, 068					
66. 00   06600   PHYSI CAL THERAPY	3, 971	1, 140, 509			l	
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0.00000		0	
68. 00 06800 SPEECH PATHOLOGY	0 700	005 000	0.00000		0	68.00
69. 00 06900 ELECTROCARDI OLOGY	24, 733				1	69.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0			0	71.00 72.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	_	۷	1		0	
73. 00 O7300 DRUGS CHARGED TO PATIENTS	20, 205	2, 278, 281	0.00886	85, 320	757	73. 00
OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC	0	0	0.00000	00 0	0	88. 00
89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER	0		0.00000		0	89.00
90. 00   09000   CLINIC	125		0.00000		0	90.00
90. 01   09001 FAMILY PRACTICE OF JAY COUNTY	9, 336				_	90.00
90. 02 09002 JAY FAMILY MEDICINE	97, 648					90.01
91. 00   09100   EMERGENCY	66, 498					
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	00,470		1		0	
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTER	89				Ö	1
200.00 Total (lines 50 through 199)	457, 350			225, 010		200.00
	1 .5., 555	0 ., 002, 0 10	I	1 223,010	2,000	1-30.00

Health Financial Systems	JAY COUNTY					u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI	RVICE OTHER PAS	S Provider CO	Provi der CCN: 15-1320		i od: om 10/01/2017	Worksheet D Part IV	
THROUGH COSTS		Component CCN: 15					
		Title	XVIII	Su	ubprovi der  - I PF	PPS	<u> </u>
Cost Center Description	Non Physician	Nursi ng	Nursi ng			Allied Health	
	Anestheti st	School	School		ost-Stepdown		
	Cost	Post-Stepdown			Adjustments		
	1.00	Adjustments	0.00		0.4	2.00	
ANCILLARY SERVICE COST CENTERS	1. 00	2A	2.00		3A	3. 00	
50. 00 05000 OPERATING ROOM	0	0		0	O	0	50.00
52. 00   05200   DELI VERY ROOM & LABOR ROOM	0	0		0	0	0	
53. 00   05300   ANESTHESI OLOGY	0	0		0	0	0	
54. 00   05400   RADI OLOGY - DI AGNOSTI C	0	0		0	o O	0	
57. 00   05700   CT   SCAN	0	0		0	ol	0	
58. 00   05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		Ö	ő	0	58.00
59. 00   05900 CARDI AC CATHETERI ZATI ON	0	0		0	o	0	1
60. 00 06000 LABORATORY	0	0		0	o	0	60.00
60. 01   06001   BLOOD   LABORATORY	0	0		0	o	0	60. 01
65. 00 06500 RESPIRATORY THERAPY	0	0		0	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0	0	0	
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0	0	0	
68. 00 06800 SPEECH PATHOLOGY	0	0		0	0	0	
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0	0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	0	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	U		U	U	0	73.00
88. 00   08800  RURAL HEALTH CLINIC	1 0	0		0	ol	0	88. 00
89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	0	
90. 00   09000   CLINI C	0	0		0	0	0	
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY	0	0		0	ol	0	
90. 02   09002   JAY FAMILY MEDICINE	0	0		Ö	ő	0	
91. 00 09100 EMERGENCY	0	0		0	o	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0		0	92.00
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0		0	o	0	93.00
200.00 Total (lines 50 through 199)				- 1			200.00

Health Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	JAY COUNTY RVICE OTHER PAS	S Provider C	CN: 15-1320 CCN: 15-M320	Peri od: From 10/01/2017 To 02/28/2018		epared:
		Titl∈	: XVIII	Subprovi der - I PF	PPS	
Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum o col. 2, 3 ar 4)	(from Wkst. f C, Part I,	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
	4. 00	5. 00	6.00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATING ROOM 52. 00   05200   DELIVERY ROOM & LABOR ROOM 53. 00   05300   ANESTHESIOLOGY	0	1	1	0 5, 592, 581 0 107, 584 0 0	0.000000	52.00
54. 00   05400  RADI OLOGY-DI AGNOSTI C 57. 00   05700  CT SCAN	0	0		0 11, 441, 333		54.00
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI) 59.00   05900   CARDIAC CATHETERIZATION	0	0		0 0	0. 000000 0. 000000	59.00
60. 00   06000   LABORATORY 60. 01   06001   BLOOD   LABORATORY 65. 00   06500   RESPI RATORY   THERAPY	0	0		0 8, 116, 885 0 0	0. 000000	60. 01
65. 00   06500   RESPI RATORY   THERAPY 66. 00   06600   PHYSI CAL   THERAPY 67. 00   06700   OCCUPATI ONAL   THERAPY	0	0		0 363, 573 0 1, 140, 509 0 0	•	66. 00
68. 00 06800 SPECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0 0 925, 223	0. 000000	68. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0. 000000 0. 000000	72.00
73. 00 O7300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	-		0 2, 278, 281	0.000000	
88. 00   08800 RURAL HEALTH CLINIC 89. 00   08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00   09000 CLINIC	0 0	1	1	0 0 0	0. 000000 0. 000000 0. 000000	89. 00
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY 90. 02 09002 JAY FAMILY MEDICINE	0	0		0 516, 694 0 366, 082	0. 000000 0. 000000	90. 01 90. 02
91. 00   09100   EMERGENCY 92. 00   09200   0BSERVATION   BEDS (NON-DISTINCT PART) 93. 00   04040   OTHER OUTPATIENT SERVICE COST CENTER	0 0	ľ		0 3, 551, 937 0 158, 066 0 23, 298	0. 000000	92.00
200. 00   Total (Lines 50 through 199)	0	1	1	0 34, 582, 046		200.00

Health Financial Systems	JAY COUNTY H	OSPLTAL		In lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI		Provi der C	CN: 15-1320	Peri od:	Worksheet D	1002 10
THROUGH COSTS			CCN: 15-M320	From 10/01/2017	Part IV	
				To 02/28/2018 Date/Time Pr 7/30/2018 12		
		Title	XVIII	Subprovi der -	PPS	30 piii
				I PF		
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	
ANCILLARY SERVICE COST CENTERS			Г			
50. 00 05000 OPERATING ROOM	0. 000000	0		0 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	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	27, 033		0	0	54.00
57. 00   05700   CT   SCAN	0. 000000	0		0	0	57.00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	74 000		0	0	59.00
60. 00 06000 LABORATORY	0. 000000	74, 089		0	0	60.00
60. 01 06001 BLOOD LABORATORY	0. 000000	0		0	0	60.01
65. 00 06500 RESPIRATORY THERAPY	0. 000000	9, 139		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	5, 126	•	0 0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	0		0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	0		0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	2, 014		0	0	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0	0	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72.00
73. 00 O7300 DRUGS CHARGED TO PATIENTS	0. 000000	85, 320		0 0	0	73. 00
OUTPATIENT SERVICE COST CENTERS 88. OO 08800 RURAL HEALTH CLINIC	0.000000			0 0	0	00.00
	0.000000	0		0 0	0	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0		0	0	89.00
90. 00   09000   CLINIC	0.000000	0		0	0	90.00
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY	0.000000	2, 575		0	0	
90. 02   09002   JAY FAMILY MEDICINE 91. 00   09100   EMERGENCY	0.000000	1, 825		0 0	0	90.02
	0.000000	17, 889		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	225 242		0 0	0	
200.00   Total (lines 50 through 199)		225, 010	I	0 0	0	200. 00

Health Financial Systems JAY COUNTY HOSPITAL In Lieu of Form CMS-2552-10 APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-1320 Peri od: Worksheet D From 10/01/2017 Part V Component CCN: 15-Z320 02/28/2018 Date/Time Prepared: To 7/30/2018 12:58 pm Title XVIII Swing Beds - SNF Cost Charges Costs PPS PPS Services Cost Center Description Cost to Cost Cost Rei mbursed Charge Ratio Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, inst.) Subject To Subject To Ded. & Coins. Part I, col. Ded. & Coins. 9 (see inst.) (see inst.) 1.00 2.00 5.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 0. 225132 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0.238195 52.00 0 52.00 0 53. 00 | 05300 | ANESTHESI OLOGY 0.000000 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.098894 0 0 0 0 0 0 0 0 0 0 0 0 0 54.00 57.00 05700 CT SCAN 0.000000 0 0 0 57.00 0 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 0.000000 0 0 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 0 0 59.00 60.00 06000 LABORATORY 0.130086 0 60.00 0 0 06001 BLOOD LABORATORY 0.000000 0 60.01 60.01 0 06500 RESPIRATORY THERAPY 0 65.00 1.670729 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.307022 0 0 66.00 06700 OCCUPATI ONAL THERAPY 0.000000 0 0 67.00 0 67.00 0 06800 SPEECH PATHOLOGY 0.000000 0 68.00 68 00 0 0 69.00 06900 ELECTROCARDI OLOGY 0.296493 0 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 0 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 0.000000 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0. 497509 Ω 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 0 89.00 90 00 09000 CLI NI C 0.000000 0 0 0 90.00 0 09001 FAMILY PRACTICE OF JAY COUNTY 0 o 90.01 0. 934087 0 0 90.01 09002 JAY FAMILY MEDICINE 1. 910261 0 0 90.02 90.02 0 0 0 0 0 09100 EMERGENCY 0. 333611 0 91.00 91.00 0 0 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 1. 216277 0 93.00 04040 OTHER OUTPATIENT SERVICE COST CENTER 0.525710 0 0 0 93.00 Subtotal (see instructions) 200.00 0 0 0 200. 00 Less PBP Clinic Lab. Services-Program 0 201.00 201.00 Only Charges

0

0

0 202.00

202.00

Net Charges (line 200 - line 201)

Health Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der C	CN: 15-1320	Peri od:	Worksheet D	
				From 10/01/2017		
		Component	CCN: 15-Z320	To 02/28/2018		
		· ·			7/30/2018 12:	58 pm_
		Title	XVIII	Swing Beds - SNF	Cost	
	Cos	its				
Cost Center Description	Cost	Cost				

			Component	CCN: 15-Z320	10	02/28/2018	7/30/2018 12	
			Title	XVIII	Swi ng	Beds - SN		оо р
		Cos						
Cost Center Description	on	Cost	Cost					
·		ei mbursed	Rei mbursed					
		Servi ces	Services Not					
	S	ubject To	Subject To					
	Dec	d. & Coins.	Ded. & Coins.					
	(5	see inst.)	(see inst.)					
		6. 00	7. 00					
ANCILLARY SERVICE COST CENTE	ERS							
50.00   05000   OPERATING ROOM		0	0					50.00
52.00   05200   DELIVERY ROOM & LABOR	ROOM	0	0					52.00
53. 00   05300   ANESTHESI OLOGY		0	0					53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C		0	0					54.00
57. 00  05700 CT SCAN		0	0					57.00
58.00 05800 MAGNETIC RESONANCE IMA	GING (MRI)	0	0					58. 00
59. 00 05900 CARDI AC CATHETERI ZATI 0	N .	0	0					59. 00
60. 00   06000   LABORATORY		0	0					60.00
60. 01   06001   BLOOD LABORATORY		0	0					60. 01
65. 00 06500 RESPIRATORY THERAPY		0	0					65.00
66.00 06600 PHYSI CAL THERAPY		0	0					66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0	0					67.00
68.00 06800 SPEECH PATHOLOGY		0	0					68. 00
69. 00 06900 ELECTROCARDI OLOGY		0	0					69.00
71.00 07100 MEDICAL SUPPLIES CHARG	SED TO PATIENTS	0	0					71.00
72.00 07200 I MPL. DEV. CHARGED TO	PATI ENTS	0	0					72.00
73.00 07300 DRUGS CHARGED TO PATIE	INTS	0	0					73.00
OUTPATIENT SERVICE COST CENT	ΓERS							
88.00 08800 RURAL HEALTH CLINIC		0	0					88. 00
89.00 08900 FEDERALLY QUALIFIED HE	ALTH CENTER	0	0					89. 00
90. 00  09000  CLI NI C		0	0					90.00
90.01 09001 FAMILY PRACTICE OF JAY	COUNTY	0	0					90. 01
90.02 09002 JAY FAMILY MEDICINE		0	0					90. 02
91.00 09100 EMERGENCY		0	0					91.00
92.00 09200 OBSERVATION BEDS (NON-		O	0					92.00
93. 00 04040 OTHER OUTPATIENT SERVI	CE COST CENTER	0	0					93.00
200.00 Subtotal (see instruct	i ons)	o	0					200.00
201.00 Less PBP Clinic Lab. S		o						201.00
Only Charges	-							1
202.00 Net Charges (line 200	- line 201)	0	0					202.00

Health Financial Systems	JAY COUNTY HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1320	From 10/01/2017	Worksheet D-1	
		10 02/28/2018	Date/Time Pre 7/30/2018 12:	
	Title XVIII	Hospi tal	Cost	
01 01 D				

		Title XVIII	Hospi tal	7/30/2018 12: Cost	58 pm
	Cost Center Description	THE AVIII	1103pi tui	0031	
	·			1. 00	
	PART I - ALL PROVIDER COMPONENTS				
1. 00 2. 00 3. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-Private room days (excluding swing-bed and observation bed da do not complete this line.	bed and newborn days)	ivate room days,	1, 172 1, 032 0	
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro reporting period	er 31 of the cost	912 59	4. 00 5. 00	
6. 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	40	6. 00
7. 00	Total swing-bed NF type inpatient days (including private rooreporting period	m days) through December	31 of the cost	25	7. 00
8. 00	Total swing-bed NF type inpatient days (including private rooreporting period (if calendar year, enter 0 on this line)	m days) after December 3	31 of the cost	16	8. 00
9. 00	Total inpatient days including private room days applicable t newborn days)	o the Program (excluding	g swing-bed and	372	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII o through December 31 of the cost reporting period (see instruc		room days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (if calendar year, e	nter 0 on this line)	,	99	
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period			0	
13.00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y	ear, enter 0 on this lir	ne)	0	13.00
14. 00 15. 00	Medically necessary private room days applicable to the Progr Total nursery days (title V or XIX only)	am (excluding swing-bed	days)	0	
16. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT	0			
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 c	of the cost		17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of	the cost		18. 00
19. 00					
20. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	155. 02	20. 00		
21. 00 22. 00	Total general inpatient routine service cost (see instruction $Swing$ -bed cost applicable to $SNF$ type services through Decemb $5 \times 1$ ine 17)	1, 817, 885 0	21. 00 22. 00		
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reportir	ng period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through Decembe $7 \times 1$ ine 19)	r 31 of the cost reporti	ng period (line	3, 433	24. 00
25. 00	Swing-bed cost applicable to NF type services after December $\mathbf{x}$ line 20)	31 of the cost reporting	period (line 8	2, 480	25. 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		164, 521 1, 653, 364	
28. 00 29. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	d and observation bed ch	narges)	0	
30.00	Semi-private room charges (excluding swing-bed charges)	· lino 20)		0,00000	
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	÷ 11ne 28)		0. 000000 0. 00	•
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00	•
34.00	Average per diem private room charge differential (line 32 mi		ctions)	0. 00	
35. 00	Average per diem private room cost differential (line 34 x li	ne 31)		0. 00	
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost	fferential (line	1, 653, 364	36. 00 37. 00	
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	USTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 602. 10	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line			595, 981	
	Medically necessary private room cost applicable to the Progr	,		0	
41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		595, 981	41.00

	Financial Systems ATION OF INPATIENT OPERATING COST	JAY COUNTY H	OSPI TAL Provi der C	°N: 15 1220		u of Form CMS-2 Worksheet D-1	
COMPUT	ATTON OF INPATIENT OPERATING COST		Provider C		Period: From 10/01/2017 To 02/28/2018	Date/Time Pre	pared:
			T: +1 -			7/30/2018 12:	58 pm
	Cost Center Description	Total Inpatient	Total Inpatient	Average Per Diem (col. 1	Hospital Program Days	Program Cost (col. 3 x	
		Cost 1.00	Days 2. 00	÷ col . 2)	4. 00	col . 4) 5.00	
42. 00	NURSERY (title V & XIX only)	0	0				42. 00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	O	0	0.0	0 0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	0	0	0. 0	0	0	45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1. 00	
	Program inpatient ancillary service cost (Wk					388, 339	
49.00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(s	see instructi	ons)		984, 320	49.00
50.00	Pass through costs applicable to Program inp	atient routine s	services (fro	m Wkst. D, sun	of Parts I and	0	50.00
51. 00	<pre>III) Pass through costs applicable to Program inp and IV)</pre>	atient ancillary	/ services (f	rom Wkst. D, s	sum of Parts II	0	51.00
52.00	Total Program excludable cost (sum of lines	50 and 51)				0	52.00
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line	9 1	ated, non-ph	ysician anesth	netist, and	0	53.00
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
55.00	Target amount per discharge					0.00	1
	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and tar	get amount (	line 56 minus	line 53)	0	
58. 00	Bonus payment (see instructions)	0.00					
59. 00	9.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						
						0.00	1
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
	Relief payment (see instructions)	•				0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)  PROGRAM INPATIENT ROUTINE SWING BED COST						0	
64. 00	<pre>Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)</pre>	ts through Decem	nber 31 of th	e cost reporti	ng period (See	0	64.00
65. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts after Decembe	er 31 of the	cost reportino	period (See	158, 608	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line 6	64 plus line	65)(title XVII	I only). For	158, 608	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	December 31	of the cost re	eporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after De	ecember 31 of	the cost repo	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69. 00
70.00	Skilled nursing facility/other nursing facil	ity/ICF/IID rout	ine service	cost (line 37)			70.00
71. 00 72. 00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		ne 70 ÷ 11ne	2)			71.00
73.00	Medically necessary private room cost applic Total Program general inpatient routine serv						73.00
74. 00 75. 00	Capital -related cost allocated to inpatient 26, line 45)	•			Part II, column		74. 00 75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li						76.00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77.00
79. 00	Aggregate charges to beneficiaries for exces	s costs (from pr		,			79.00
80. 00 81. 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		ost limitatio	n (line 78 mir	nus line 79)		80.00
82.00	Inpatient routine service cost limitation (I	ine 9 x line 81)					82.00
83. 00 84. 00	Reasonable inpatient routine service costs ( Program inpatient ancillary services (see in		5)				83. 00 84. 00
85.00	Utilization review - physician compensation	(see instruction					85.00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS		ough 85)				86.00
	Total observation bed days (see instructions					120	87.00
87. 00 88. 00	,	•	11			1, 602. 10	1

Health Financial Systems JAY COUNTY HOS			SPITAL In Lieu of Form CMS-			2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 10/01/2017 To 02/28/2018	Date/Time Pre 7/30/2018 12:	
		Title	XVIII	Hospi tal	Cost	
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	169, 945	1, 817, 885	0. 09348	5 192, 252	17, 973	90.00
91.00 Nursing School cost	o	1, 817, 885	0.00000	0 192, 252	0	91.00
92.00 Allied health cost	0	1, 817, 885	0.00000	0 192, 252	0	92.00
93.00 All other Medical Education	0	1, 817, 885	0.00000	0 192, 252	0	93.00

Health Financial Systems	JAY COUNTY HOSPITAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1320	Peri od: From 10/01/2017	Worksheet D-1
	Component CCN: 15-M320		
	Title XVIII	Subprovi der -	PPS
		IPF	

Past 1 - ALL PROVIDED COMPONENTS   1.00				I PF		
MARTIEL MAS		Cost Center Description			1 00	
Inpartient days (including private room days and swing-bed days, excluding newborn)		PART I - ALL PROVIDER COMPONENTS			1.00	
Inpatient days (including private room days, excluding swing-bed and newborn days)   402   2.00						
Private room days (excluding swing-bed and observation bed days). If you have only private room days. do 0 a.00 do not complete this line. do 10 do not complete this line. do 10 do						
do not complete this line.  4. 00 Sein-private room days (execluding swing-bed and observation bed days)  1. 10 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  1. 10 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  1. 10 Total swing-bed MF type inpatient days (including private room days) through December 31 of the cost reporting period in the cost reporting period (if calendar year, enter 0 on this line)  1. 10 Total swing-bed MF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  1. 10 Saing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and next on the cost reporting period (if calendar year, enter 0 on this line)  1. 10 Saing-bed SNF type inpatient days applicable to the SNF (including private room days) after ship the cost reporting period (if calendar year, enter 0 on this line)  1. 10 Saing-bed SNF type inpatient days applicable to the SNF (including private room days) after ship through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  1. 10 Saing-bed SNF (type inpatient days applicable to title SNF or XNF and y (including private room days) after streeped on SNF (including perivate room days)  1. 10 Saing-bed SNF (type inpatient days applicable to title SNF or XNF and y (including private room days)  1. 11 SNF or SNF (including				ivate room days.		
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reporting period (if calendar year, enter 0 on this line) 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.0						
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24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 x line 20) 26.00 Total swing-bed cost (see instructions) 26.00 Total swing-bed cost (see instructions) 27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 29.00 Private room charges (excluding swing-bed and observation bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 32.00 Average per diem private room per diem charge (line 30 + line 3) 33.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 3 x line 35) 36.00 Private room cost differential dijustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 30 x line 35) 38.00 Application (line 30 x line 35) 39.00 Average per diem private room cost differential (line 3 x line 35) 39.00 Private room cost differential (line 3 x line 35) 39.00 Average per diem private room cost differential (line 3 x line 35) 39.00 Private room cost differential (line 3 x line 35) 39.00 Average per diem private room cost differential (line 3 x line 35) 39.00 Average per diem private room cost differential (line 3 x line 35) 39.00 Average per diem private room cost differential (line 3 x line 35) 39.00 Average per diem private room cost differential (line 3 x line 35) 39.00 Average per diem private room cost differential (line 3 x line 35) 39.00 Average per diem private room cost differential (line 3 x line 35) 39.00 Average per diem private room cost differential (line 3 x line 35) 39.00 Average per diem private room cost differential (line 3 x line 35) 39.00 Average per diem private room cost differential (line 3 x line 35) 39.00 Average per di	23. 00		31 of the cost reportin	g period (line 6	0	23. 00
7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 v line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 + line 28)  32.00 Average private room per diem charge (line 29 + line 3)  33.00 Average semi-private room per diem charge (line 29 + line 3)  34.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 909, 944)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	0.4.00		. 04 . 6 . 1		0	04.00
x line 20)  26.00  Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 28.00 29.00 Private room charges (excluding swing-bed charges) 0 29.00 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 0.000000 31.00 Average private room per diem charge (line 29 + line 3) 0.00 32.00 Average semi-private room per diem charge (line 30 + line 4) 0.00 33.00 Average per diem private room cost differential (line 34 x line 31) 0.00 Average per diem private room cost differential (line 34 x line 31) 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.	24.00	] 3 11 31	r 31 or the cost reporti	ng period (line	Ü	24.00
26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRI VATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Pri vate room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 General inpatient routine service cost/charge ratio (line 27 + line 28)  30.00 Average pri vate room per diem charge (line 29 + line 3)  30.00 Average semi-private room per diem charge (line 30 + line 4)  30.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  516,030 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	25. 00		31 of the cost reporting	period (line 8	0	25. 00
PRI VATE ROOM DIFFERENTIAL ADJUSTMENT  28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29. 00 Pri vate room charges (excluding swing-bed charges)  30. 00 Semi-pri vate room charges (excluding swing-bed charges)  31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32. 00 Average pri vate room per diem charge (line 29 ÷ line 3)  33. 00 Average semi-pri vate room per diem charge (line 30 ÷ line 4)  34. 00 Average per diem pri vate room charge differential (line 32 minus line 33) (see instructions)  35. 00 Average per diem pri vate room cost differential (line 34 x line 31)  36. 00 Pri vate room cost differential adjustment (line 3 x line 35)  37. 00 General inpatient routine service cost net of swing-bed cost and pri vate room cost differential (line 909, 944)  37. 00 Average per diem pri vate room cost net of swing-bed cost and pri vate room cost differential (line 909, 944)  38. 00 Ajusted general inpatient routine service cost per diem (see instructions)  39. 00 Program general inpatient routine service cost (line 9 x line 38)  516, 030  90 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 28. 00  28. 00  29. 00  29. 00  29. 00  29. 00  29. 00  29. 00  29. 00  29. 00  29. 00  29. 00  29. 00  29. 00  29. 00  29. 00  29. 00  29. 00  29. 00  20. 00  30. 00	26. 00				0	26. 00
28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  32.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 909, 944)  37.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  516,030 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 28.00 29.00  29.00 29.00  30.00 30.00  30.00 0.000000  31.00  0.000000  31.00  0.000000  32.0	27. 00		(line 21 minus line 26)		909, 944	27. 00
29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  33.00 Average semi-private room per diem charge (line 29 ÷ line 3)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 909, 944)  37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  39.00 Program general inpatient routine service cost (line 9 x line 38)  516,030 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 30.00  29.00  29.00  30.00	20 00		d and observation had ch	argos)	0	20 00
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 909, 944 one 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			d and observation bed en	ai ges)		
32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 909, 944) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						1
33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 909, 944)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	31.00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0.000000	31.00
Average per diem private room charge differential (line 32 minus line 33) (see instructions)  34.00 Average per diem private room cost differential (line 34 x line 31)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 909, 944)  27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  79.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 909, 944 37.00 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.00
36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 36.00  37.00 Program inpatient routine service cost and private room cost differential (line 909, 944)  37.00 Program general inpatient routine service cost per diem (see instructions)  1, 969.58 38.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00	34.00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instruc	tions)	0.00	34.00
36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 36.00  37.00 Program inpatient routine service cost and private room cost differential (line 909, 944)  37.00 Program general inpatient routine service cost per diem (see instructions)  1, 969.58 38.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00	35.00	Average per diem private room cost differential (line 34 x li	ne 31)		0.00	35.00
37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38. 00 Adjusted general inpatient routine service cost per diem (see instructions)  7. 909, 944 37. 00  1. 969, 58 38. 00  1. 969, 58					0	36.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1, 969.58 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38)  516,030 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00		General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	909, 944	
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1, 969.58 38.00 Program general inpatient routine service cost (line 9 x line 38)  516,030 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00						
38.00Adjusted general inpatient routine service cost per diem (see instructions)1,969.5838.0039.00Program general inpatient routine service cost (line 9 x line 38)516,03039.0040.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.00			ISTMENTS			1
39.00 Program general inpatient routine service cost (line 9 x line 38) 516,030 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	38 00			T	1 969 59	38 00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		, , , , , , , , , , , , , , , , , , , ,				
			*			
						1

Heal th	Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUT	TATION OF INPATIENT OPERATING COST			CN: 15-1320	Peri od: From 10/01/2017	Worksheet D-1	
				CCN: 15-M320	To 02/28/2018	Date/Time Pre 7/30/2018 12:	
			Titl∈	e XVIII	Subprovi der - I PF	PPS	
	Cost Center Description	Total I npati ent	Total Inpatient	Average Per Diem (col.	Program Days	Program Cost (col. 3 x	
		1. 00	Days 2. 00	÷ col. 2)	4.00	col . 4) 5.00	
42. 00		0	2.00 C				42.00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	0	C	0. (	ool o	0	43.00
44.00	CORONARY CARE UNIT	1					44.00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	0	C	0. (	00 0	0	45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wk: Total Program inpatient costs (sum of lines			one)		84, 057 600, 087	
49.00	PASS THROUGH COST ADJUSTMENTS	41 through 46) (	see Histructi	ulis)		800, 087	49.00
50. 00	Pass through costs applicable to Program inpa	atient routine	services (fro	m Wkst. D, su	um of Parts I and	0	50.00
51.00	Pass through costs applicable to Program inpa and IV)	atient ancillar	y services (f	rom Wkst. D,	sum of Parts II	2, 535	51.00
52.00	Total Program excludable cost (sum of lines!					2, 535	
53. 00	Total Program inpatient operating cost excluded medical education costs (line 49 minus line !		elated, non-ph	ysician anest	hetist, and	597, 552	53.00
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
55.00	Target amount per discharge						55.00
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operati	ing cost and ta	irget amount (	line 56 minus	s line 53)	0	56. 00 57. 00
58. 00	Bonus payment (see instructions)					0.00	58. 00 59. 00
59. 00	2.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						
60.00	60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by						
01.00	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target						
62. 00	amount (line 56), otherwise enter zero (see instructions) 2.00 Relief payment (see instructions)						
63.00	63.00 Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST						
64. 00	64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						
65. 00	7 7	ts after Decemb	er 31 of the	cost reportir	ng period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routin CAH (see instructions)	ne costs (line	64 plus line	65)(title XVI	II only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs through	December 31	of the cost r	reporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs after D	ecember 31 of	the cost rep	porting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili				7)		70.00
71.00	Adjusted general inpatient routine service co	ost per diem (I			,		71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applications)	•	ı (line 14 x l	ine 35)			72. 00 73. 00
74.00	Total Program general inpatient routine servi	•		•	Dort II column		74.00
75. 00	Capital-related cost allocated to inpatient (26, line 45)	routine service	COSTS (TIOIII	worksneet b,	Part II, Corumn		75.00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ line Program capital-related costs (line 9 x line						76. 00 77. 00
78.00	Inpatient routine service cost (line 74 minus	s line 77)					78. 00
79. 00 80. 00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa				nus line 79)		79. 00 80. 00
81.00	Inpatient routine service cost per diem limit	tati on		(			81.00
82. 00 83. 00	Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (:		* .				82. 00 83. 00
84.00	Program inpatient ancillary services (see in	structions)					84.00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST	· g/				
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per of		line 2)			0 0. 00	87. 00 88. 00
89. 00	Observation bed cost (line 87 x line 88) (see	e instructions)				0	89. 00

Health Financial Systems JAY COUNTY HOSPITAL				In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
		Component (	CCN: 15-M320	From 10/01/2017 To 02/28/2018	Date/Time Pre 7/30/2018 12:	
		Title	XVIII	Subprovi der -	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	909, 944	0. 00000	00	0	90.00
91.00 Nursing School cost	0	909, 944	0. 00000	00	0	91.00
92.00 Allied health cost	0	909, 944	0. 00000	00	0	92.00
93.00 All other Medical Education	0	909, 944	0. 00000	00	0	93.00

Health Financial Systems	JAY COUNTY HOSPITAL	In Lieu of Form CMS-2552-1		
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1320	Peri od: From 10/01/2017 To 02/28/2018	Worksheet D-1 Date/Time Pre 7/30/2018 12:	
	Ti tle XIX	Hospi tal	Cost	
Cook Cooks Decoming to				

		Title XIX	Hospi tal	Cost	50 piii
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, Inpatient days (including private room days, excluding swing-bed			1, 172 1, 032	
2. 00 3. 00	Private room days (excluding swing-bed and observation bed days)		ivate room days	1, 032	3.00
	do not complete this line.	, ,			
4. 00	Semi-private room days (excluding swing-bed and observation bed			912	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room reporting period	days) through Decembe	er 31 of the cost	59	5.00
6. 00	Total swing-bed SNF type inpatient days (including private room	days) after December	31 of the cost	40	6.00
	reporting period (if calendar year, enter 0 on this line)	•			
7. 00	Total swing-bed NF type inpatient days (including private room d reporting period	lays) through December	31 of the cost	25	7.00
8. 00	Total swing-bed NF type inpatient days (including private room d	lavs) after December 3	31 of the cost	16	8.00
	reporting period (if calendar year, enter 0 on this line)	,			
9. 00	Total inpatient days including private room days applicable to t	he Program (excluding	g swing-bed and	16	9.00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII only	(including private r	room days)	0	10.00
	through December 31 of the cost reporting period (see instructio	ins)	• •		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only		room days) after	0	11.00
12. 00	December 31 of the cost reporting period (if calendar year, ente Swing-bed NF type inpatient days applicable to titles V or XIX o		e room days)	0	12.00
12.00	through December 31 of the cost reporting period	in y (Therauting privat	le room days)	O	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX o			0	13.00
14 00	after December 31 of the cost reporting period (if calendar year			0	14 00
	Medically necessary private room days applicable to the Program Total nursery days (title V or XIX only)	(excluding swing-bed	days)	0 92	14. 00 15. 00
	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to services	through December 31 c	of the cost		17.00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to services	after December 31 of	the cost		18.00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services t	hrough December 31 of	the cost	0. 00	19.00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services a	fter December 31 of t	he cost	0.00	20.00
	reporting period				
	Total general inpatient routine service cost (see instructions)	24 . C. I.I		1, 817, 885	
22. 00	Swing-bed cost applicable to SNF type services through December 5 x line 17)	31 of the cost report	ing period (line	0	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 31	of the cost reportir	ng period (line 6	0	23.00
	x line 18)				
24. 00	Swing-bed cost applicable to NF type services through December 3 $7 \times 1$ ine 19)	1 of the cost reporti	ng period (line	0	24.00
25. 00	Swing-bed cost applicable to NF type services after December 31	of the cost reporting	period (line 8	0	25.00
	x line 20)				
	Total swing-bed cost (see instructions)	21   ! 2/)		159, 126	
	General inpatient routine service cost net of swing-bed cost (li PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	ne 21 minus ime 20)		1, 658, 759	] 27.00
	General inpatient routine service charges (excluding swing-bed a	nd observation bed ch	narges)	0	28.00
29. 00	Private room charges (excluding swing-bed charges)			0	
30.00	Semi-private room charges (excluding swing-bed charges)	1 00)		0	
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 ÷ I Average private room per diem charge (line 29 ÷ line 3)	The 28)		0. 000000 0. 00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	1
34. 00	Average per diem private room charge differential (line 32 minus	line 33)(see instruc	ctions)	0. 00	
	Average per diem private room cost differential (line 34 x line	, ,	, (, 0, 10)	0. 00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	- ,		0.00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and	private room cost di	fferential (line	1, 658, 759	
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTI	MENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see in			1, 607. 33	38.00
	Program general inpatient routine service cost (line 9 x line 38	-		25, 717	
39. 00	Medically necessary private room cost applicable to the Program	•		0	40.00

MCRI F32 - 14. 4. 165. 0

Heal th	Financial Systems JAY COUNTY HOSPITAL In Lieu	u of Form CMS-2	2552-10			
	ATION OF INPATIENT OPERATING COST Provider CCN: 15-1320 Period:	Worksheet D-1	10			
	From 10/01/2017 To 02/28/2018	Date/Time Pre	pared:			
		7/30/2018 12:				
	Cost Center Description Total Total Average Per Program Days	Cost Program Cost				
	Inpatient Inpatient Diem (col. 1	(col. 3 x				
	Cost Days ÷ col. 2)	col . 4)				
42.00	1.00   2.00   3.00   4.00   NURSERY (title V & XIX only)   123,931   92   1,347.08   0	5. 00	42.00			
	Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT 0 0 0.00 0	0				
44. 00 45. 00	BURN INTENSIVE CARE UNIT 0 0 0.00 0	0	44. 00 45. 00			
46. 00	SURGI CAL INTENSI VE CARE UNI T		46. 00			
47. 00	OTHER SPECIAL CARE (SPECIFY)		47. 00			
	Cost Center Description	1. 00				
48. 00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	18, 066				
49. 00	Total Program inpatient costs (sum of lines 41 through 48) (see instructions)	43, 783	49. 00			
50. 00	PASS THROUGH COST ADJUSTMENTS  Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and	0	50. 00			
	111)					
51. 00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00			
52. 00	Total Program excludable cost (sum of lines 50 and 51)	0	52. 00			
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and	0	53.00			
	medical education costs (line 49 minus line 52) TARGET AMOUNT AND LIMIT COMPUTATION					
54.00	Program di scharges	0	54.00			
55.00	Target amount per discharge	0. 00				
56. 00 57. 00	Target amount (line 54 x line 55)  Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	56. 00 57. 00			
58. 00	Bonus payment (see instructions)	0	58.00			
59. 00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the	0.00				
60. 00	market basket Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0. 00	60. 00			
61. 00	, , , , , , , , , , , , , , , , , , , ,	0.00	61.00			
	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target					
62. 00	amount (line 56), otherwise enter zero (see instructions) Relief payment (see instructions)	0	62. 00			
63. 00						
		64. 00				
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See						
65.00	instructions)(title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See					
44 00	instructions)(title XVIII only)	0	44 00			
66. 00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66. 00			
67. 00		0	67. 00			
68 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period	0	68. 00			
00.00	(line 13 x line 20)	O	00.00			
69. 00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69. 00			
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70. 00			
71. 00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71. 00			
72.00	Program routine service cost (line 9 x line 71)		72.00			
73. 00 74. 00	Medically necessary private room cost applicable to Program (line 14 x line 35)  Total Program general inpatient routine service costs (line 72 + line 73)		73. 00 74. 00			
75. 00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column		75. 00			
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ line 2)		76. 00			
77.00	Program capital-related costs (line 9 x line 76)		77.00			
78. 00	Inpatient routine service cost (line 74 minus line 77)		78. 00			
79. 00 80. 00	Aggregate charges to beneficiaries for excess costs (from provider records)  Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		79. 00 80. 00			
81.00	Inpatient routine service costs for comparison to the cost frimitation (fine 78 minus fine 79)		81.00			
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00			
83. 00 84. 00	Reasonable inpatient routine service costs (see instructions)  Program inpatient ancillary services (see instructions)		83. 00 84. 00			
85.00	Utilization review - physician compensation (see instructions)		85.00			
	Total Program inpatient operating costs (sum of lines 83 through 85)		86. 00			
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions)	120	87. 00			
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1, 607. 32				
89. 00	Observation bed cost (line 87 x line 88) (see instructions)	192, 878	89. 00			

Health Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 10/01/2017 To 02/28/2018	Date/Time Pre 7/30/2018 12:	
			e XIX	Hospi tal	Cost	
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	169, 945	1, 817, 885	0. 09348	5 192, 878	18, 031	90.00
91.00 Nursing School cost	0	1, 817, 885	0.00000	0 192, 878	0	91.00
92.00 Allied health cost	0	1, 817, 885	0.00000	0 192, 878	0	92.00
93.00 All other Medical Education	0	1, 817, 885	0. 00000	192, 878	0	93.00

Health Financial Systems	JAY COUNTY HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1320	Peri od: From 10/01/2017	Worksheet D-1
	Component CCN: 15-M320		
	Title XIX	Subprovi der -	Cost
		I PF	

	I PF	İ	
	Cost Center Description	1.00	
	DADT I ALL DOOM DED COMPONENTS	1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS		
1. 00	Inpatient days (including private room days and swing-bed days, excluding newborn)	462	1. 00
2. 00	Inpatient days (including private room days, excluding swing-bed and newborn days)	462	2. 00
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3. 00
3.00	do not complete this line.	٥	3.00
4. 00	Semi-private room days (excluding swing-bed and observation bed days)	462	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5. 00
5. 00	reporting period	Ĭ	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	o	6.00
0.00	reporting period (if calendar year, enter 0 on this line)	Ĭ	0.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	ol	7.00
	reporting period		
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8.00
	reporting period (if calendar year, enter 0 on this line)		
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	21	9.00
	newborn days)		
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
	through December 31 of the cost reporting period (see instructions)		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
	through December 31 of the cost reporting period		
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	
15. 00	Total nursery days (title V or XIX only)	92	15.00
16. 00	Nursery days (title V or XIX only)	0	16.00
47.00	SWING BED ADJUSTMENT		47.00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost		17. 00
10 00	reporting period		10.00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost		18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0 00	19. 00
17.00	reporting period	0.00	17.00
20. 00	Medicald rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20.00
20.00	report in giperiod	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions)	909, 944	21.00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line		22.00
	5 x line 17)		
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	o	23.00
	x line 18)		
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24.00
	7 x line 19)		
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25.00
	x line 20)		
26. 00	Total swing-bed cost (see instructions)	0	26.00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	909, 944	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28. 00
29. 00	Private room charges (excluding swing-bed charges)	0	
30. 00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	31.00
32. 00	Average private room per diem charge (line 29 ÷ line 3)	0. 00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0. 00	
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	909, 944	37.00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 969. 58	
39. 00	Program general inpatient routine service cost (line 9 x line 38)	41, 361	
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41. 00	Total Program general inpatient routine service cost (line 39 + line 40)	41, 361	41. 00

Heal th	Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUT	TATION OF INPATIENT OPERATING COST			CN: 15-1320	Peri od: From 10/01/2017	Worksheet D-1	
			·	CCN: 15-M320	To 02/28/2018	7/30/2018 12:	
			Ti tl	e XIX	Subprovi der  - I PF	Cost	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)		Program Cost (col. 3 x col. 4)	
10.00	Thursday, and the same of the	1. 00	2.00	3. 00	4.00	5. 00	40.00
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	C	0.0	00 0	0	42.00
43.00	INTENSIVE CARE UNIT	0	C	0.0	00 0	0	
44. 00 45. 00	BURN INTENSIVE CARE UNIT	0	C	0. 0	0 0	0	44. 00 45. 00
	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)  Cost Center Description						47.00
48. 00	Program inpatient ancillary service cost (Wk	st N_3 col 3	line 200)			1. 00 6, 653	48. 00
	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS			ons)		48, 014	
50.00	Pass through costs applicable to Program inpa	atient routine	services (fro	m Wkst. D, su	m of Parts I and	0	50.00
51. 00	Pass through costs applicable to Program inpart and IV)	atient ancillar	y services (f	rom Wkst. D,	sum of Parts II	0	51.00
52.00	Total Program excludable cost (sum of lines!					0	52.00
53. 00	Total Program inpatient operating cost exclude medical education costs (line 49 minus line ! TARGET AMOUNT AND LIMIT COMPUTATION		lated, non-ph	ysician anest	hetist, and	0	53.00
54. 00	Program di scharges					0	54.00
55. 00 56. 00						0.00	55. 00 56. 00
57.00	Difference between adjusted inpatient operati	ing cost and ta	rget amount (	line 56 minus	line 53)	0	57.00
58. 00 59. 00							58. 00 59. 00
market basket 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 0.0						0.00	60.00
61. 00							61.00
62 00	amount (line 56), otherwise enter zero (see instructions) 62.00 Relief payment (see instructions)						62.00
	63.00 Allowable Inpatient cost plus incentive payment (see instructions)						63.00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost instructions) (title XVIII only)	ts through Dece	mber 31 of th	e cost report	ing period (See	0	64. 00
65. 00	7 7	ts after Decemb	er 31 of the	cost reportin	g period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routing CAH (see instructions)				-		66. 00
67. 00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)						67. 00
68. 00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)			•	orting period		68. 00
69. 00	Total title V or XIX swing-bed NF inpatient IPART III - SKILLED NURSING FACILITY, OTHER NU					0	69.00
70.00	Skilled nursing facility/other nursing facili	ity/ICF/IID rou	tine service	cost (line 37	)		70.00
71. 00 72. 00	Adjusted general inpatient routine service co Program routine service cost (line 9 x line		ine 70 ÷ iine	2)			71. 00 72. 00
73.00	Medically necessary private room cost applica						73.00
74. 00 75. 00	Total Program general inpatient routine servi Capital-related cost allocated to inpatient ( 26, line 45)			•	Part II, column		74. 00 75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li						76. 00
77. 00 78. 00	Program capital-related costs (line 9 x line   Inpatient routine service cost (line 74 minus						77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for excess	s costs (from p			70)	1	79.00
80. 00 81. 00							80. 00 81. 00
82.00	82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00
83. 00 84. 00	Reasonable inpatient routine service costs ( Program inpatient ancillary services (see in:		5)			1	83. 00 84. 00
85.00	Utilization review - physician compensation	(see instructio					85.00
86.00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		rougn 85)				86.00
87. 00 88. 00	Total observation bed days (see instructions: Adjusted general inpatient routine cost per o	•	line 2)			0	87. 00 88. 00
	Observation bed cost (line 87 x line 88) (see	•	2)				89.00

Health Financial Systems	JAY COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
		Component (	CCN: 15-M320	From 10/01/2017 To 02/28/2018		
		Ti tl	e XIX	Subprovi der -	Cost	
				I PF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observation	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	67, 697	909, 944	0. 07439	97 0	0	90.00
91.00 Nursing School cost	0	909, 944	0. 00000	00	0	91.00
92.00 Allied health cost	0	909, 944	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	909, 944	0. 00000	00	0	93.00

Health Financial Systems	JAY COUNTY HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der C		Peri od:	Worksheet D-3	
				From 10/01/2017 To 02/28/2018	Date/Time Pre 7/30/2018 12:	
		Titl∈	XVIII	Hospi tal	Cost	
Cost Center Description			Ratio of Cos	t Inpatient	I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x	
					col . 2)	
			1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			•			
30. 00 03000 ADULTS & PEDI ATRI CS				637, 400		30.00
31.00 03100 INTENSIVE CARE UNIT				0		31.00
33.00 03300 BURN INTENSIVE CARE UNIT				0		33.00
40 00 0 4000 CURREDOW DED. 1 DE					i '	1 40 00

To Charges   Program Costs (col. 1 x col. 2)   1.00   2.00   3.00
INPATIENT ROUTINE SERVICE COST CENTERS   1.00   2.00   3.00   30.00   30.00   31.00
NPATIENT ROUTINE SERVICE COST CENTERS   30. 00   3000   ADULTS & PEDIATRICS   637, 400   30. 00   31. 00   3100   INTENSIVE CARE UNIT   0   31. 00   33. 00   3300   BURN INTENSIVE CARE UNIT   0   33. 00   33. 00   04000   SUBPROVIDER - IPF   0   40. 00   41. 00   04100   SUBPROVIDER - IRF   0   41. 00   42. 00   04200   SUBPROVIDER   0   04200   04200   SUBPROVIDER   0   04200   04200   SUBPROVIDER   0   04200   04200   04200   SUBPROVIDER   0   04200   042
30. 00   03000   ADULTS & PEDI ATRI CS   30. 00   31. 00
31. 00   03100   INTENSIVE CARE UNIT   0   31. 00   33. 0
33. 00   03300   BURN I NTENSI VE CARE UNI T   0   33. 00   40. 00   04000   SUBPROVI DER - I PF   0   40. 00   41. 00   04100   SUBPROVI DER - I RF   0   41. 00   42. 00   04200   SUBPROVI DER   0   042. 00   04200   SUBPROVI DER   0   042. 00   0
40. 00       O4000       SUBPROVI DER - I PF       0       40. 00         41. 00       O4100       SUBPROVI DER - I RF       0       41. 00         42. 00       O4200       SUBPROVI DER       0       42. 00
41. 00   04100   SUBPROVI DER - I RF   0   41. 00   42. 00   04200   SUBPROVI DER   0   42. 00
42. 00   04200   SUBPROVI DER   0   42. 00
43. 00 <u>04300</u>   NURSERY 43. 00
ANCILLARY SERVICE COST CENTERS
50. 00   05000   0PERATING ROOM   0. 225132   145, 759   32, 815   50. 00
52. 00   05200   DELI VERY ROOM & LABOR ROOM   0. 238195   0   52. 00
53. 00   05300   ANESTHESI OLOGY   0.000000   0   53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C   0. 098894   159, 134   15, 737   54. 00
57. 00   05700   CT SCAN   0.000000   0   57. 00
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)   0.000000   0   58.00
59. 00   05900   CARDI AC CATHETERI ZATI ON   0. 000000   0   59. 00
60. 00   06000   LABORATORY   0. 130086   318, 241   41, 399   60. 00
60. 01   06001   BLOOD LABORATORY   0. 000000   0   60. 01
65. 00   06500   RESPI RATORY THERAPY 1. 670729 103, 379 172, 718   65. 00
66. 00   06600   PHYSI CAL THERAPY   0. 307022   75, 789   23, 269   66. 00
67. 00   06700   0CCUPATI ONAL THERAPY   0. 000000   0   67. 00
68. 00   06800   SPEECH PATHOLOGY   0. 000000   0   68. 00
69. 00   06900   ELECTROCARDI OLOGY   0. 296493   44, 448   13, 179   69. 00
71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   0.000000   0   71.00
72.00   07200   IMPL. DEV. CHARGED TO PATIENTS   0.000000   0   72.00
73. 00   07300   DRUGS CHARGED TO PATIENTS   0. 497509   178, 954   89, 031   73. 00
OUTPATIENT SERVICE COST CENTERS
88. 00   08800   RURAL   HEALTH   CLINIC   0.000000   0   88. 00
89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER 0. 000000 0   89. 00
90. 00   09000  CLINIC   0. 000000  0   0   90. 00
90. 01   09001   FAMILY PRACTICE OF JAY COUNTY   0. 934087   0   0   90. 01
90. 02   09002   JAY FAMILY MEDICINE   1. 910261   0   90. 02
91. 00   09100   EMERGENCY   0. 333611   573   191   91. 00
92.00   09200   0BSERVATION BEDS (NON-DISTINCT PART)   1.216277   0   0   92.00
93. 00   04040   OTHER OUTPATI ENT SERVI CE COST CENTER   0. 525710   0   93. 00
200.00 Total (sum of lines 50 through 94 and 96 through 98) 1,026,277 388,339 200.00
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00
202.00   Net charges (line 200 minus line 201)   1,026,277   202.00

	Financial Systems  ENT ANCILLARY SERVICE COST APPORTIONMENT  JAY COUNTY HC		CN: 15-1320	Peri od:	u of Form CMS-2 Worksheet D-3	
			CCN: 15-M320	From 10/01/2017 To 02/28/2018	Date/Time Pre 7/30/2018 12:	
		Title	e XVIII	Subprovi der -	PPS	оо рііі
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges	Program Charges	Program Costs (col. 1 x	
				Chai ges	col . 2)	
			1.00	2. 00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS			0		30.00
	03100 INTENSIVE CARE UNIT			0		31.00
33.00	03300 BURN INTENSIVE CARE UNIT			0		33.00
40.00	04000 SUBPROVI DER - I PF			209, 600		40.00
41.00	04100 SUBPROVI DER - I RF			0		41.00
42.00	04200 SUBPROVI DER			0		42.00
	04300 NURSERY					43.00
	ANCILLARY SERVICE COST CENTERS					
	05000 OPERATING ROOM		0. 2251		0	
	05200 DELIVERY ROOM & LABOR ROOM		0. 2381		0	
	05300 ANESTHESI OLOGY		0.0000		0	
	05400 RADI OLOGY-DI AGNOSTI C		0. 0988	·	2, 673	
	05700 CT SCAN		0.0000		0	
	05800 MAGNETIC RESONANCE IMAGING (MRI)		0.0000		0	
	05900 CARDI AC CATHETERI ZATI ON		0.0000		0	
	06000 LABORATORY		0. 1300			60.00
	O6001   BLOOD LABORATORY		0.0000		15 240	
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY		1. 6707 0. 3070	·	15, 269 1, 574	
	06700 OCCUPATI ONAL THERAPY		0. 3070		1,574	
	06800 SPEECH PATHOLOGY		0.0000		0	1
	06900 ELECTROCARDI OLOGY		0. 2964		597	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.0000	·	0	
	07200 IMPL. DEV. CHARGED TO PATIENTS		0.0000		0	
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 4975		42, 447	
	OUTPATIENT SERVICE COST CENTERS				.=,	
88. 00	08800 RURAL HEALTH CLINIC		0.0000	00	0	88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000	00	0	89.00
	09000 CLI NI C		0.0000	00 0	0	90.00
90. 01	09001 FAMILY PRACTICE OF JAY COUNTY		0. 9340	87 2, 575	2, 405	90. 01
90.02	09002 JAY FAMILY MEDICINE		1. 9102	61 1, 825	3, 486	90.02
	09100 EMERGENCY		0. 3336	·	5, 968	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 2162		0	
	04040 OTHER OUTPATIENT SERVICE COST CENTER		0. 5257		0	
200.00				225, 010	84, 057	200.00
201.00		s (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)			225, 010		202.00

Health Financial Systems	JAY COUNTY HOSPITAL	In Lie	u of Form CMS-2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Peri od: From 10/01/2017	Worksheet D-3
	Component CCN: 15-Z320		Date/Time Prepared: 7/30/2018 12:58 pm
	Title XVIII	Swing Beds - SNF	Cost
Cost Center Description	Ratio of Cos	t Inpatient	I npati ent

		Component	CCN: 15-Z320	To 02/28/2018	Date/Time Pre 7/30/2018 12:	pared: 58 pm
		Title	XVIII	Swing Beds - SNF	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					
	03000 ADULTS & PEDIATRICS			0		30.00
	03100 INTENSIVE CARE UNIT			0		31.00
	03300 BURN INTENSIVE CARE UNIT			0		33.00
	04000 SUBPROVI DER - I PF			0		40.00
	04100 SUBPROVI DER - I RF			0		41.00
	04200 SUBPROVI DER			0		42.00
	04300 NURSERY					43.00
	ANCILLARY SERVICE COST CENTERS				1	
	05000 OPERATING ROOM		0. 2251:			50.00
	05200 DELIVERY ROOM & LABOR ROOM		0. 2381			52.00
	05300 ANESTHESI OLOGY		0. 00000		_	53.00
	05400 RADI OLOGY-DI AGNOSTI C		0. 09889			1
	05700 CT SCAN		0. 00000		_	57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 00000		_	58. 00
	05900 CARDI AC CATHETERI ZATI ON		0. 00000		0	59.00
	06000 LABORATORY		0. 1300			60.00
	06001 BLOOD LABORATORY		0. 00000		0	60. 01
	06500 RESPIRATORY THERAPY		1. 6707:			1
	06600 PHYSI CAL THERAPY		0. 3070	· ·		1
	06700 OCCUPATI ONAL THERAPY		0. 00000		_	67.00
	06800 SPEECH PATHOLOGY		0. 00000		_	68. 00
	06900 ELECTROCARDI OLOGY		0. 2964			
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 00000		_	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 00000		_	72.00
	07300 DRUGS CHARGED TO PATIENTS		0. 49750	09 20, 344	10, 121	73.00
	OUTPATIENT SERVICE COST CENTERS				1	
	08800 RURAL HEALTH CLINIC		0. 00000		0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER		0. 00000		0	89. 00
	09000 CLI NI C		0. 00000		_	90.00
	09001 FAMILY PRACTICE OF JAY COUNTY		0. 9340		0	90. 01
	09002 JAY FAMILY MEDICINE		1. 9102		0	90. 02
	09100 EMERGENCY		0. 3336		9	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 2162		_	92.00
	04040 OTHER OUTPATIENT SERVICE COST CENTER		0. 5257 <sup>-</sup>		_	93.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)			123, 935		
201.00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201.00
202. 00	Net charges (line 200 minus line 201)		l	123, 935	1	202. 00

Health Financial Systems	JAY COUNTY HOSPI	TAL		In Lie	u of Form CMS-2	552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Pr	rovider CC		Peri od: From 10/01/2017	Worksheet D-3	
				To 02/28/2018	Date/Time Prep 7/30/2018 12:5	
		Ti tl e	e XIX	Hospi tal	Cost	
Cost Center Description			Ratio of Cos	t Inpatient	I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x	

				To 02/28/2018	Date/Time Pre 7/30/2018 12:	
-		Ti tl	e XIX	Hospi tal	Cost	оо р
	Cost Center Description		Ratio of Cost		Inpatient	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x	
				Ů	col . 2)	
			1.00	2. 00	3. 00	
	ATIENT ROUTINE SERVICE COST CENTERS					
	DO ADULTS & PEDIATRICS			22, 421		30.00
	DO INTENSIVE CARE UNIT			0		31.00
	DO BURN INTENSIVE CARE UNIT			0		33. 00
	OO SUBPROVI DER - I PF			0		40. 00
	OO SUBPROVI DER - I RF			0		41.00
	OO SUBPROVI DER			0		42.00
	DO NURSERY			0		43.00
	LLARY SERVICE COST CENTERS					
	OO OPERATING ROOM		0. 22513		6, 337	50.00
	DO DELIVERY ROOM & LABOR ROOM		0. 23819		0	52.00
	DO ANESTHESI OLOGY		0.00000		0	
	DO RADI OLOGY-DI AGNOSTI C		0. 09889		902	•
	OO CT SCAN		0.00000		0	57.00
	DO MAGNETIC RESONANCE IMAGING (MRI)		0.00000		0	58.00
	DO CARDI AC CATHETERI ZATI ON		0.00000		0	59.00
	DO LABORATORY		0. 13008			60.00
	D1 BLOOD LABORATORY		0.00000		0	60.01
	DO RESPIRATORY THERAPY		1. 67072		3, 199	65.00
	OO PHYSI CAL THERAPY		0. 30702		•	1
	OO OCCUPATIONAL THERAPY		0.00000		0	67.00
	DO SPEECH PATHOLOGY DO ELECTROCARDI OLOGY		0.00000		0	68.00
			0. 29649		94	•
	DO MEDICAL SUPPLIES CHARGED TO PATIENTS DO IMPL. DEV. CHARGED TO PATIENTS		0. 00000 0. 00000		0	71. 00 72. 00
	DO DRUGS CHARGED TO PATIENTS		0. 49750		3, 313	1
	PATIENT SERVICE COST CENTERS		0.49750	9 0,000	3, 313	73.00
	OO RURAL HEALTH CLINIC		0.00000	0 0	0	88. 00
	OO FEDERALLY QUALIFIED HEALTH CENTER		0.00000		0	89.00
	00 CLINIC		0.00000		0	90.00
	D1 FAMILY PRACTICE OF JAY COUNTY		0. 93408			1
	D2 JAY FAMILY MEDICINE		1. 91026		32	90.02
	DO EMERGENCY		0. 33361		1, 432	
	OO OBSERVATION BEDS (NON-DISTINCT PART)		1. 21627		1, 432	92.00
	40 OTHER OUTPATIENT SERVICE COST CENTER		0. 52571		0	93.00
200. 00	Total (sum of lines 50 through 94 and 96 through 98)		3. 32371	62, 335		
201.00	Less PBP Clinic Laboratory Services-Program only charges	s (line 61)		02,000		201.00
202.00	Net charges (line 200 minus line 201)	- ( 01)		62, 335		202.00
	1 3 ()		i .	1 2=7 000	ı	

	Financial Systems JAY COUNTY H	HOSPITAL		In Lie	u of Form CMS-2	2552-10
INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-1320	Peri od:	Worksheet D-3	3
		Component	CCN: 15-M320	From 10/01/2017 To 02/28/2018	Date/Time Pre 7/30/2018 12:	
		Ti tl	e XIX	Subprovi der - I PF	Cost	p
	Cost Center Description		Ratio of Cos	st Inpatient	I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x	
					col. 2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1			
	03000 ADULTS & PEDI ATRI CS			0		30.00
	03100   INTENSIVE CARE UNIT			0		31.00
	03300 BURN INTENSIVE CARE UNIT			0		33. 00
	04000 SUBPROVI DER - I PF			16, 705		40. 00
	04100 SUBPROVI DER - I RF			0		41.00
	04200 SUBPROVI DER			0		42.00
	04300 NURSERY			0		43.00
	ANCILLARY SERVICE COST CENTERS					
	05000 OPERATI NG ROOM		0. 2251		0	1
	05200 DELIVERY ROOM & LABOR ROOM		0. 2381		0	
	05300 ANESTHESI OLOGY		0.0000		0	
	05400 RADI OLOGY-DI AGNOSTI C		0. 0988		185	
1	05700 CT SCAN		0.0000		0	
	05800 MAGNETIC RESONANCE IMAGING (MRI)		0.0000		0	
	05900 CARDI AC CATHETERI ZATI ON		0.0000		0	
	06000 LABORATORY		0. 1300	· ·	1, 418	
	06001 BLOOD LABORATORY		0.0000		0	
	06500 RESPIRATORY THERAPY		1. 6707		748	1
	06600 PHYSI CAL THERAPY		0. 3070		50	
	06700 OCCUPATI ONAL THERAPY		0.0000		0	
	06800 SPEECH PATHOLOGY		0.0000		0	
	06900 ELECTROCARDI OLOGY		0. 2964		20	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.0000		0	
	07200 IMPL. DEV. CHARGED TO PATIENTS		0.0000		0	
	07300 DRUGS CHARGED TO PATIENTS		0. 4975	09 6, 639	3, 303	73. 00
	OUTPATIENT SERVICE COST CENTERS  08800 RURAL HEALTH CLINIC		0.0000	00	0	00 00
			1			
	08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000		0	
	09000 CLINIC		0.0000		0	
	09001 FAMILY PRACTICE OF JAY COUNTY		0. 9340		0	
	09002 JAY FAMILY MEDICINE		1. 9102		0	
	09100 EMERGENCY		0. 3336		929	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 2162		0	
93. 00 200. 00	04040 OTHER OUTPATIENT SERVICE COST CENTER		0. 5257		0	
	Total (sum of lines 50 through 94 and 96 through 98)	oo (line (1)		22, 880	6, 653	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charg	es (iine ol)	I	0		201. 00
202.00	Net charges (line 200 minus line 201)			22, 880		202.00

Health Financial Systems	JAY COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Period: Worksheet D-3 From 10/01/2017
		To 02/28/2018 Date/Time Prepared:

11017411	ENT ANOTEEART SERVICE COST ATTORTTONIMENT	i i ovi dei o	ON. 15 1520	From 10/01/2017	WOT KSTICCT D 3	
		Component	CCN: 15-Z320	To 02/28/2018	Date/Time Pre	pared:
					7/30/2018 12:	
		Ti tl	e XIX	Swing Beds - SNF		
	Cost Center Description		Ratio of Cos	st Inpatient	I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x	
				Ŭ	col. 2)	
			1.00	2.00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS		•	<u> </u>		
30.00	03000 ADULTS & PEDI ATRI CS			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 SUBPROVI DER - I PF			0		40.00
41.00	04100 SUBPROVI DER - I RF			0		41.00
42.00	04200 SUBPROVI DER			0		42.00
	04300 NURSERY			0		43.00
	ANCILLARY SERVICE COST CENTERS		'		!	
	05000 OPERATING ROOM		0. 2251	32 0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		0. 2381	95 0	0	52.00
	05300 ANESTHESI OLOGY		0.0000		0	53.00
	05400 RADI OLOGY-DI AGNOSTI C		0. 0988		0	54.00
	05700 CT SCAN		0.0000		Ō	57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)		0.0000		0	58.00
	05900 CARDI AC CATHETERI ZATI ON		0.0000		0	59.00
	06000 LABORATORY		0. 1300		1	60.00
	06001 BLOOD LABORATORY		0.0000		0	60. 01
	06500 RESPI RATORY THERAPY		1. 6707		1	65.00
	06600 PHYSI CAL THERAPY		0. 3070		1	66.00
	06700 OCCUPATI ONAL THERAPY		0.0000		0	67.00
	06800 SPEECH PATHOLOGY		0.0000		Ö	68.00
	06900 ELECTROCARDI OLOGY		0. 2964		0	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.0000		· -	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS		0.0000			72.00
	07300 DRUGS CHARGED TO PATIENTS		0. 4975		1	73.00
	OUTPATIENT SERVICE COST CENTERS		0.4773	07  0	0	73.00
	08800 RURAL HEALTH CLINIC		0.0000	00 0	0	88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000		1	89.00
	09000 CLINIC		0.0000		0	90.00
	09000 CETNIC 09001 FAMILY PRACTICE OF JAY COUNTY		0.0000		0	90.00
	09002 JAY FAMILY MEDICINE		1. 9102		1	90.01
	09100 EMERGENCY		0. 3336		1	90.02
	O9200 OBSERVATION BEDS (NON-DISTINCT PART)		1		1	91.00
	04040 OTHER OUTPATIENT SERVICE COST CENTER		1. 2162		0	
			0. 5257		ı	, , , , , ,
200.00		(lin- (1)	[	0	l	200.00
201.00		s (Tine 61)		0	l .	201.00
202. 00	Net charges (line 200 minus line 201)		1	0	l	202. 00

Health Financial Systems	JAY COUNTY HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1320		Worksheet E Part B Date/Time Prepared: 7/30/2018 12:58 pm

NAME   S. NODICAL AND OTHER HALTH SERVICES   1.09   1.00				10 02/20/2010	7/30/2018 12:	58 pm
ART B - MEDICAL AND OTHER REALTH SERVICES   2,025,091   1.00   Modical and other services (see instructions)   2,025,091   1.00   2.0			Title XVIII	Hospi tal	Cost	
ART B - MEDICAL AND OTHER REALTH SERVICES   2,025,091   1.00   Modical and other services (see instructions)   2,025,091   1.00   2.0						
		DADT B. HEDLOAL AND OTHER HEALTH OFFILM OF			1. 00	
New York   See   New	1 00				2 025 001	1 00
3.00   OPPS payments   0   3.00   0			tions)			1
Qualifier payment (see instructions)						1
A.01   Out-lier reconcilitation amount (see instructions)   0.00   5.00		, ,			0	1
Line 2   Line 5   Line 5   Co.	4. 01				0	4. 01
	5.00	Enter the hospital specific payment to cost ratio (see instru	ictions)		0.000	5. 00
Transit fional corridor payment (see Instructions)   0   8.00   0.00						1
Ancil lary service other pass through costs from Wist. D. Pt. IV, col. 13, line 200   0 , 0.0						1
10.00   Organ acquisit tions		, , , , , , , , , , , , , , , , , , , ,	IV col 12 line 200			1
1.00			TV, COL. 13, TITLE 200			1
COMPUTATION for ELESSER OF COST OR CHARGES						1
Reasonable charges					2/020/071	1 55
13.00   Organ acquisition charges (From Wist. D.4, Pt. III., col. 4, Iiin. 69)   0   13.00						İ
14.00   Total reasonable charges (sum of lines 12 and 13)	12.00	Ancillary service charges			0	12. 00
Customary charges			ine 69)			
15.00   Aggregate amount actually collected from patients liable for payment for services on a charge basis   0   15.00	14. 00				0	14.00
16.00   Amounts that would have been realized from patients   Iable for payment for services on a chargebasis   had such payment been made in accordance with 42 CFR \$413.13(e)	15 00		nayment for caryless on	a charge basis	0	15 00
had such payment been made in accordance with 42 CFR §413. 13(e)						
17.00   Ratio of line 15 to line 16 (not to exceed 1.000000)   17.00   18.00   17.00   18.00   17.00   18.00	10.00			ii a chargebasi s	O	10.00
19.00   Excess of customary Charges over reasonable cost (complete only if line 18 exceeds line 11) (see   19.00   19.00	17. 00				0.000000	17. 00
Instructions	18. 00				0	18. 00
20.00   Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see   0   20.00	19. 00		ly if line 18 exceeds li	ne 11) (see	0	19. 00
Instructions    2,045,342   21.00	00.00		1 16 11	10) (		00.00
2.045,342   21.00	20.00		ily it line li exceeds il	ne 18) (see	Ü	20.00
22.00   Interns and residents (see instructions)   0   22.00   23.00	21 00	· · · · · · · · /			2 045 342	21 00
23. 00   Cost of physicians' services in a teaching hospital (see instructions)   0   23. 00		,				
COMPUTATION OF REIMBURSEMENT SETTLEMENT   Deductibles and coinsurance (for CAH, see instructions)   Deductibles and coinsurance (for CAH, see instructions)   Deductibles and coinsurance relating to amount on line 24 (for CAH, see instructions)   O 26 00		1	ructions)			1
25.00   Deductible and coinsurance (for CAH, see instructions)   1, 362, 981   25.00   26.00   26.00   27.00   28.00   28.00   29.00   28.00   29.00   28.00   29.00   28.00   29.00   28.00   29.00   28.00   29.00   28.00   29.00   29.00   28.00   29.00	24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	·		0	24. 00
26.00   Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)   0 26.00   27.00   Debutotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)   0 28.00   Direct graduate medical education payments (from Wkst. E-4, line 50)   0 28.00   0 29.00   28.00   Direct graduate medical education costs (from Wkst. E-4, line 36)   0 29.00   29.						
27. 00   Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)   0   28. 00   1   1   1   1   1   1   1   1   1		1			1, 362, 981	1
Instructions				and 221 (acc	(14.070	1
28. 00   Direct graduate medical education payments (from Wkst. E-4, line 50)   CSRD direct medical education costs (from Wkst. E-4, line 36)   O 29. 00   CSRD direct medical education costs (from Wkst. E-4, line 36)   O 29. 00	27.00		prus the sum of frhes 22	and 23] (see	614, 870	27.00
9.9 .00         ESRD diffect medical education costs (from Wkst. E-4, line 36)         29,00           30.00         Subtotal (sum of lines 27 through 29)         614,870           31.00         Primary payer payments         0 31.00           32.00         Subtotal (line 30 minus line 31)         614,870           ALOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)         0           33.00         Composite rate ESRD (from Wkst. I-5, line 11)         0         33.00           34.00         Allowable bad debts (see instructions)         0         34.00           35.00         Allowable bad debts (see instructions)         0         35.00           36.00         Allowable bad debts for dual eligible beneficiaries (see instructions)         0         36.00           37.00         Subtotal (see instructions)         0         36.00           38.00         MSP-LCC reconciliation amount from PS&R         374         38.00           39.00         OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)         0         39.50           39.91         Demonstration payment adjustment amount before sequestration         0         39.50           39.92         Partial or full credits received from manufacturers for replaced devices (see instructions)         0         39.99           40.01         Sequestration	28. 00		ine 50)		0	28. 00
31.00   Primary payer payments   0   31.00   32.00   Subtotal (line 30 minus line 31)   614,870   32.00   ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   32.00   Composite rate ESRD (from Wkst. I - 5, line 11)   0   33.00   34.00   Allowable bad debts (see instructions)   0   35.00   35.00   Adjusted reimbursable bad debts (see instructions)   0   36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   0   36.00   36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   0   36.00   36.00   MSP-LCC reconciliation amount from PS&R   374   38.00   MSP-LCC reconciliation amount from PS&R   374   38.00   MSP-LCC reconciliation amount from PS&R   39.00   MSP-LCC reconciliation payment adjustment (see instructions)   39.00   39.00   39.90					0	1
32.00	30.00	Subtotal (sum of lines 27 through 29)			614, 870	
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   33.00   Composite rate ESRD (from Wkst. 1-5, line 11)   0   33.00     34.00   Allowable bad debts (see instructions)   0   34.00     35.00   Adjusted reimbursable bad debts (see instructions)   0   35.00     36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   0   36.00     37.00   Subtotal (see instructions)   614,870     37.00   Subtotal (see instructions)   614,870     37.00   Subtotal (see instructions)   0   39.00     39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.00     39.50   Joneor ACO demonstration payment adjustment (see instructions)   39.50     39.97   Demonstration payment adjustment (see instructions)   0   39.97     39.98   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39.99     40.00   Subtotal (see instructions)   614,496   40.00     40.01   Sequestration adjustment (see instructions)   12,290   40.01     40.02   Demonstration payment adjustment amount after sequestration   20.00     40.01   Interim payments   868,433   41.00     40.02   Tentative settlement (for contractors use only)   2-266,227   43.00     40.00   Seauch device of the payment of th						
33.00   Composite rate ESRD (from Wkst. I - 5, line 11)	32. 00		056)		614, 870	32.00
34.00	22 00		CES)		0	22 00
35.00   Adjusted reimbursable bad debts (see instructions)   0   35.00   36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   0   36.00   37.00   Subtotal (see instructions)   614,870   37.00   38.00   MSP-LCC reconciliation amount from PS&R   37.40   38.00   39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.00   39.50   Pioneer ACO demonstration payment adjustment (see instructions)   0   39.50   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39.98   39.99   RECOVERY OF ACCELERATED DEPRECIATION   0   39.99   RECOVERY OF ACCELERATED DEPRECIATION   0   39.99   40.00   Subtotal (see instructions)   12,290   40.01   40.02   Demonstration payment adjustment amount after sequestration   12,290   40.01   40.02   41.00   1nterim payments   868,433   41.00   42.00   Tentative settlement (for contractors use only)   81.52   To BE COMPLETED BY CONTRACTOR   0   40.00   41.00						1
36. 00						1
38. 00       MSP-LCC reconciliation amount from PS&R       374       38. 00         39. 00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       39. 00         39. 50       Pioneer ACO demonstration payment adjustment (see instructions)       39. 50         39. 97       Demonstration payment adjustment amount before sequestration       0       39. 97         39. 98       Partial or full credits received from manufacturers for replaced devices (see instructions)       0       39. 98         39. 99       RECOVERY OF ACCELERATED DEPRECIATION       0       39. 99         40. 00       Subtotal (see instructions)       614, 496       40. 00         40. 01       Sequestration adjustment (see instructions)       12, 290       40. 01         40. 02       Demonstration payment adjustment amount after sequestration       0       40. 02         41. 00       Interim payments       868, 433       41. 00         42. 00       Fentative settlement (for contractors use only)       0       42. 00         43. 00       Balance due provider/program (see instructions)       -266, 227       43. 00         44. 00       Fils. 2       TO BE COMPLETED BY CONTRACTOR       0       90. 00         90. 00       Original outlier amount (see instructions)       0       90. 00		, , , , , , , , , , , , , , , , , , , ,	ructions)		0	
39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.50 Pi oneer ACO demonstration payment adjustment (see instructions) 39.97 Demonstration payment adjustment amount before sequestration 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 RECOVERY OF ACCELERATED DEPRECIATION 40.00 Subtotal (see instructions) 40.01 Demonstration payment adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 40.02 Demonstration payment adjustment amount after sequestration 41.00 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2 To BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 70.00 Outlier reconciliation adjustment amount (see instructions) 71.00 Outlier reconciliation adjustment amount (see instructions) 72.00 The rate used to calculate the Time Value of Money 73.00 Time Value of Money (see instructions) 74.00 Opi.00					•	
39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.97 Demonstration payment adjustment amount before sequestration 39.97 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.97 Octobroacy 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.97 Octobroacy 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 40.00 Subtotal (see instructions) 40.01 Subtotal (see instructions) 40.02 Pemonstration adjustment amount after sequestration 40.02 Pemonstration payment adjustment amount after sequestration 40.02 Pemonstration payment adjustment amount after sequestration 40.02 Pemonstration payment adjustment amount after sequestration 40.02 Pemonstration payment adjustment amount after sequestration 40.02 Pemonstration payment adjustment amount after sequestration 40.02 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 41.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 42.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 45.00 Protest						
39. 97 39. 98 39. 99 Recovery of Accelerated Depreciation  40. 00 Subtotal (see instructions)  50. 39. 99 40. 00 Squestration adjustment (see instructions)  614, 496 40. 00 40. 01 Demonstration payment adjustment amount after sequestration  614, 496 40. 00 40. 01 Demonstration payment adjustment amount after sequestration  614, 496 40. 00 40. 01 Demonstration payment adjustment amount after sequestration  615, 496 40. 01 Demonstration payment adjustment amount after sequestration  70. 02 Demonstration payment adjustment amount after sequestration  868, 433 41. 00 42. 00 Demonstration payment adjustment amount after sequestration  868, 433 41. 00 42. 00 Demonstration payment adjustment amount after sequestration  868, 433 41. 00 42. 00 Demonstration payment adjustment amount after sequestration  868, 433 41. 00 Adv. 00 Demonstration payment adjustment amount after sequestration  868, 433 Adv. 00 Demonstration payment amount (see instructions)  90. 00 Demonstration payment adjustment amount (see instructions)  90. 00 Demonstration payment (see instructions)  90. 00 Demonstration payment adjustment amount (see instructions)  90. 00 Demonstration payment (see instruction		1 , , , , , , , , , , , , , , , , , , ,	`		0	1
39. 98       Partial or full credits received from manufacturers for replaced devices (see instructions)       0       39. 98         39. 99       RECOVERY OF ACCELERATED DEPRECIATION       0       39. 99         40. 00       Subtotal (see instructions)       614, 496       40. 00         40. 01       Sequestration adjustment (see instructions)       12, 290       40. 01         40. 02       Demonstration payment adjustment amount after sequestration       0       40. 02         41. 00       Interim payments       868, 433       41. 00         42. 00       Tentative settlement (for contractors use only)       0       42. 00         43. 00       Balance due provider/program (see instructions)       -266, 227       43. 00         44. 00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 51.5.2       0       44. 00         90. 00       Original outlier amount (see instructions)       0       90. 00         91. 00       Outlier reconciliation adjustment amount (see instructions)       0       91. 00         92. 00       The rate used to calculate the Time Value of Money       0. 00       92. 00         93. 00       Time Value of Money (see instructions)       0       93. 00			IS)		0	
39. 99   RECOVERY OF ACCELERATED DEPRECIATION   0   39. 99		1	red devices (see instruc	tions)		
40.00       Subtotal (see instructions)       614,496       40.00         40.01       Sequestration adjustment (see instructions)       12,290       40.01         40.02       Demonstration payment adjustment amount after sequestration       0 40.02         41.00       Interim payments       868,433       41.00         42.00       Tentative settlement (for contractors use only)       9.200       0 42.00         43.00       Balance due provider/program (see instructions)       -266,227       43.00         44.00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2       0 44.00         90.00       Original outlier amount (see instructions)       0 90.00         91.00       Outlier reconciliation adjustment amount (see instructions)       0 91.00         92.00       The rate used to calculate the Time Value of Money       0.00       92.00         93.00       Time Value of Money (see instructions)       0 93.00		•	ded devices (see institue	(10113)		
40.01 Sequestration adjustment (see instructions)  40.02 Demonstration payment adjustment amount after sequestration  11, 290 40.01  40.02  41.00 Interim payments  868, 433 41.00  42.00 Tentative settlement (for contractors use only)  43.00 Balance due provider/program (see instructions)  44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  8115.2  80.00 Original outlier amount (see instructions)  90.00 Outlier reconciliation adjustment amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  940.01 Time Value of Money (see instructions)						
41.00   Interim payments   868, 433   41.00   42.00   Tentative settlement (for contractors use only)   0   42.00   43.00   Balance due provider/program (see instructions)   -266, 227   43.00   44.00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,   0   44.00   S115.2   TO BE COMPLETED BY CONTRACTOR   0   0   0   0   0   0   0   0   0		1			12, 290	40. 01
42.00 Tentative settlement (for contractors use only)  43.00 Balance due provider/program (see instructions)  44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  5115.2  TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  93.00 Time Value of Money (see instructions)  94.00 Value of Money (see instructions)  95.00 Value of Money (see instructions)  96.00 Value of Money (see instructions)  97.00 Value of Money (see instructions)  98.00 Value of Money (see instructions)  99.00 Value of Money (see instructions)	40. 02	Demonstration payment adjustment amount after sequestration			0	40. 02
43.00 Balance due provider/program (see instructions)  44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 \$\frac{5115.2}{TO BE COMPLETED BY CONTRACTOR}  90.00 Outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  93.00 Time Value of Money (see instructions)  94.00 Outlier reconciliation adjustment amount (see instructions)  93.00 Time Value of Money (see instructions)  94.00 Outlier reconciliation adjustment amount (see instructions)  95.00 Outlier reconciliation adjustment amount (see instructions)  97.00 Outlier reconciliation adjustment amount (see instructions)  98.00 Outlier reconciliation adjustment amount (see instructions)  99.00 Outlier reconciliation adjustment amount (see instructions)		' '				
44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\frac{5}{115.2}\$ TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  93.00 Time Value of Money (see instructions)		,				
\$115.2 TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 0 outlier reconciliation adjustment amount (see instructions) 0 of 91.00 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 of 93.00		, , , , , , , , , , , , , , , , , , , ,	ince with CMS Dub 15 2	chanter 1		1
70 BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  94.00 Outlier reconciliation adjustment amount (see instructions)  95.00 Outlier reconciliation adjustment amount (see instructions)  97.00 Outlier reconciliation adjustment amount (see instructions)  98.00 Outlier reconciliation adjustment amount (see instructions)  99.00 Outlier reconciliation adjustment amount (see instructions)	44. UU	,	ince with two Pub. 15-2,	chapter I,	Ü	44.00
90.00 Original outlier amount (see instructions) 0 90.00 91.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00 92.00 The rate used to calculate the Time Value of Money 0.00 92.00 93.00 Time Value of Money (see instructions) 0 93.00						1
91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  0 91.00  92.00  93.00 Time Value of Money (see instructions)	90.00				0	90.00
93.00 Time Value of Money (see instructions) 0 93.00		, ,			0	91.00
94. UU   TOTAL (SUM OF TIMES 91 AND 93)						
	94.00	Liorai (2011 of Lines 41 gild 43)		ļ	0	J 94. UU

Health Financial Systems JANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED JAY COUNTY HOSPITAL In Lieu of Form CMS-2552-10 Peri od: Worksheet E-1
From 10/01/2017 Part I
To 02/28/2018 Date/Time Prepared: 7/30/2018 12:58 pm Provider CCN: 15-1320 Title XVIII Hospi tal Cost Inpatient Part A Part B mm/dd/yyyy Amount mm/dd/yyyy Amount 2.00 3.00 1.00 Total interim payments paid to provider 756, 172 868, 433

Substitute of to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero	2. 00	Interim payments payable on individual bills, either	0		0	2. 00
Write "NONE" or enter a zero   3.00		submitted or to be submitted to the contractor for				
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   ADJUSTMENTS TO PROVIDER   0						
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)	2 00					2 00
for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  DJUSTMENTS TO PROVIDER  3. 01 3. 02 3. 03 3. 04 3. 05 3. 06 3. 03 3. 04 3. 05 3. 06 3. 07 3. 08 3. 08 3. 08 3. 09 3. 08 3. 00 3. 03 3. 04 3. 05 3. 01 3. 02 3. 03 3. 04 3. 05 3. 05 3. 06 3. 07 3. 05 3. 07 3. 06 3. 07 3. 07 3. 08 3. 08 3. 09 3. 08 3. 09 3. 0	3.00					3.00
Dayment. If none, write "NONE" or enter a zero. (1)   Program to Provider						
Program to Provider   ADJUSTMENTS TO PROVIDER   O   O   O   O   O   O   O   O   O						
ADJUSTMENTS TO PROVIDER						
3.02 3.03 3.04 3.05 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 0 0 0 3.05 3.51 3.52 3.53 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 0 0 0 3.55 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 756,172 868,433 4.00 Citransfer to Wikst. E-3. line and column as appropriate) TO BE COMPLETED BY CONTRACTOR  5.00 List separately each tentative settlement payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 EINTATIVE TO PROVIDER 0 0 0 5.02 5.03 Provider to Program 5.50 TENTATIVE TO PROGRAM 0 0 0 5.50 5.51 5.52 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 0 0 0 5.50 5.03 Provider to Program 5.50.0 TENTATIVE TO PROGRAM 0 0 0 5.50 5.51 5.52 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 0 0 5.52 5.03 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETILEMENT TO PROGRAM 0 0 0 5.52 7.00 Total Medicare program liability (see instructions) 0 0 0.05 Contractor (Mo/Day/Yr) 10.00 2.00 1.00 2.00	2 01				0	2 01
3.03 3.04 3.05 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 0 0 0 3.05 3.51 3.52 3.53 3.54 0 0 0 3.55 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 0 0 0 3.59 3.50-3.99 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR TO BE COMPLETED BY CONTRACTOR TO BE COMPLETED BY CONTRACTOR TENTATIVE TO PROVIDER 5.00 TENTATIVE TO PROVIDER 5.50 TENTATIVE TO PROVIDER 5.50 TENTATIVE TO PROVIDER 5.50 TENTATIVE TO PROGRAM 5.50 TENTATIVE TO PROGRAM 6.60 Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROGRAM 6.00 Total index appropriate) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROGRAM 6.00 Total index appropriate) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROGRAM 6.00 Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) 7.00 Total Medicare program liability (see instructions) 7.00 Total Medicare program liability (see instructions) 7.00 Total Medicare program liability (see instructions) 7.00 Total Medicare program liability (see instructions) 7.00 Total Medicare program liability (see instructions) 7.00 Total Medicare program liability (see instructions) 8.00 RPR Bate (Mo/Day/Yr) NPR Bate (Mo/Day/Yr)		ADJUSTIMENTS TO FROVIDER	I		-	
3.04   3.05   3.04   3.05   3.08   3.05   3.05   3.08   3.05   3.08   3.05   3.08   3.05   3.08   3.05   3.05   3.08   3.05			I		-	
3.05   Provider to Program						
Provider to Program					- 1	
3.50   ADJUSTMENTS TO PROGRAM   0	3. 05	Durani dana da Daranana			0	3.05
3.51   3.52   3.53   0   0   0   3.51   3.52   3.53   0   0   0   3.53   3.53   3.54   3.99   5.50-3.98   3.50-3	2 50				0	2 50
3.52   3.53   3.54   0   0   0   3.52   3.53   3.54   3.99   3.50-3.98   0   0   3.53   3.54   3.99   3.50-3.98   0   0   3.53   3.54   3.99   3.50-3.98   0   0   3.59   3.50-3.98   0   0   3.59   3.50-3.98   0   0   3.59   3.50-3.98   0   0   3.59   3.50-3.98   0   0   3.59   3.50-3.98   0   0   3.59   3.50-3.98   0   0   3.59   3.50-3.98   0   0   0   3.59   3.50-3.98   0   0   0   3.59   3.50-3.98   0   0   0   3.59   3.50-3.98   0   0   0   0   0   0   0   0   0		ADJUSTMENTS TO PROGRAM			- 1	
3.53   3.54   3.54   3.59   3.50   3.59   3.50   3.98   3.50   3.98   3.50   3.98   3.50   3.98   3.50   3.98   3.50   3.98   3.50   3.98   3.50   3.98   3.50   3.98   3.50   3.98   3.50   3.98   3.50   3.98   3.50   3.98   3.50   3.98   3.50   3.98   3.50   3.98   3.50   3.98   3.50			1		- 1	
3.54   3.99   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   4.00   Total interim payments (sum of lines 1, 2, and 3.99)   Total interim payments (sum of lines 1, 2, and 3.99)   Total interim payments (sum of lines 1, 2, and 3.99)   Total interim payments (sum of lines 1, 2, and 3.99)   Total interim payments (sum of lines 1, 2, and 3.99)   Total interim payments (sum of lines 1, 2, and 3.99)   Total interim payments (sum of lines 1, 2, and 3.99)   Total interim payments (sum of lines 1, 2, and 3.99)   Total interim payments (sum of lines 1, 2, and 3.99)   Total interim payments (sum of lines 2, 3, line and column as appropriate)   Total interim payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider   O			I		-	
3. 99   Subtotal (sum of lines 3. 01-3. 49 minus sum of lines 3. 50-3. 98)   3. 50-3. 98)   4. 00   Total interim payments (sum of lines 1, 2, and 3. 99) (transfer to Wist. E or Wist. E-3, line and column as appropriate)   To BE COMPLETED BY CONTRACTOR					-	
3.50-3.98   Total interim payments (sum of lines 1, 2, and 3.99)   Total interim payments (sum of lines 1, 2, and 3.99)   Total interim payments (sum of lines 1, 2, and 3.99)   Total interim payments (sum of lines 1, 2, and 3.99)   Total interim payments (sum of lines 1, 2, and 3.99)   Total interim payments (sum of lines 1, 2, and 3.99)   Total interim payments (sum of lines 1, 2, and 3.99)   Total interim payments (sum of lines 1, 2, and 3.99)   Total Medicare program to Wist. E-3, line and column as appropriate)   Total medicare program to Provider					-	
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)   TO BE COMPLETED BY CONTRACTOR	3. 99	3. 50-3. 98)	0		0	3. 99
appropriate   TO BE COMPLETED BY CONTRACTOR	4. 00	Total interim payments (sum of lines 1, 2, and 3.99)	756, 172		868, 433	4.00
TO BE COMPLETED BY CONTRACTOR						
S.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)						
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						
Write "NONE" or enter a zero. (1)   Program to Provider	5. 00					5. 00
Program to Provider						
TENTATIVE TO PROVIDER						
5.02	- 01		1			- 04
Description   Description		TENTATIVE TO PROVIDER	•			
Provider to Program					- 1	
TENTATI VE TO PROGRAM   0	5.03				0	5.03
5.51	F F0					F F0
5. 52   5. 99   Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98)   6. 00   Determined net settlement amount (balance due) based on the cost report. (1)   6. 01   SETTLEMENT TO PROVIDER   102, 503   0   6. 01   6. 02   SETTLEMENT TO PROGRAM   0   266, 227   6. 02   7. 00   Total Medicare program liability (see instructions)   858, 675   Contractor Number (Mo/Day/Yr)   0   1. 00   2. 00		TENTATIVE TO PROGRAM	I		-	
5. 99 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 102, 503 0 6. 01 6. 02 SETTLEMENT TO PROGRAM 0 266, 227 7. 00 Total Medicare program liability (see instructions) 858, 675 Contractor Number (Mo/Day/Yr) 0 1. 00 2. 00			0		-	
5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  858,675  Contractor Number (Mo/Day/Yr)  0 1.00 2.00			0		-	
the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  102,503 0 266,227 6.02 7.00 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	5. 99	5. 50-5. 98)	0		0	5. 99
6. 01 SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions)  Contractor Number (Mo/Day/Yr)  0 1. 00 2. 00	6.00	Determined net settlement amount (balance due) based on				6.00
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  Contractor Number (Mo/Day/Yr)  0 1.00 2.00						
7.00         Total Medicare program liability (see instructions)         858,675         602,206         7.00           Contractor Number (Mo/Day/Yr)         Number (Mo/Day/Yr)         0         1.00         2.00	6. 01	SETTLEMENT TO PROVIDER	102, 503		0	6. 01
Contractor         NPR Date           Number         (Mo/Day/Yr)           0         1.00         2.00	6. 02	SETTLEMENT TO PROGRAM				6.02
Number         (Mo/Day/Yr)           0         1.00         2.00	7. 00	Total Medicare program liability (see instructions)	858, 675			7.00
0 1.00 2.00						
8.00   Name of Contractor   8.00		In the second se	0	1. 00	2. 00	
	8. 00	Name of Contractor	I			8. 00

		Title	xVIII	Subprovi der -	7/30/2018 12: PPS	<u> </u>
		I npati en	it Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1. 00	Total interim payments paid to provider		264, 050	)	0	
2.00	Interim payments payable on individual bills, either		C	)	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
3. 00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment					3.00
3.00	amount based on subsequent revision of the interim rate					3.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider			'		
3. 01	ADJUSTMENTS TO PROVIDER		C	)	0	3. 01
3. 02			(	)	0	3. 02
3.03			(		0	
3. 04			C		0	
3. 05			C	)	0	3.05
0.50	Provi der to Program					
3.50	ADJUSTMENTS TO PROGRAM				0	
3. 51 3. 52					0	
3. 52					0	
3. 54					0	0.00
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines				Ö	
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		264, 050	)	0	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR		T			
5. 00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER				0	5.01
5. 02				)	0	5. 02
5.03			(	)	0	5. 03
	Provider to Program					
5. 50	TENTATI VE TO PROGRAM		(		0	
5. 51			C		0	
5. 52			C		0	
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		C	)	0	5. 99
6. 00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		(		0	
6. 02	SETTLEMENT TO PROGRAM		C		0	
7. 00	Total Medicare program liability (see instructions)		264, 050		0	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		(	 )	1. 00	2. 00	
8. 00	Name of Contractor			1.00	2.00	8.00
5. 55	2: 33 43.0.			1	1	, 5.55

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-1320 Peri od: Worksheet E-1 From 10/01/2017 Part I Component CCN: 15-Z320 02/28/2018 Date/Time Prepared: To 7/30/2018 12:58 pm Title XVIII Swing Beds - SNF Cost Inpatient Part A Part B mm/dd/yyyy Amount mm/dd/yyyy Amount 1.00 2.00 3.00 4.00 1.00 Total interim payments paid to provider 179, 533 1.00 Interim payments payable on individual bills, either 2 00 2 00 submitted or to be submitted to the contractor for services rendered in the cost reporting period. write "NONE" or enter a zero List separately each retroactive lump sum adjustment 3.00 3.00 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 ADJUSTMENTS TO PROVIDER 0 3.01 0 3.02 0 3.02 0 3 03 0 3 03 3.04 0 0 3.04 0 3.05 3.05 0 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 0 0 3.50 0 0 3.51 3.51 0 0 3.52 3.52 3 53 0 0 3 53 3.54 0 0 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 0 0 3.99 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 179, 533 0 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropri ate) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after 5.00 5.00 desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  $\,$ Program to Provider 5.01 TENTATI VE TO PROVI DER 0 0 5.01 0 0 5.02 0 5.02 5.03 0 5.03 Provider to Program 5.50 TENTATI VE TO PROGRAM 0 0 5.50 5.51 0 0 5. 51 5.52 0 0 5.52 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 0 5.99 5. 50-5. 98) 6.00 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 32, 750 0 6.01

0

0

NPR Date

(Mo/Day/Yr)

2.00

212, 283

Contractor Number

1.00

6.02

7.00

8.00

SETTLEMENT TO PROGRAM

8.00 Name of Contractor

Total Medicare program liability (see instructions)

6.02

7.00

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	Peri od:	Worksheet E-1	
			From 10/01/2017 To 02/28/2018	Part II  Date/Time Pre	nared.
			0272072010	7/30/2018 12:	
		Title XVIII	Hospi tal	Cost	
	_				
	TO DE COMPLETED BY CONTRACTOR FOR MONCTANDARD COST REPORTS			1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATIO	INI			+
1. 00	Total hospital discharges as defined in AARA §4102 from Wkst		0.14		1.00
2. 00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1,		C 14		2.00
3. 00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	0-12			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	0 12			5.00
6. 00	Total hospital charity care charges from Wkst. S-10, col. 3	line 20			6.00
7. 00	CAH only - The reasonable cost incurred for the purchase of		Wkst S-2 Pt I		7.00
	line 168				
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				1
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	Other Adjustment (specify)				31.00
32.00	32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)				32.00

		Component CCN: 15-2320	10 02/28/2018	7/30/2018 12:	
		Title XVIII	Swing Beds - SNF		
			Part A	Part B	
			1. 00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES			_	
1.00	Inpatient routine services - swing bed-SNF (see instructions)		160, 194	0	
2.00	Inpatient routine services - swing bed-NF (see instructions)		50.050		2.00
3. 00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Par		59, 053	0	3.00
4 00	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see in:	-		0.00	4 00
4. 00	Per diem cost for interns and residents not in approved teach	ing program (see		0. 00	4.00
5. 00	instructions) Program days		99	0	5.00
6. 00	Interns and residents not in approved teaching program (see i	netructione)	77	0	6.00
7. 00	Utilization review - physician compensation - SNF optional me		0	O	7.00
8. 00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	thou only	219, 247	0	1
9. 00	Primary payer payments (see instructions)		0	Ö	
10.00	Subtotal (line 8 minus line 9)		219, 247	0	
11. 00	Deductibles billed to program patients (exclude amounts applied	cable to physician	0	0	11.00
	professional services)	, 3			
12.00	Subtotal (line 10 minus line 11)		219, 247	0	12.00
13.00	Coinsurance billed to program patients (from provider records)	) (excl ude coi nsurance	2, 632	0	13.00
	for physician professional services)				
14. 00	80% of Part B costs (line 12 x 80%)			0	
15. 00	Subtotal (enter the lesser of line 12 minus line 13, or line	14)	216, 615	0	
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16. 50	Pioneer ACO demonstration payment adjustment (see instructions				16.50
16. 55	Rural community hospital demonstration project (§410A Demonstration project (§410A Demonstration)	ration) payment	0		16. 55
16. 99	adjustment (see instructions)  Demonstration payment adjustment amount before sequestration		0	0	16. 99
17. 00	Allowable bad debts (see instructions)		0	0	
17. 00	Adjusted reimbursable bad debts (see instructions)		0	0	
18. 00	Allowable bad debts for dual eligible beneficiaries (see insti	ructions)	0	0	
19. 00	Total (see instructions)	r de trons)	216, 615	0	
19. 01	Sequestration adjustment (see instructions)		4, 332	Ö	
19. 02	Demonstration payment adjustment amount after sequestration)		0	0	
20.00	Interim payments		179, 533	0	
21.00	Tentative settlement (for contractor use only)		0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20,	and 21)	32, 750	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2,	0	0	23. 00
	chapter 1, §115.2				]
	Rural Community Hospital Demonstration Project (§410A Demonstr				
200.00	Is this the first year of the current 5-year demonstration pe	riod under the 21st			200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.				
201 00	Cost Reimbursement Medicare swing-bed SNF inpatient routine service costs (from N	Wkst D 1 Dt II line			201.00
201.00	66 (title XVIII hospital))	wkst. D-1, Pt. 11, Tille			201.00
202 00	Medicare swing-bed SNF inpatient ancillary service costs (from	m Wkst D-3 col 3 lin	ne		202. 00
202.00	200 (title XVIII swing-bed SNF))	mat. b o, cor. o, rri			202.00
203.00	Total (sum of lines 201 and 202)				203.00
	Medicare swing-bed SNF discharges (see instructions)				204.00
	Computation of Demonstration Target Amount Limitation (N/A in	first year of the curre	ent 5-year demons	trati on	
	peri od)				
	Medicare swing-bed SNF target amount				205. 00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 t				206. 00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs				
	Program reimbursement under the §410A Demonstration (see inst				207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-	2, col. 1, sum of lines	1		208. 00
200 00	and 3)	-+!>			200 00
	Adjustment to Medicare swing-bed SNF PPS payments (see instru Reserved for future use	CLI UIIS)			209. 00 210. 00
∠ 1U. UU	Comparision of PPS versus Cost Reimbursement				J≥ 10.00
215 00	Total adjustment to Medicare swing-bed SNF PPS payment (line :	209 nlus line 210) (see			215. 00
210.00	linstructions)	20, prus rine 210) (see			[ 13.00

				7/30/2018 12:	58 pm
		Title XIX	wing Beds - SNF	Cost	
			Part A	Part B	
			1. 00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		0		1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)		0		2.00
3. 00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A		0		3. 00
4 00	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instr		0.00		4 00
4. 00	Per diem cost for interns and residents not in approved teaching instructions)	g program (see	0.00		4. 00
5. 00	Program days		0		5. 00
6. 00	Interns and residents not in approved teaching program (see inst	tructions)	0		6.00
7. 00	Utilization review - physician compensation - SNF optional metho	•	0		7.00
8. 00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	od om y	0		8.00
9. 00	Primary payer payments (see instructions)		0		9.00
10.00	Subtotal (line 8 minus line 9)		Ö		10.00
11. 00	Deductibles billed to program patients (exclude amounts applicate	ole to physician	0		11.00
	professional services)	or project and			
12.00	Subtotal (line 10 minus line 11)		0		12.00
13.00	Coinsurance billed to program patients (from provider records)	(excl ude coi nsurance	0		13.00
	for physician professional services)				
14.00	80% of Part B costs (line 12 x 80%)		0		14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	)	0		15. 00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		16. 00
16. 50	Pioneer ACO demonstration payment adjustment (see instructions)				16. 50
16. 55	Rural community hospital demonstration project (§410A Demonstration	tion) payment			16. 55
	adjustment (see instructions)				
16. 99	Demonstration payment adjustment amount before sequestration		0		16. 99
17.00	Allowable bad debts (see instructions)		0		17.00
17. 01	Adjusted reimbursable bad debts (see instructions)	+!>	0		17. 01
18. 00 19. 00	Allowable bad debts for dual eligible beneficiaries (see instruc	ctions)	0		18.00
19.00	Total (see instructions) Sequestration adjustment (see instructions)		0		19. 00 19. 01
19. 01	Demonstration payment adjustment amount after sequestration)		0		19.01
20.00			0		20.00
21. 00	Tentative settlement (for contractor use only)		0		21.00
22. 00	Balance due provider/program (line 19 minus lines 19.01, 20, and	1 21)	0		22.00
23. 00	Protested amounts (nonallowable cost report items) in accordance	•	0		23.00
20.00	chapter 1, §115.2	5 III C. SING . GD 15 2,			20.00
	Rural Community Hospital Demonstration Project (§410A Demonstrat	ion) Adjustment			
200.00	Is this the first year of the current 5-year demonstration perio				200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.				
	Cost Reimbursement				
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wks	st. D-1, Pt. II, line			201. 00
	66 (title XVIII hospital))				
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from V	Wkst. D-3, col. 3, line	9		202. 00
202 00	200 (title XVIII swing-bed SNF))				202 00
	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fi	ret weer of the curren	t E voor domone:	tration	204. 00
	period)	ist year or the currer	it 5-year deliloris	tration	
205 00	Medicare swing-bed SNF target amount				205. 00
	Medicare swing-bed SNF inpatient routine cost cap (line 205 time	es line 204)			206.00
200.00	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursen		1		200.00
207.00	Program reimbursement under the §410A Demonstration (see instruc				207.00
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2,	•			208.00
	and 3)				
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructi	ons)			209. 00
210.00	Reserved for future use				210.00
	Comparision of PPS versus Cost Reimbursement				
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209	9 plus line 210) (see			215. 00
	instructions)		1		l

Health Financial Systems	JAY COUNTY HOS	SPI TAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-1320	From 10/01/2017	
			To 02/28/2018	Date/Time Prepared: 7/30/2018 12:58 pm
		Title XVIII	Hospi tal	Cost

PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT   1.00				10 02/20/2018	7/30/2018 12:	
PART V - CALCULATION OF RELIMBURSEWENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST RELIMBURSEMENT			Title XVIII	Hospi tal		
PART V - CALCULATION OF RELIMBURSEWENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST RELIMBURSEMENT						
Inpatient services   984,320   1.00   2.00   Nursing and Allied Health Managed Care payment (see instructions)   0   2.00   0.					1. 00	
Nursing and Allied Health Managed Care payment (see instructions)   0   2.00   0.00		PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE	PART A SERVICES - COST	REIMBURSEMENT		
0.00   Subtotal (sum of lines 1 through 3)   994, 320   4,004   5,000   5,00	1.00	Inpatient services			984, 320	1.00
Subtotal (sum of lines 1 through 3)	2.00	Nursing and Allied Health Managed Care payment (see instructio	ns)		٠,	
Description   Description	3.00	Organ acquisition			0	3.00
Total cost (line 4 less line 5). For CAH (see instructions)   994, 163   6.00	4.00	Subtotal (sum of lines 1 through 3)			984, 320	4.00
COMPUTATION OF LESSER OF COST OR CHARGES  Reasonable charges  Routine services on a charge basis  Discourant shat would have been realized from patients liable for payment for services on a charge basis  Discourant shat would have been realized from patients liable for payment for services on a charge basis  Discourant shat would have been realized from patients liable for payment for services on a charge basis  Discourant shat would have been realized from patients liable for payment for services on a charge basis  Discourant shat would have been realized from patients liable for payment for services on a charge basis  Discourant shat would have been realized from patients liable for payment for services on a charge basis  Discourant shat would have been realized from patients liable for payment for services on a charge basis  Discourant shat would have been realized from patients liable for payment for services on a charge basis  Discourant shat would have been realized from patients liable for payment for services on a charge basis  Discourant shat would have been services (se	5.00	Primary payer payments			0	5.00
Reasonable charges	6.00				994, 163	6.00
Routine service charges   0   7.00		COMPUTATION OF LESSER OF COST OR CHARGES				
Ancillary service charges   0   8.00   0.0		Reasonable charges				
Organ acquisition charges   0   9.00	7.00	Routine service charges			0	7.00
10.00   Total reasonable charges   0   10.00   Customary charges   0   10.00   Customary charges   0   10.00   Aggregate amount actually collected from patients liable for payment for services on a charge basis   0   11.00   Aggregate amount actually collected from patients liable for payment for services on a charge basis   0   12.00   Amounts that would have been realized from patients liable for payment for services on a charge basis   0   12.00   Amounts that would have been realized from patients liable for payment for services on a charge basis   0   12.00   1	8.00	Ancillary service charges			0	8.00
Customary charges Aggregate amount actually collected from patients liable for payment for services on a charge basis Aggregate amount actually collected from patients liable for payment for services on a charge basis On Amounts that would have been realized from patients liable for payment for services on a charge basis On Ratio of line 11 to line 12 (not to exceed 1.000000) On Occupance of the following of th	9.00	Organ acquisition charges, net of revenue			0	9.00
1.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis and actually collected from patients liable for payment for services on a charge basis and such payment been made in accordance with 42 CFR 413.13(e) and such payment been made in accordance with 42 CFR 413.13(e) and such payment been made in accordance with 42 CFR 413.13(e) and such payment been made in accordance with 42 CFR 413.13(e) and such payment charges (see instructions) and accordance with 42 CFR 413.13(e) and such mary charges (see instructions) and accordance with 42 CFR 413.13(e) and such mary charges (see instructions) and accordance with 42 CFR 413.13(e) and such mary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions) and accordance with 42 CFR 413.13(e) and such mary charges over reasonable cost (complete only if line 6 exceeds line 6) (see instructions) and accordance with 42 CFR 413.13(e) and accordance with 42 CFR 413.13(e) and accordance with 42 CFR 413.13(e) and accordance with 42 CFR 413.13(e) and accordance with 42 CFR 413.13(e) and accordance with 42 CFR 413.13(e) and accordance with 42 CFR 413.13(e) and accordance with 42 CFR 413.13(e) and accordance with 42 CFR 413.13(e) and accordance with 42 CFR 413.13(e) and accordance with 42 CFR 413.13(e) and accordance with 42 CFR 413.13(e) and accordance with 42 CFR 413.13(e) and 42.00	10.00	Total reasonable charges			0	10.00
2.00   Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)   0.000000   13.00   0.000000   14.00   15.00						
had such payment been made in accordance with 42 CFR 413.13(e)   Ratio of line 11 to line 12 (not to exceed 1.000000)   0.000000   13.00   14.00   15.00   1	11. 00	Aggregate amount actually collected from patients liable for p	ayment for services on	a charge basis	0	11.00
Nationary   Nati	12.00	Amounts that would have been realized from patients liable for	payment for services of	on a charge basis	0	12.00
Total customary charges (see instructions)   Carcess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)   15.00						
Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions) 6.00 Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions) 7.00 Cost of physicians' services in a teaching hospital (see instructions)  COMPUTATION OF REIMBURSEMENT SETTLEMENT  8.00 Direct graduate medical education payments (from Worksheet E-4, line 49) 0 Direct graduate medical education payments (from Worksheet E-4, line 49) 0 Deductibles (exclude professional component) 117, 964 120,00 Deductibles (exclude professional component) 117, 964 120,00 Subtotal (line 19 minus line 20 and 21) 130,00 Cost of covered services 130,00 Cost of covered services 140,00 Subtotal (line 19 minus line 20 and 21) 151,00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 152,00 Allowable bad debts (exclude bad debts (see instructions) 164,00 Allowable bad debts for dual eligible beneficiaries (see instructions) 165,00 Allowable bad debts for dual eligible beneficiaries (see instructions) 170,00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 170,00 Demonstration payment adjustment (see instructions) 170,00 Subtotal (see instructions) 170,00 Sequestration adjustment (see instructions) 170,00 Sequestration adjustment (see instructions) 170,00 Inter im payments 170,00 Demonstration payment adjustment amount before sequestration 170,00 Sequestration adjustment (see instructions) 170,00 Inter im payments 170,00 Demonstration payment adjustment amount after sequestration 170,00 Inter im payments 170,00 Demonstration payment adjustment amount after sequestration 170,00 Inter im payments 170,00 Demonstration payment adjustment amount after sequestration 170,00 Demonstration payment adjustment amount after sequestration 170,00 Inter im payments 170,00 Demonstration payment adjustment amount after sequestration 170,00 Demonstration payment adjustment in a solution and adjustment (see instructions) 170,00 Demonstration payments 170,00 Demonstr	13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0. 000000	13.00
Instructions   Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)   16.00	14.00	Total customary charges (see instructions)			0	14.00
Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)   16.00	15.00	Excess of customary charges over reasonable cost (complete onl	y if line 14 exceeds li	ne 6) (see	0	15.00
instructions) Cost of physicians' services in a teaching hospital (see instructions) Cost of physicians' services in a teaching hospital (see instructions)  Direct graduate medical education payments (from Worksheet E-4, line 49)  0 Cost of covered services (sum of lines 6, 17 and 18)  994, 163  19.00  Deductibles (exclude professional component)  117, 94  20.00  21.00  Excess reasonable cost (from line 16)  12.00  Subtotal (line 19 minus line 20 and 21)  Coinsurance  23.00  Subtotal (line 22 minus line 23)  25.00  Allowable bad debts (exclude bad debts for professional services) (see instructions)  26.00  Adjusted reimbursable bad debts (see instructions)  27.00  Subtotal (sum of lines 24 and 25, or line 26)  OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  Pioneer ACO demonstration payment adjustment (see instructions)  10.01  17.00  Subtotal (see instructions)  10.02  17.00  Subtotal (see instructions)  10.03  10.04  10.05  10.06  10.07		instructions)				
17.00   Cost of physicians' services in a teaching hospital (see instructions)   0   17.00     17.00     17.00     18.00   18.00   19.00   19.00   19.00   19.00   19.00   19.00   117.964   19.00   119.964   1	16.00		y if line 6 exceeds lir	ne 14) (see	0	16.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT  10 Direct graduate medical education payments (from Worksheet E-4, line 49) 10 Cost of covered services (sum of lines 6, 17 and 18) 117, 964 119, 00 Deductibles (exclude professional component) 117, 964 110, 00 Excess reasonable cost (from line 16) 110, 00 Subtotal (line 19 minus line 20 and 21) 110, 00 Subtotal (line 22 minus line 23) 111, 00 Subtotal (line 22 minus line 23) 112, 00 Subtotal (line 22 minus line 23) 113, 00 Coin surance 114, 00 Subtotal (line 22 minus line 23) 115, 00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 117, 964 118, 00 One of the company						
18.00   Direct graduate medical education payments (from Worksheet E-4, line 49)   0   0   0   0   0   0   0   0   0	17. 00		uctions)		0	17. 00
19.00   Cost of covered services (sum of lines 6, 17 and 18)   994, 163   19.00   Deductibles (exclude professional component)   117, 964   20.00   20.00   Excess reasonable cost (from line 16)   21.00   Subtotal (line 19 minus line 20 and 21)   876, 199   22.00   23.00   23.00   Coinsurance   23.00   Subtotal (line 22 minus line 23)   876, 199   24.00   25.00   Allowable bad debts (exclude bad debts for professional services) (see instructions)   26.00   Adjusted reimbursable bad debts (see instructions)   25.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   27.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   27.00   876, 199   28.00   29.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   29.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   29.00   29.50   29.00   29.50   29.00						ļ
20.00 Deductibles (exclude professional component) Excess reasonable cost (from line 16) Color Subtotal (line 19 minus line 20 and 21) Color Subtotal (line 29 minus line 23) Excess reasonable bad debts (exclude bad debts for professional services) (see instructions) Excess reasonable cost (from line 16) Color Subtotal (line 21 minus line 20 and 21) Excess reasonable cost (from line 16) Color Subtotal (line 29 minus line 20 and 21) Excess reasonable cost (from line 16) Color Subtotal (line 22 minus line 20 and 21) Excess reasonable cost (from line 16) Color Subtotal (line 22 minus line 20 and 21) Excess reasonable cost (from line 16) Color Subtotal (line 22 minus line 23) Excess reasonable cost (from line 16) Color Subtotal (line 22 minus line 23) Excess reasonable cost (from line 16) Color Subtotal (line 22 minus line 23) Excess reasonable cost (from line 16) Color Subtotal (line 22 minus line 23) Excess reasonable cost (from line 16) Color Subtotal (line 22 minus line 23) Excess reasonable cost (from line 16) Color Subtotal (line 22 minus line 23) Excess reasonable cost (from line 16) Color Subtotal (line 22 minus line 23) Excess reasonable cost (from line 26) Excess reasonable cost (from line 16) Color Subtotal (line 20 minus line 26) Excess reasonable cost (from line 19 minus line 26) Excess reasonable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  117, 964 20.00 Excess reasonable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  117, 964 Color Subtotal (line 20 minus line 30 minus lines 30.01, 30.02, 31, and 32) Excess reasonable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  117, 964 Excess reasonable cost report items in accordance with CMS Pub. 15-2, chapter 1,		, , , ,	, line 49)			
Excess reasonable cost (from line 16) Subtotal (line 19 minus line 20 and 21) Subtotal (line 22 minus line 23) Subtotal (line 22 minus line 23) Subtotal (line 22 minus line 23) Subtotal (line 22 minus line 23) Subtotal (line 22 minus line 23) Subtotal (line 22 minus line 23) Subtotal (line 22 minus line 23) Subtotal (sum of lines 24 minus line 23) Subtotal (sum of lines 24 and 25, or line 26) Subtotal (sum of lines 24 and 25, or line 26) Subtotal (sum of lines 24 and 25, or line 26) Subtotal (sum of lines 24 and 25, or line 26) Subtotal (sum of lines 24 and 25, or line 26) Subtotal (sum of lines 24 and 25, or line 26) Subtotal (sum of lines 24 and 25, or line 26) Subtotal (sum of lines 24 and 25, or line 26) Subtotal (see instructions) Subtotal (se		· · · · · · · · · · · · · · · · · · ·				
22.00   Subtotal (line 19 minus line 20 and 21)   876, 199   22.00   23.00   23.00   24.00   25.00   25.00   25.00   26.00   26.00   27.00		, , , , , , , , , , , , , , , , , , , ,				
Coinsurance Subtotal (line 22 minus line 23)  Allowable bad debts (exclude bad debts for professional services) (see instructions)  Adjusted reimbursable bad debts (see instructions)  Allowable bad debts for dual eligible beneficiaries (see instructions)  Subtotal (sum of lines 24 and 25, or line 26)  OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  Pioneer ACO demonstration payment adjustment (see instructions)  Demonstration payment adjustment amount before sequestration  Subtotal (see instructions)  Subtotal (see instructions)  Pequestration adjustment (see instructions)  Demonstration payment adjustment amount after sequestration  Interim payments  Tentative settlement (for contractor use only)  Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)  Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,		·				
87.00 Subtotal (line 22 minus line 23) 88.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 89.00 Adjusted reimbursable bad debts (see instructions) 89.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 89.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 89.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 89.09 Demonstration payment adjustment (see instructions) 80.00 Subtotal (see instructions) 80.00 Subtotal (see instructions) 80.00 Demonstration adjustment amount before sequestration 80.00 Demonstration payment adjustment amount after sequestration 80.00 Demonstration payment adjustment amount after sequestration 81.00 Interim payments 82.00 Tentative settlement (for contractor use only) 83.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 84.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,		,				
Allowable bad debts (exclude bad debts for professional services) (see instructions)  Adjusted reimbursable bad debts (see instructions)  Adjusted reimbursable bad debts (see instructions)  Allowable bad debts for dual eligible beneficiaries (see instructions)  Bas 00  Bas 00  Bat 00					- 1	
Adjusted reimbursable bad debts (see instructions)  Adjusted reimbursable bad debts (see instructions)  Allowable bad debts for dual eligible beneficiaries (see instructions)  Boundary of the Adjustment (see instructions)  Control of the Adjustment (se						
Allowable bad debts for dual eligible beneficiaries (see instructions)  8. 00 Subtotal (sum of lines 24 and 25, or line 26)  8. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  9. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  9. 00 Demonstration payment adjustment (see instructions)  9. 00 Subtotal (see instructions)  9. 00 Subtotal (see instructions)  9. 00 Subtotal (see instructions)  9. 00 Demonstration adjustment (see instructions)  9. 01 Demonstration payment adjustment amount after sequestration  9. 02 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  9. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  9. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  9. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  9. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  9. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  9. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  9. 00 OTHER ADJUSTMENT (SEE INSTRUCTIONS) (SPECIFY)  9. 00 OTHER ADJUSTMENT (SEE INSTRUCTIONS) (SPECIFY)  9. 00 OTHER ADJUSTMEN		, ·	es) (see instructions)		-	1
28.00 Subtotal (sum of lines 24 and 25, or line 26) 29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 30.00 Subtotal (see instructions) 30.01 Sequestration adjustment (see instructions) 30.02 Demonstration payment adjustment amount after sequestration 30.02 Demonstration payment adjustment amount after sequestration 30.02 Demonstration payment adjustment amount after sequestration 30.02 Demonstration payment adjustment amount after sequestration 30.02 Tentative settlement (for contractor use only) 30.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 30.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,					-	
19.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 19.50 Pioneer ACO demonstration payment adjustment (see instructions) 19.99 Demonstration payment adjustment amount before sequestration 19.00 Subtotal (see instructions) 10.01 Sequestration adjustment (see instructions) 10.02 Demonstration payment adjustment amount after sequestration 10.03 Demonstration payment adjustment amount after sequestration 10.04 Interim payments 10.05 Demonstration payments 10.06 Interim payments 10.07 Tentative settlement (for contractor use only) 10.08 Demonstration payments 10.09 Demonstration payment adjustment amount after sequestration 10.00 Demonstration payment adjustment amount after sequestration 10.00 Demonstration payment adjustment amount after sequestration 10.00 Demonstration payment adjustment amount after sequestration 10.00 Demonstration payment adjustment amount after sequestration 10.00 Demonstration payment adjustment amount after sequestration 10.00 Demonstration payment adjustment amount after sequestration 10.00 Demonstration payment adjustment amount after sequestration 10.00 Demonstration payment adjustment amount after sequestration 10.00 Demonstration payment adjustment amount after sequestration 10.00 Demonstration payment adjustment amount after sequestration 10.00 Demonstration payment adjustment amount after sequestration 10.00 Demonstration payment adjustment amount after sequestration 10.00 Demonstration adjustment (see instructions) 10.00 Demonstration payment adjustment amount after sequestration 10.00 Demonstration payment adjustment amount after sequestration 10.00 Demonstration adjustment (see instructions) 10.00 Demonstration payment adjustment amount after sequestration 10.00 Demonstration adjustment (see instructions) 10.00 Demonstration adjustment (see instructions) 10.00 Demonstration adjustment (see instructions) 10.00 Demonstration adjustment (see instructions) 10.00 Demonstration adjustment (see instructions) 10.00 Demonstration adjustment (see instructions) 10.00 Demonstration adjustm			uctions)			
Pioneer ACO demonstration payment adjustment (see instructions)  Demonstration payment adjustment amount before sequestration  Subtotal (see instructions)  Sequestration adjustment (see instructions)  Demonstration payment adjustment amount after sequestration  Interim payments  Interim payments  Demonstration payment adjustment amount after sequestration  Interim payments  Demonstration payment adjustment amount after sequestration  Demonstration payment adjustment amount after sequestration  Demonstration payment adjustment amount after sequestration  Demonstration payment adjustment amount after sequestration  Demonstration payment adjustment amount after sequestration  Demonstration payment adjustment (see instructions)  Demonstration payment adjustment amount after sequestration  Demonstration payment adjustment amount after sequestration  Demonstration payment adjustment amount after sequestration  Demonstration payment adjustment amount after sequestration  Demonstration payment adjustment amount after sequestration  Demonstration payment adjustment amount after sequestration  Demonstration payment adjustment amount after sequestration  Demonstration payment adjustment amount amount amount after sequestration  Demonstration payment adjustment amount after sequestration  Demonstration payment adjustment amount amount after sequestration  Demonstration payment adjustment amount after sequestration  Demonstration adjustment (see instructions)  Demonstration payment adjustment amount after sequestration  Demonstration adjustment amount after sequestration  Demonstration adjustment amount after sequestration  Demonstration adjustment amount after sequestration  Demonstration adjustment amount after sequestration  Demonstration adjustment amount after sequestration  Demonstration adjustment amount after sequestration  Demonstration adjustment amount after sequestration  Demonstration adjustment amount after sequestration  Demonstration adjustment amount after sequestration  Demonstration adjustment amount afte						
29. 99 Demonstration payment adjustment amount before sequestration  Subtotal (see instructions)  Social Sequestration adjustment (see instructions)  Demonstration adjustment (see instructions)  Demonstration payment adjustment amount after sequestration  Demonstration payment adjustment amount after sequestration  Demonstration payment adjustment amount after sequestration  Demonstration payment adjustment (see instructions)  Demonstration payment adjustment (see instructions)  Demonstration payment adjustment amount after sequestration  Demonstration payment adjustment amount after sequestration  Demonstration payment adjustment amount after sequestration  Demonstration payment adjustment amount after sequestration  Demonstration payment adjustment amount after sequestration  Demonstration payment adjustment amount after sequestration  Demonstration payment adjustment amount after sequestration  Demonstration payment adjustment amount after sequestration  Demonstration payment adjustment amount after sequestration  Demonstration payment adjustment amount after sequestration  Demonstration payment adjustment amount after sequestration  Demonstration after sequestration  Demonstration adjustment amount after sequestration  Demonstration adjustment amount after sequestration  Demonstration adjustment amount after sequestration  Demonstration adjustment amount after sequestration  Demonstration adjustment amount after sequestration  Demonstration adjustment amount after sequestration  Demonstration adjustment amount after sequestration  Demonstration adjustment amount after sequestration  Demonstration adjustment amount after sequestration  Demonstration adjustment amount after sequestration  Demonstration adjustment amount after sequestration  Demonstration adjustment amount after sequestration  Demonstration adjustment amount after sequestration  Demonstration adjustment amount after sequestration  Demonstration adjustment amount after sequestration  Demonstration adjustment amount after sequestration  Demonstr						
80.00 Subtotal (see instructions) 80.01 Sequestration adjustment (see instructions) 80.02 Demonstration payment adjustment amount after sequestration 81.00 Interim payments 82.00 Tentative settlement (for contractor use only) 83.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 84.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,			)		-	
30.01 Sequestration adjustment (see instructions)  30.02 Demonstration payment adjustment amount after sequestration  30.02 Interim payments  31.00 Interim payments  32.00 Tentative settlement (for contractor use only)  33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)  34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,					- 1	
BOLOZ Demonstration payment adjustment amount after sequestration  O 30.02 B1.00 Interim payments  Tentative settlement (for contractor use only)  O 32.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)  O Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  O 34.00		·				
31.00 Interim payments 756,172 31.00 1.00 Tentative settlement (for contractor use only) 0 32.00 1.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 102,503 33.00 1.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00						
32.00 Tentative settlement (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34.00						
33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  102,503   33.00   34.						
14.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34.00						
	34.00		ce with CMS Pub. 15-2,	cnapter 1,	0	34.00
13110.2		§115. 2		I	l	l

Health Financial Systems	JAY COUNTY HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1320		Worksheet E-3
		From 10/01/2017	
	Component CCN: 15-M320	To 02/28/2018	Date/Time Prepared:
	· ·		7/30/2018 12:58 pm
	Title XVIII	Subprovi der -	PPS
		LDE	

	IPF		
	DADT 11 MEDICADE DADT A CEDITIONS	1. 00	
1 00	PART II - MEDICARE PART A SERVICES - IPF PPS	245 002	1 00
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	245, 993	1.00
2. 00 3. 00	Net IPF PPS Outlier Payments Net IPF PPS ECT Payments	59, 074 0	2. 00 3. 00
4. 00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November	0.00	4. 00
4.00	15, 2004. (see instructions)	0.00	4.00
4. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by	0. 00	4. 01
1. 01	program or hospital closure, that would not be counted without a temporary cap adjustment under 42	0.00	1.01
	CFR \$412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new	0.00	6.00
	teaching program" (see instuctions)		
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new	0. 00	7.00
	teaching program" (see instuctions)		
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0. 00	8.00
9. 00	Average Daily Census (see instructions)	3. 059603	
10. 00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0. 000000	
11. 00	Teaching Adjustment (line 1 multiplied by line 10).	0	11. 00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	305, 067	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	305, 067	
17. 00 18. 00	Primary payer payments	0 305, 067	17. 00 18. 00
19.00	Subtotal (line 16 less line 17).  Deductibles	25, 100	
20.00	Subtotal (line 18 minus line 19)	25, 100 279, 967	
21.00	Coi nsurance	10, 528	
22. 00	Subtotal (line 20 minus line 21)	269, 439	
23. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	207, 437	23. 00
24. 00	Adjusted reimbursable bad debts (see instructions)	0	
25. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	25. 00
26. 00	Subtotal (sum of lines 22 and 24)	269, 439	
27. 00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	
28. 00	Other pass through costs (see instructions)	o l	
29. 00	Outlier payments reconciliation	ol	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30. 50	Pioneer ACO demonstration payment adjustment (see instructions)	o	30.50
30. 99	Demonstration payment adjustment amount before sequestration	o	30. 99
31.00	Total amount payable to the provider (see instructions)	269, 439	31.00
31. 01	Sequestration adjustment (see instructions)	5, 389	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	
32.00	Interim payments	264, 050	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	35.00
	§115. 2		
	TO BE COMPLETED BY CONTRACTOR		
50.00		59, 074	
51.00	` '	0	51.00
52.00	· · · · · · · · · · · · · · · · · · ·		52.00
53.00	Time Value of Money (see instructions)	, 0	53.00

Health Financial Systems	JAY COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1320	Peri od: Worksheet E-3 From 10/01/2017 Part VII To 02/28/2018 Date/Time Prepared:

			10 02/28/2018	7/30/2018 12:	
		Title XIX	Hospi tal	Cost	
		,	Inpatient	Outpati ent	
			1.00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVI	CES FOR TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient hospital/SNF/NF services		43, 783		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		43, 783	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		43, 783	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES				1
	Reasonabl e Charges				1
8.00	Routine service charges		22, 421		8.00
9.00	Ancillary service charges		62, 335	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		84, 756	0	12.00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for s	services on a charge	0	0	13.00
	basis				
14.00	Amounts that would have been realized from patients liable for p	9	0	0	14.00
	a charge basis had such payment been made in accordance with 42	CFR §413. 13(e)			
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0. 000000	
16.00	Total customary charges (see instructions)		84, 756	0	
17. 00	Excess of customary charges over reasonable cost (complete only	if line 16 exceeds	40, 973	0	17.00
10.00	line 4) (see instructions)		7	0	10 00
18. 00	Excess of reasonable cost over customary charges (complete only	II Tine 4 exceeds Tine	٩	0	18.00
19. 00	16) (see instructions) Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instruc	eti one)		0	
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		43, 783	0	
21.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co			0	21.00
22 00	Other than outlier payments	mpreted for 113 provid	0	0	22.00
	Outlier payments		o	0	
	Program capital payments		0	Ü	24.00
	Capital exception payments (see instructions)		0		25.00
26. 00	Routine and Ancillary service other pass through costs		o	0	
27. 00	Subtotal (sum of lines 22 through 26)		o	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	
29.00	Titles V or XIX (sum of lines 21 and 27)		43, 783	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		43, 783	0	31.00
32.00	Deducti bl es		0	0	32.00
33.00			0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		43, 783	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		43, 783	0	38.00
39.00			0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		43, 783	0	40.00
41.00	Interim payments		29, 360	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		14, 423	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub 15-2,	0	0	43.00
	chapter 1, §115.2		1		1

Health Financial Systems	JAY COUNTY HOSPITAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1320	Peri od: From 10/01/2017	Worksheet E-3
	Component CCN: 15-M320		
	Title XIX	Subprovi der -	Cost

		II tie xix	I PF	COST	
			Inpati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVIC	ES FOR TITLES V OR XI		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	ES TOR TITLES V OR XI	X SERVICES		
1.00	Inpatient hospital/SNF/NF services		48, 014		1.00
2. 00	Medical and other services		10,011	0	2.00
3. 00	Organ acquisition (certified transplant centers only)		0	o .	3.00
4. 00	Subtotal (sum of lines 1, 2 and 3)		48, 014	0	4.00
5. 00	Inpatient primary payer payments		0	· ·	5. 00
6. 00	Outpatient primary payer payments		Ĭ	0	6.00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		48, 014	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES		,,	-	
	Reasonable Charges				
8.00	Routine service charges		16, 705		8. 00
9.00	Ancillary service charges		22, 880	0	9. 00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		39, 585	0	12.00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for se	rvices on a charge	0	0	13.00
	basis	_			
14.00	Amounts that would have been realized from patients liable for pa	yment for services on	0	0	14.00
	a charge basis had such payment been made in accordance with 42 C	FR §413.13(e)			
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.000000	15.00
16.00	Total customary charges (see instructions)		39, 585	0	16. 00
17. 00	Excess of customary charges over reasonable cost (complete only i	f line 16 exceeds	0	0	17. 00
	line 4) (see instructions)				
18. 00	Excess of reasonable cost over customary charges (complete only i	fline 4 exceeds line	8, 429	0	18. 00
40.00	16) (see instructions)				40.00
19. 00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instruct	ions)	0	0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)		39, 585	0	21. 00
22 00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be com	pretea for PPS provid		0	22.00
	Other than outlier payments		0	0	22.00
23. 00	Outlier payments Program capital payments		0	0	23. 00 24. 00
25.00	Capital exception payments (see instructions)				25. 00
26. 00	Routine and Ancillary service other pass through costs			0	26.00
27. 00	Subtotal (sum of lines 22 through 26)			0	27.00
28. 00	Customary charges (title V or XIX PPS covered services only)			0	28.00
29. 00	Titles V or XIX (sum of lines 21 and 27)		39, 585	0	29.00
27.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		37, 303	0	27.00
30 00	Excess of reasonable cost (from line 18)		8, 429	0	30.00
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		39, 585	0	31.00
32. 00	Deductibles		0	0	32. 00
33. 00	Coinsurance		o	0	33. 00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35. 00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33		39, 585	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		39, 585	0	38. 00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39. 00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		39, 585	0	40.00
41.00	Interim payments		10, 137	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		29, 448	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub 15-2,	0	0	43.00
	chapter 1, §115.2				

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

Health Financial Systems

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

Provider CCN: 15-1320

Peri od: Worksheet G
From 10/01/2017
To 02/28/2018 Date/Time Prepared: 7/30/2018 12:58 pm

——————————————————————————————————————	<u> </u>				7/30/2018 12:	58 pm
		General Fund	Speci fi c	Endowment	Plant Fund	
		1.00	Purpose Fund 2.00	Fund 3. 00	4. 00	
	CURRENT ASSETS					
1. 00	Cash on hand in banks	0	0	0	0	
2.00	Temporary investments	0		0	0	
3.00	Notes receivable	0	-	0	0	
4. 00 5. 00	Accounts recei vabl e  Other recei vabl e	0	0	0	0	1
6. 00	Allowances for uncollectible notes and accounts receivable		0	0	0	
7. 00	Inventory	0	0	0	0	
8. 00	Prepai d expenses	0	Ö	0	0	1
9. 00	Other current assets	0	0	0	0	9. 00
10.00	Due from other funds	0	0	0	0	10.00
11. 00	Total current assets (sum of lines 1-10)	0	0	0	0	11. 00
10.00	FI XED ASSETS	1 0				10.00
12. 00 13. 00	Land	0	0	0	0	
	Land improvements Accumulated depreciation			0	0	1
	Buildings	0		0	0	15. 00
	Accumulated depreciation	0	Ö	0	0	1
17.00	Leasehold improvements	0	0	0	0	17. 00
18.00	Accumul ated depreciation	0	0	0	0	18. 00
	Fi xed equipment	0		0	0	
	Accumulated depreciation	0	0	0	0	20.00
21. 00	Automobiles and trucks	0	0	0	0	21.00
	Accumulated depreciation Major movable equipment	0	0	0	0	22. 00 23. 00
	Accumulated depreciation		· - 1	0	0	24.00
	Minor equipment depreciable		0	0	0	1
	Accumulated depreciation	0	-	0	0	
	HIT designated Assets	0	0	0	0	1
28.00	Accumulated depreciation	0	0	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0		0	0	29. 00
30. 00	Total fixed assets (sum of lines 12-29)	0	0	0	0	30.00
21 00	OTHER ASSETS	1 0		0	0	21 00
31.00	Investments Deposits on Leases	0		0	0	
	Due from owners/officers	0	-	0	0	1
34. 00	Other assets	0	-	0	0	
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	0	0	0	0	36. 00
	CURRENT LI ABI LI TI ES	T				
	Accounts payable	0		0	0	
	Salaries, wages, and fees payable Payroll taxes payable	0	0	0	0	
40. 00	Notes and Loans payable (short term)		-	0	0	1
41. 00	Deferred income	0	0	0	0	41.00
42.00	Accel erated payments	0		-		42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	0	-	0	0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	0	0	0	0	45. 00
44 00	LONG TERM LIABILITIES	1 0		0	0	44 00
46. 00 47. 00	Mortgage payable Notes payable	0		0	0	
48. 00	Unsecured Loans		-	0	0	
	Other long term liabilities	0		0	0	1
	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	0	0	0	0	51.00
	CAPITAL ACCOUNTS					1
52. 00	General fund balance	0				52.00
53.00	Specific purpose fund		0	0		53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55. 00 56. 00	Donor created - endowment fund balance - unrestricted Governing body created - endowment fund balance			0		55. 00 56. 00
57. 00	Plant fund balance - invested in plant			O	0	1
58. 00	Plant fund balance - reserve for plant improvement,				0	1
	replacement, and expansion					
59.00	Total fund balances (sum of lines 52 thru 58)	0		0	0	
60.00	Total liabilities and fund balances (sum of lines 51 and	0	0	0	0	60.00
	[59]	I	l l			I

JAY COUNTY HOSPITAL In Lieu of Form CMS-2552-10

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES Peri od: Worksheet G-1 From 10/01/2017 Provi der CCN: 15-1320

			Γο 02/28/2018	Date/Time Pre 7/30/2018 12:	pared: 58 pm
General	Fund	Special Pu	urpose Fund	Endowment Fund	
1. 00	2. 00	3. 00	4.00	5. 00	
	33, 410, 480 -33, 410, 480 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
0 0 0 0	0 0	(		0 0 0 0 0	11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
Endowment Fund	PI ant	Fund			
6. 00	7. 00	8. 00			
0	0 0 0 0 0	(			1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
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
	1.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	33, 410, 480 -33, 410, 480 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	General Fund   Special Property   Special Propert	General Fund   Special Purpose Fund	Special Purpose Fund   Endowment Fund   Special Purpose Fund   Endowment Fund   Special Purpose Fund   Special P

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

			'	0 02/20/2016	7/30/2018 12:	
	Cost Center Description		I npati ent	Outpati ent	Total	
	<b>'</b>		1.00	2.00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Services					
1.00	Hospi tal		2, 260, 914		2, 260, 914	1.00
2.00	SUBPROVI DER - I PF		379, 920		379, 920	2.00
3.00	SUBPROVI DER - I RF		0		0	3.00
4.00	SUBPROVI DER		0		0	4. 00
5. 00	Swing bed - SNF		0		0	5. 00
6.00	Swing bed - NF		O		0	6. 00
7.00	SKILLED NURSING FACILITY					7.00
8.00	NURSING FACILITY					8.00
9.00	OTHER LONG TERM CARE		2 (40 024		2 (40 024	9.00
10. 00	Total general inpatient care services (sum of lines 1-9) Intensive Care Type Inpatient Hospital Services		2, 640, 834		2, 640, 834	10.00
11. 00	INTENSIVE CARE UNIT		0		0	11. 00
12.00	CORONARY CARE UNIT		·		U	12.00
13.00	BURN INTENSIVE CARE UNIT		o		0	13. 00
14. 00	SURGICAL INTENSIVE CARE UNIT		٥		O	14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)					15. 00
16. 00	Total intensive care type inpatient hospital services (sum of	Lines	0		0	
.0.00	11-15)				, and the second	
17.00	Total inpatient routine care services (sum of lines 10 and 16)	)	2, 640, 834		2, 640, 834	17.00
18.00	Ancillary services		3, 687, 648		31, 523, 648	18.00
19.00	Outpati ent servi ces		328, 423	6, 921, 282	7, 249, 705	19.00
20.00	RURAL HEALTH CLINIC		0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER		C	0	0	21.00
22. 00	HOME HEALTH AGENCY					22.00
23.00	AMBULANCE SERVICES					23.00
24.00	CMHC					24.00
24. 10	CORF		0	0	0	24. 10
25. 00	AMBULATORY SURGICAL CENTER (D. P.)					25.00
26. 00	HOSPI CE					26.00
27. 00	PHYSI CI AN OFFI CES		382, 754		3, 192, 795	27. 00
28. 00	Total patient revenues (sum of lines 17-27) (transfer column 3	to Wkst.	7, 039, 659	37, 567, 323	44, 606, 982	28. 00
	G-3, line 1)					
29. 00	PART II - OPERATING EXPENSES  Operating expenses (per Wkst. A, column 3, line 200)			18, 091, 829		29. 00
30.00	ADD (SPECIFY)		o			30.00
31.00	ADD (SPECIFY)					31. 00
32.00						32.00
33. 00						33. 00
34. 00			Ö			34. 00
35. 00			i o			35. 00
36. 00	Total additions (sum of lines 30-35)		Ĭ	0		36. 00
37. 00	DEDUCT (SPECIFY)		l o			37. 00
38.00			C			38.00
39.00			O			39.00
40.00			O			40.00
41.00			O			41.00
42.00	Total deductions (sum of lines 37-41)			0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42	2)(transfer		18, 091, 829		43.00
	to Wkst. G-3, line 4)					

			_	eu of Form CMS-2552-10	
STATEMENT OF REVENUES AND EXPENSES  Provider CCN: 15-1320   Period:   From 10/01/201		Worksheet G-3			
			Date/Time Prepared:		
			02,20,2010	7/30/2018 12:	
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)			44, 606, 982	1.00
2.00	Less contractual allowances and discounts on patients' accounts			30, 781, 163	2.00
3.00	Net patient revenues (line 1 minus line 2)			13, 825, 819	ı
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)			18, 091, 829	ł
5.00	Net income from service to patients (line 3 minus line 4)			-4, 266, 010	5.00
	OTHER INCOME				
6.00				0	
7.00				0	,,,,,
8.00				0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			0	10.00
	Rebates and refunds of expenses			0	
	Parking lot receipts			0	1 .2.00
	Revenue from Laundry and Linen service			0	
	O Revenue from meals sold to employees and guests			0	
	Revenue from rental of living quarters			0	
	Revenue from sale of medical and surgical supplies to other than patients			0	1 .0.00
	Revenue from sale of drugs to other than patients			0	1 . , ,
	Revenue from sale of medical records and abstracts			0	1 .0.00
	0 Tuition (fees, sale of textbooks, uniforms, etc.)			0	
	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21. 00	Rental of vending machines			0	21.00
22. 00	Rental of hospital space			0	22. 00
	Governmental appropriations			0	23. 00
24.00	OTHER OPER AND NONOP REV			1, 680, 173	24.00

1, 680, 173 25. 00 1, 680, 173 25. 00 -2, 585, 837 26. 00 30, 824, 643 27. 00 30, 824, 643 28. 00 -33, 410, 480 29. 00

25.00 Total other income (sum of lines 6-24)
26.00 Total (line 5 plus line 25) 27. 00 TRANSFER TO IU HEALTH JAY HOSPITAL

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