This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050
EXPIRES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-1320	Period: From 03/01/2018 To 12/31/2018	Worksheet S Parts I-III Date/Time Prepared: 5/24/2019 10:13 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/24/2019 Time: 10:13 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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 IU HEALTH JAY HOSPITAL (15-1320) for the cost reporting period beginning 03/01/2018 and ending 12/31/2018 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.

[X] I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

(Signed) JONATHAN VANATOR
Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER
Title

(Dated when report is electronically signed.)
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	647,260	2,906,925	0	0	1.00
2.00	Subprovider - IPF	0	1,712	83		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	132,323	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	781,295	2,907,008	0	0	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.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1320	Period: From 03/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/24/2019 10:13 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 500 W. VOTAW	PO Box:			1.00
2.00	City: PORTLAND	State: IN	Zip Code: 47371	County: JAY	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	IU HEALTH JAY HOSPITAL	151320	99915	1	01/01/2004	N	O	P	3.00
4.00	Subprovider - IPF	IU HEALTH JAY HOSPITAL - PSYCH UNIT	15M320	99915	4	10/01/2005	N	P	O	4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	IUHP SWING BEDS	15Z320	99915		01/01/2004	N	O	N	7.00
8.00	Swing Beds - NF									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	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
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)	03/01/2018	12/31/2018	20.00
21.00	Type of Control (see instructions)	2		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate 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.	N	N		22.00
22.01	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 reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	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 in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result 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 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N		23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the 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.	0	0	0	0	0	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/24/2019 10:13 am

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.00	If this provider is an IRF, enter the in-state 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.	0	0	0	0	0		25.00

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00

		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)	N			60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/24/2019 10:13 am

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20

		1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)	N	63.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting 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 of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/24/2019 10:13 am

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 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 of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	Y			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most 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)	N		0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. 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)			0	76.00

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					1.00	
	Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.				N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.				N	81.00
	TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.				N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.				N	87.00
				V	XIX	
				1.00	2.00	
	Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N	Y	98.06
	Rural Providers					
105.00	Does this hospital qualify as a CAH?			Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			N		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.			N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N		108.00
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
					1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N	110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/24/2019 10:13 am

		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	104,910	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.00	122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15H059	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/24/2019 10:13 am

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: INDIANA UNIVERSITY HEALTH	Contractor's Name: WISCONSIN PHYSICIAN SERVICES	Contractor's Number: 08101	141.00
142.00	Street: 340 WEST TENTH STREET	PO Box:		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46204	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.			145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	Y	11/15/2018	146.00

		1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	Y	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N	149.00

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	04/01/2018	06/30/2018	170.00

		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in 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)	Y	15	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet S-2 Part II | Date/Time Prepared: 5/24/2019 10:13 am

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	Y	03/01/2018	1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	02/28/2019	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/03/2019	Y	04/03/2019	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet S-2 Part II Date/Time Prepared: 5/24/2019 10:13 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				Y	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.					33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			Y		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RHONDA		UTTER		41.00
42.00	Enter the employer/company name of the cost report preparer.	INDIANA UNIVERSITY HEALTH				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-962-1093		RUTTER@IUHEALTH.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1320	Period: From 03/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Prepared: 5/24/2019 10:13 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet S-3 Part I Date/Time Prepared: 5/24/2019 10:13 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	7,650	39,096.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	7,650	39,096.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	7,650	39,096.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	10	3,060		0	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						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	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		35				27.00
28.00	Observation Bed Days					0	28.00
29.00	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)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/24/2019 10:13 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	759	22	1,629			1.00
2.00	HMO and other (see instructions)	167	272				2.00
3.00	HMO IPF Subprovider	25	313				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	146	0	146			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	42			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	905	22	1,817			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		4	144			13.00
14.00	Total (see instructions)	905	26	1,961	0.00	192.62	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	405	23	1,158	0.00	12.41	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						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	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			30			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	205.03	27.00
28.00	Observation Bed Days		11	701			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/24/2019 10:13 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	234	9	630	1.00
2.00	HMO and other (see instructions)			61	110		2.00
3.00	HMO IPF Subprovider				56		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 beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	234	9	630	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	51	5	197	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						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	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						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						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 outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-1320	Period: From 03/01/2018 To 12/31/2018	Worksheet S-10 Date/Time Prepared: 5/24/2019 10:13 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.411457	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,217,458	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	14,598,252	6.00
7.00	Medicaid cost (line 1 times line 6)	6,006,553	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	4,789,095	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	4,789,095	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	1,859,684	3,705	1,863,389	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	765,180	3,705	768,885	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	765,180	3,705	768,885	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	896,642	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	56,017	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	86,179	27.01
28.00	Non-Medicare bad debt expense (see instructions)	810,463	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	363,633	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,132,518	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	5,921,613	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/24/2019 10:13 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	984,324	984,324	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MOB		0	0	62,689	62,689	1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT-POB		0	0	29,192	29,192	1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT-WJ		0	0	20,127	20,127	1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT-INTEREST		0	0	0	0	1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP		341,765	341,765	1,674,950	2,016,715	2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB		0	0	5,278	5,278	2.01
2.02	00202	CAP REL COSTS-MVBLE EQUIP - POB		0	0	0	0	2.02
2.03	00203	CAP REL COSTS-MVBLE EQUIP - WJ		0	0	0	0	2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	170,330	35,725	206,055	2,150,668	2,356,723	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,932,493	2,589,858	4,522,351	-164,615	4,357,736	5.00
7.00	00700	OPERATION OF PLANT	231,227	2,570,464	2,801,691	-1,223,882	1,577,809	7.00
7.01	00701	OPERATION OF PLANT - MOB	0	121,683	121,683	-65,640	56,043	7.01
7.02	00702	OPERATION OF PLANT - POB	0	50,989	50,989	-24,355	26,634	7.02
7.03	00703	OPERATION OF PLANT - WJ	0	28,949	28,949	-11,792	17,157	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	26,477	3,384	29,861	35,572	65,433	8.00
9.00	00900	HOUSEKEEPING	297,191	213,260	510,451	-136,211	374,240	9.00
10.00	01000	DIETARY	322,746	359,950	682,696	-490,612	192,084	10.00
11.00	01100	CAFETERIA	0	0	0	356,300	356,300	11.00
13.00	01300	NURSING ADMINISTRATION	1,150,346	285,884	1,436,230	-191,554	1,244,676	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	25,576	25,576	467,645	493,221	14.00
15.00	01500	PHARMACY	386,181	1,293,934	1,680,115	-1,117,282	562,833	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,384,644	1,143,699	2,528,343	-687,491	1,840,852	30.00
40.00	04000	SUBPROVIDER - IPF	755,803	318,430	1,074,233	-173,344	900,889	40.00
43.00	04300	NURSERY	0	0	0	59,092	59,092	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,129,150	2,293,132	3,422,282	-966,593	2,455,689	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	20,744	20,744	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	631,522	1,166,003	1,797,525	-899,303	898,222	54.00
60.00	06000	LABORATORY	0	1,652,366	1,652,366	-66,608	1,585,758	60.00
65.00	06500	RESPIRATORY THERAPY	315,018	164,860	479,878	-119,498	360,380	65.00
66.00	06600	PHYSICAL THERAPY	408,458	8,584	417,042	-3,978	413,064	66.00
67.00	06700	OCCUPATIONAL THERAPY	74,718	459	75,177	-459	74,718	67.00
68.00	06800	SPEECH PATHOLOGY	14,944	0	14,944	0	14,944	68.00
69.00	06900	ELECTROCARDIOLOGY	0	65,695	65,695	0	65,695	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	238,297	238,297	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	38,540	38,540	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,363,712	1,363,712	73.00
76.00	03160	CARDIOPULMONARY	89,943	214,379	304,322	-36,996	267,326	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	507,115	603,905	1,111,020	-307,343	803,677	90.01
90.02	09002	JAY FAMILY MEDICINE	665,653	806,279	1,471,932	-275,186	1,196,746	90.02
90.03	09003	WOUND CLINIC	50,855	10,816	61,671	-5,743	55,928	90.03
90.04	09004	OP ORTHO CLINIC	0	115,349	115,349	-103	115,246	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	318,543	544,085	862,628	-166,904	695,724	90.05
90.06	09006	INFUSION CLINIC	53,079	8,299	61,378	-3,875	57,503	90.06
91.00	09100	EMERGENCY	788,811	1,804,026	2,592,837	-273,906	2,318,931	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	30,195	13,072	43,267	5,221	48,488	93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,735,442	18,854,859	30,590,301	99,078	30,689,379	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	-28	-28	28	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	28,587	28,587	-7,860	20,727	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.02	07952	WEST JAY CLINIC	235,530	435,817	671,347	-63,571	607,776	194.02
194.03	07953	JAY MERIDIAN URGENT CARE	146,242	192,434	338,676	-27,675	311,001	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	12,117,214	19,511,669	31,628,883	0	31,628,883	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/24/2019 10:13 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-267,350	716,974		1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MOB	-62,689	0		1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT-POB	-29,192	0		1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT-WJ	-20,127	0		1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT-INTEREST	0	0		1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-710,590	1,306,125		2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB	14,726	20,004		2.01
2.02	00202	CAP REL COSTS-MVBLE EQUIP - POB	0	0		2.02
2.03	00203	CAP REL COSTS-MVBLE EQUIP - WJ	0	0		2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-94,532	2,262,191		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,343,358	10,701,094		5.00
7.00	00700	OPERATION OF PLANT	91,397	1,669,206		7.00
7.01	00701	OPERATION OF PLANT - MOB	0	56,043		7.01
7.02	00702	OPERATION OF PLANT - POB	-19,028	7,606		7.02
7.03	00703	OPERATION OF PLANT - WJ	-17,157	0		7.03
8.00	00800	LAUNDRY & LINEN SERVICE	0	65,433		8.00
9.00	00900	HOUSEKEEPING	0	374,240		9.00
10.00	01000	DIETARY	0	192,084		10.00
11.00	01100	CAFETERIA	-130,919	225,381		11.00
13.00	01300	NURSING ADMINISTRATION	463,261	1,707,937		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-785	492,436		14.00
15.00	01500	PHARMACY	248,217	811,050		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0		16.00
17.00	01700	SOCIAL SERVICE	0	0		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-412,002	1,428,850		30.00
40.00	04000	SUBPROVIDER - IPF	-97,160	803,729		40.00
43.00	04300	NURSERY	0	59,092		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-1,207,122	1,248,567		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	20,744		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	139,462	1,037,684		54.00
60.00	06000	LABORATORY	0	1,585,758		60.00
65.00	06500	RESPIRATORY THERAPY	26,083	386,463		65.00
66.00	06600	PHYSICAL THERAPY	30,623	443,687		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	74,718		67.00
68.00	06800	SPEECH PATHOLOGY	0	14,944		68.00
69.00	06900	ELECTROCARDIOLOGY	0	65,695		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	238,297		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	38,540		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,363,712		73.00
76.00	03160	CARDIOPULMONARY	-168,025	99,301		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	-251,150	552,527		90.01
90.02	09002	JAY FAMILY MEDICINE	-472,748	723,998		90.02
90.03	09003	WOUND CLINIC	0	55,928		90.03
90.04	09004	OP ORTHO CLINIC	-115,246	0		90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	-348,239	347,485		90.05
90.06	09006	INFUSION CLINIC	0	57,503		90.06
91.00	09100	EMERGENCY	-1,212,743	1,106,188		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
93.00	04950	OUTPATIENT PSYCH	0	48,488		93.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,720,323	32,409,702		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	20,727		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.00
194.02	07952	WEST JAY CLINIC	0	607,776		194.02
194.03	07953	JAY MERIDIAN URGENT CARE	0	311,001		194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	1,720,323	33,349,206		200.00

RECLASSIFICATIONS | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/24/2019 10:13 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA					
1.00	CAFETERIA	11.00	209,697	146,603		1.00
	0		209,697	146,603		
	B - DRUGS RECLASS					
1.00	PHARMACY	15.00	0	29,665		1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,363,712		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
	0		0	1,393,377		
	C - SUPPLIES/IMPLANTS					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	468,697		1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	238,297		2.00
3.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	38,540		3.00
4.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	28		4.00
5.00	JAY MERIDIAN URGENT CARE	194.03	0	20		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
	0		0	745,582		
	D - LAUNDRY					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	36,727		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
	0		0	36,727		
	E - DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	960,104		1.00
2.00	CAP REL COSTS-BLDG & FIXT-MOB	1.01	0	62,689		2.00
3.00	CAP REL COSTS-BLDG & FIXT-POB	1.02	0	29,192		3.00
4.00	CAP REL COSTS-BLDG & FIXT-WJ	1.03	0	20,127		4.00
5.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,674,950		5.00
6.00	CAP REL COSTS-MVBLE EQUIP - MOB	2.01	0	5,278		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00

RECLASSIFICATIONS | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/24/2019 10:13 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
	0		0	2,752,340	
	F - PROPERTY TAXES				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,702	1.00
2.00		0.00	0	0	2.00
	0		0	2,702	
	G - PROPERTY INSURANCE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	21,518	1.00
	0		0	21,518	
	H - HOUSEKEEPING SUPPLIES				
1.00	HOUSEKEEPING	9.00	0	4,362	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
	0		0	4,362	
	I - MAINTENANCE SALARIES				
1.00	OPERATION OF PLANT - MOB	7.01	2,327	0	1.00
2.00	OPERATION OF PLANT - POB	7.02	4,837	0	2.00
3.00	OPERATION OF PLANT - WJ	7.03	475	0	3.00
	0		7,639	0	
	J - EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,170,609	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
	0		0	2,170,609	
	K - NURSERY AND LABOR AND DELIVERY				
1.00	NURSERY	43.00	54,609	4,483	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	19,170	1,574	2.00
	TOTALS		73,779	6,057	
	L - PSYCH				
1.00	OUTPATIENT PSYCH	93.00	12,752	2,709	1.00
	TOTALS		12,752	2,709	
500.00	Grand Total: Increases		303,867	7,282,586	500.00

RECLASSIFICATIONS | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/24/2019 10:13 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA						
1.00	DIETARY	10.00	209,697	146,603	0		1.00
	0		209,697	146,603			
	B - DRUGS RECLASS						
1.00	PHARMACY	15.00	0	1,032,531	0		1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	19,927	0		2.00
3.00	HOUSEKEEPING	9.00	0	4	0		3.00
4.00	DIETARY	10.00	0	534	0		4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	152	0		5.00
6.00	ADULTS & PEDIATRICS	30.00	0	10,646	0		6.00
7.00	SUBPROVIDER - IPF	40.00	0	11	0		7.00
8.00	OPERATING ROOM	50.00	0	17,027	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	29,719	0		9.00
10.00	RESPIRATORY THERAPY	65.00	0	154	0		10.00
11.00	CARDIOPULMONARY	76.00	0	2,052	0		11.00
12.00	FAMILY PRACTICE OF JAY COUNTY	90.01	0	133,146	0		12.00
13.00	JAY FAMILY MEDICINE	90.02	0	75,228	0		13.00
14.00	WOUND CLINIC	90.03	0	283	0		14.00
15.00	OP ORTHO CLINIC	90.04	0	55	0		15.00
16.00	JAY FAMILY FIRST HEALTH CARE	90.05	0	63,863	0		16.00
17.00	INFUSION CLINIC	90.06	0	453	0		17.00
18.00	EMERGENCY	91.00	0	7,592	0		18.00
	0		0	1,393,377			
	C - SUPPLIES/IMPLANTS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	14	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	37	0		2.00
3.00	OPERATION OF PLANT	7.00	0	26,435	0		3.00
4.00	HOUSEKEEPING	9.00	0	5,234	0		4.00
5.00	DIETARY	10.00	0	1,454	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	285	0		6.00
7.00	PHARMACY	15.00	0	3,693	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	103,220	0		8.00
9.00	SUBPROVIDER - IPF	40.00	0	4,159	0		9.00
10.00	OPERATING ROOM	50.00	0	396,959	0		10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	73,834	0		11.00
12.00	LABORATORY	60.00	0	370	0		12.00
13.00	RESPIRATORY THERAPY	65.00	0	13,864	0		13.00
14.00	PHYSICAL THERAPY	66.00	0	2,706	0		14.00
15.00	OCCUPATIONAL THERAPY	67.00	0	459	0		15.00
16.00	CARDIOPULMONARY	76.00	0	2,533	0		16.00
17.00	FAMILY PRACTICE OF JAY COUNTY	90.01	0	21,681	0		17.00
18.00	JAY FAMILY MEDICINE	90.02	0	11,550	0		18.00
19.00	WOUND CLINIC	90.03	0	2,341	0		19.00
20.00	OP ORTHO CLINIC	90.04	0	48	0		20.00
21.00	JAY FAMILY FIRST HEALTH CARE	90.05	0	14,032	0		21.00
22.00	INFUSION CLINIC	90.06	0	989	0		22.00
23.00	EMERGENCY	91.00	0	58,753	0		23.00
24.00	OUTPATIENT PSYCH	93.00	0	1	0		24.00
25.00	WEST JAY CLINIC	194.02	0	931	0		25.00
	0		0	745,582			
	D - LAUNDRY						
1.00	HOUSEKEEPING	9.00	0	30,464	0		1.00
2.00	DIETARY	10.00	0	350	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	46	0		3.00
4.00	OPERATING ROOM	50.00	0	5,867	0		4.00
	0		0	36,727			
	E - DEPRECIATION						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	69,817	9		1.00
2.00	OPERATION OF PLANT	7.00	0	1,136,840	9		2.00
3.00	OPERATION OF PLANT - MOB	7.01	0	67,967	9		3.00
4.00	OPERATION OF PLANT - POB	7.02	0	29,192	9		4.00
5.00	OPERATION OF PLANT - WJ	7.03	0	12,267	9		5.00
6.00	HOUSEKEEPING	9.00	0	105	9		6.00
7.00	DIETARY	10.00	0	9,883	0		7.00
8.00	NURSING ADMINISTRATION	13.00	0	810	0		8.00
9.00	CENTRAL SERVICES & SUPPLY	14.00	0	900	0		9.00
10.00	PHARMACY	15.00	0	46,470	0		10.00
11.00	ADULTS & PEDIATRICS	30.00	0	202,526	0		11.00
12.00	SUBPROVIDER - IPF	40.00	0	12,534	0		12.00
13.00	OPERATING ROOM	50.00	0	278,147	0		13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	670,901	0		14.00
15.00	LABORATORY	60.00	0	66,238	0		15.00

RECLASSIFICATIONS | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/24/2019 10:13 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
16.00	RESPIRATORY THERAPY	65.00	0	36,855	0		16.00
17.00	PHYSICAL THERAPY	66.00	0	1,179	0		17.00
18.00	CARDIOPULMONARY	76.00	0	19,039	0		18.00
19.00	WOUND CLINIC	90.03	0	1,028	0		19.00
20.00	INFUSION CLINIC	90.06	0	297	0		20.00
21.00	EMERGENCY	91.00	0	75,008	0		21.00
22.00	OUTPATIENT PSYCH	93.00	0	6,477	0		22.00
23.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	7,860	0		23.00
	0		0	2,752,340			
	F - PROPERTY TAXES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	396	13		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,306	0		2.00
	0		0	2,702			
	G - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	21,518	12		1.00
	0		0	21,518			
	H - HOUSEKEEPING SUPPLIES						
1.00	OPERATION OF PLANT	7.00	0	26	0		1.00
2.00	DIETARY	10.00	0	1,937	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	537	0		3.00
4.00	SUBPROVIDER - IPF	40.00	0	171	0		4.00
5.00	OPERATING ROOM	50.00	0	285	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	301	0		6.00
7.00	RESPIRATORY THERAPY	65.00	0	137	0		7.00
8.00	PHYSICAL THERAPY	66.00	0	93	0		8.00
9.00	CARDIOPULMONARY	76.00	0	50	0		9.00
10.00	FAMILY PRACTICE OF JAY COUNTY	90.01	0	327	0		10.00
11.00	JAY FAMILY MEDICINE	90.02	0	203	0		11.00
12.00	JAY FAMILY FIRST HEALTH CARE	90.05	0	189	0		12.00
13.00	EMERGENCY	91.00	0	106	0		13.00
	0		0	4,362			
	I - MAINTENANCE SALARIES						
1.00	OPERATION OF PLANT	7.00	7,639	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	0		7,639	0			
	J - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	72,847	0		1.00
2.00	OPERATION OF PLANT	7.00	0	52,942	0		2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	1,155	0		3.00
4.00	HOUSEKEEPING	9.00	0	104,766	0		4.00
5.00	DIETARY	10.00	0	120,154	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	190,459	0		6.00
7.00	PHARMACY	15.00	0	64,253	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	290,680	0		8.00
9.00	SUBPROVIDER - IPF	40.00	0	141,008	0		9.00
10.00	OPERATING ROOM	50.00	0	268,308	0		10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	122,242	0		11.00
12.00	RESPIRATORY THERAPY	65.00	0	68,488	0		12.00
13.00	CARDIOPULMONARY	76.00	0	13,322	0		13.00
14.00	FAMILY PRACTICE OF JAY COUNTY	90.01	0	152,189	0		14.00
15.00	JAY FAMILY MEDICINE	90.02	0	188,205	0		15.00
16.00	WOUND CLINIC	90.03	0	2,091	0		16.00
17.00	JAY FAMILY FIRST HEALTH CARE	90.05	0	88,820	0		17.00
18.00	INFUSION CLINIC	90.06	0	2,136	0		18.00
19.00	EMERGENCY	91.00	0	132,447	0		19.00
20.00	OUTPATIENT PSYCH	93.00	0	3,762	0		20.00
21.00	WEST JAY CLINIC	194.02	0	62,640	0		21.00
22.00	JAY MERIDIAN URGENT CARE	194.03	0	27,695	0		22.00
	0		0	2,170,609			
	K - NURSERY AND LABOR AND DELIVERY						
1.00	ADULTS & PEDIATRICS	30.00	73,779	6,057	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		73,779	6,057			
	L - PSYCH						
1.00	SUBPROVIDER - IPF	40.00	12,752	2,709	0		1.00
	TOTALS		12,752	2,709			
500.00	Grand Total: Decreases		303,867	7,282,586			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet A-7 Part I | Date/Time Prepared: 5/24/2019 10:13 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	1,006,948	0	1,006,948	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	19,125,052	0	19,125,052	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	0	8,736,480	0	8,736,480	762,425	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	0	28,868,480	0	28,868,480	762,425	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	0	28,868,480	0	28,868,480	762,425	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,006,948	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	19,125,052	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	7,974,055	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	28,106,055	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	28,106,055	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet A-7 Part II | Date/Time Prepared: 5/24/2019 10:13 am

	Cost Center Description	SUMMARY OF CAPITAL					
		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 WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT-MOB	0	0	0	0	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT-POB	0	0	0	0	0	1.02
1.03	CAP REL COSTS-BLDG & FIXT-WJ	0	0	0	0	0	1.03
1.04	CAP REL COSTS-BLDG & FIXT-INTEREST	0	0	0	0	0	1.04
2.00	CAP REL COSTS-MVBLE EQUIP	341,765	0	0	0	0	2.00
2.01	CAP REL COSTS-MVBLE EQUIP - MOB	0	0	0	0	0	2.01
2.02	CAP REL COSTS-MVBLE EQUIP - POB	0	0	0	0	0	2.02
2.03	CAP REL COSTS-MVBLE EQUIP - WJ	0	0	0	0	0	2.03
3.00	Total (sum of lines 1-2)	341,765	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT-MOB	0	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT-POB	0	0	1.02
1.03	CAP REL COSTS-BLDG & FIXT-WJ	0	0	1.03
1.04	CAP REL COSTS-BLDG & FIXT-INTEREST	0	0	1.04
2.00	CAP REL COSTS-MVBLE EQUIP	0	341,765	2.00
2.01	CAP REL COSTS-MVBLE EQUIP - MOB	0	0	2.01
2.02	CAP REL COSTS-MVBLE EQUIP - POB	0	0	2.02
2.03	CAP REL COSTS-MVBLE EQUIP - WJ	0	0	2.03
3.00	Total (sum of lines 1-2)	0	341,765	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet A-7 Part III Date/Time Prepared: 5/24/2019 10:13 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	28,106,055	0	28,106,055	1.000000	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT-MOB	0	0	0	0.000000	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT-POB	0	0	0	0.000000	0	1.02
1.03	CAP REL COSTS-BLDG & FIXT-WJ	0	0	0	0.000000	0	1.03
1.04	CAP REL COSTS-BLDG & FIXT-INTEREST	0	0	0	0.000000	0	1.04
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
2.01	CAP REL COSTS-MVBLE EQUIP - MOB	0	0	0	0.000000	0	2.01
2.02	CAP REL COSTS-MVBLE EQUIP - POB	0	0	0	0.000000	0	2.02
2.03	CAP REL COSTS-MVBLE EQUIP - WJ	0	0	0	0.000000	0	2.03
3.00	Total (sum of lines 1-2)	28,106,055	0	28,106,055	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	692,754	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT-MOB	0	0	0	0	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT-POB	0	0	0	0	0	1.02
1.03	CAP REL COSTS-BLDG & FIXT-WJ	0	0	0	0	0	1.03
1.04	CAP REL COSTS-BLDG & FIXT-INTEREST	0	0	0	0	0	1.04
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,306,125	0	2.00
2.01	CAP REL COSTS-MVBLE EQUIP - MOB	0	0	0	20,004	0	2.01
2.02	CAP REL COSTS-MVBLE EQUIP - POB	0	0	0	0	0	2.02
2.03	CAP REL COSTS-MVBLE EQUIP - WJ	0	0	0	0	0	2.03
3.00	Total (sum of lines 1-2)	0	0	0	2,018,883	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	21,518	2,702	0	716,974	1.00
1.01	CAP REL COSTS-BLDG & FIXT-MOB	0	0	0	0	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT-POB	0	0	0	0	0	1.02
1.03	CAP REL COSTS-BLDG & FIXT-WJ	0	0	0	0	0	1.03
1.04	CAP REL COSTS-BLDG & FIXT-INTEREST	0	0	0	0	0	1.04
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	1,306,125	2.00
2.01	CAP REL COSTS-MVBLE EQUIP - MOB	0	0	0	0	20,004	2.01
2.02	CAP REL COSTS-MVBLE EQUIP - POB	0	0	0	0	0	2.02
2.03	CAP REL COSTS-MVBLE EQUIP - WJ	0	0	0	0	0	2.03
3.00	Total (sum of lines 1-2)	0	21,518	2,702	0	2,043,103	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/24/2019 10:13 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-45,864	CAP REL COSTS-BLDG & FIXT	1.00	9	1.00
1.01	Investment income - CAP REL COSTS-BLDG & FIXT-MOB (chapter 2)		0	CAP REL COSTS-BLDG & FIXT-MOB	1.01	0	1.01
1.02	Investment income - CAP REL COSTS-BLDG & FIXT-POB (chapter 2)		0	CAP REL COSTS-BLDG & FIXT-POB	1.02	0	1.02
1.03	Investment income - CAP REL COSTS-BLDG & FIXT-WJ (chapter 2)		0	CAP REL COSTS-BLDG & FIXT-WJ	1.03	0	1.03
1.04	Investment income - CAP REL COSTS-BLDG & FIXT-INTEREST (chapter 2)		0	CAP REL COSTS-BLDG & FIXT-INTEREST	1.04	0	1.04
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
2.01	Investment income - CAP REL COSTS-MVBLE EQUIP - MOB (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP - MOB	2.01	0	2.01
2.02	Investment income - CAP REL COSTS-MVBLE EQUIP - POB (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP - POB	2.02	0	2.02
2.03	Investment income - CAP REL COSTS-MVBLE EQUIP - WJ (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP - WJ	2.03	0	2.03
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-3,262,235			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	12,538,853			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-130,919	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/24/2019 10:13 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - CAP REL COSTS-BLDG & FIXT-MOB		0	CAP REL COSTS-BLDG & FIXT-MOB	1.01	0	26.01
26.02	Depreciation - CAP REL COSTS-BLDG & FIXT-POB		0	CAP REL COSTS-BLDG & FIXT-POB	1.02	0	26.02
26.03	Depreciation - CAP REL COSTS-BLDG & FIXT-WJ		0	CAP REL COSTS-BLDG & FIXT-WJ	1.03	0	26.03
26.04	Depreciation - CAP REL COSTS-BLDG & FIXT-INTEREST		0	CAP REL COSTS-BLDG & FIXT-INTEREST	1.04	0	26.04
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
27.01	Depreciation - CAP REL COSTS-MVBLE EQUIP - MOB		0	CAP REL COSTS-MVBLE EQUIP - MOB	2.01	0	27.01
27.02	Depreciation - CAP REL COSTS-MVBLE EQUIP - POB		0	CAP REL COSTS-MVBLE EQUIP - POB	2.02	0	27.02
27.03	Depreciation - CAP REL COSTS-MVBLE EQUIP - WJ		0	CAP REL COSTS-MVBLE EQUIP - WJ	2.03	0	27.03
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 therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	EMPLOYEE BENEFITS	A	-2,169,810	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
33.01	HOSPITAL ASSESSMENT FEES	B	-1,284,834	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	MISCELLANEOUS INCOME	B	-37,956	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	MISCELLANEOUS INCOME	B	-25,909	OPERATION OF PLANT	7.00	9	33.03
33.04	MISCELLANEOUS INCOME	B	-17,157	OPERATION OF PLANT - WJ	7.03	9	33.04
33.05	MISCELLANEOUS INCOME	B	-295	NURSING ADMINISTRATION	13.00	9	33.05
33.06	MISCELLANEOUS INCOME	B	-785	CENTRAL SERVICES & SUPPLY	14.00	0	33.06
33.07	MISCELLANEOUS INCOME	B	-20,413	PHARMACY	15.00	0	33.07
33.08	MISCELLANEOUS INCOME	B	-11,001	EMERGENCY	91.00	0	33.08
33.09	ACCRUED PTO EXPENSE	A	-170,330	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.09
33.10	MARKETING EXPENSES	A	-15,793	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	MARKETING EXPENSES	A	-575	OPERATING ROOM	50.00	0	33.11
33.12	LATE FEES	A	-65	RADIOLOGY-DIAGNOSTIC	54.00	0	33.12
33.13	MARKETING EXPENSES	A	-1,186	RESPIRATORY THERAPY	65.00	0	33.13
33.14	MARKETING EXPENSES	A	-575	FAMILY PRACTICE OF JAY COUNTY	90.01	0	33.14
33.15	MARKETING EXPENSES	A	-599	JAY FAMILY MEDICINE	90.02	0	33.15
33.16	MARKETING EXPENSES	A	-1,150	JAY FAMILY FIRST HEALTH CARE	90.05	0	33.16
33.17	CONTRACTED HOSPITALIST	A	-412,002	ADULTS & PEDIATRICS	30.00	0	33.17
33.18	CONTRACTED CRNA	A	-611,478	OPERATING ROOM	50.00	0	33.18
33.19	START UP COSTS - HOME OFFICE	A	-1,953,005	ADMINISTRATIVE & GENERAL	5.00	0	33.19
33.20	AMORTIZED START UP COST	A	489,023	ADMINISTRATIVE & GENERAL	5.00	0	33.20
33.21	RECRUITING EXPENSES	A	-208	ADMINISTRATIVE & GENERAL	5.00	0	33.21
33.22	MEDICARE DEPRECIATION EXPENSE	A	-255,524	CAP REL COSTS-BLDG & FIXT	1.00	9	33.22
33.23	MEDICARE DEPRECIATION EXPENSE	A	-62,689	CAP REL COSTS-BLDG & FIXT-MOB	1.01	9	33.23
33.24	MEDICARE DEPRECIATION EXPENSE	A	-29,192	CAP REL COSTS-BLDG & FIXT-POB	1.02	9	33.24
33.25	MEDICARE DEPRECIATION EXPENSE	A	-20,127	CAP REL COSTS-BLDG & FIXT-WJ	1.03	9	33.25
33.26	MISCELLANEOUS INCOME	B	-19,028	OPERATION OF PLANT - POB	7.02	0	33.26
33.27	MEDICARE DEPRECIATION EXPENSE	A	-761,575	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.27
33.28	MEDICARE DEPRECIATION EXPENSE	A	14,726	CAP REL COSTS-MVBLE EQUIP - MOB	2.01	9	33.28

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/24/2019 10:13 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		1,720,323				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet A-8-1 | Date/Time Prepared: 5/24/2019 10:13 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	34,038	0	1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	2,245,608	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	8,021,844	1,470,441	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	1,953,005	0	3.01
3.02	5.00	ADMINISTRATIVE & GENERAL	RELATED PARTY	825,906	184,183	3.02
3.03	7.00	OPERATION OF PLANT	RELATED PARTY	117,306	0	3.03
3.04	13.00	NURSING ADMINISTRATION	RELATED PARTY	463,556	0	3.04
3.05	15.00	PHARMACY	RELATED PARTY	268,630	0	3.05
3.06	50.00	OPERATING ROOM	RELATED PARTY	14,855	0	3.06
3.07	54.00	RADIOLOGY-DIAGNOSTIC	RELATED PARTY	139,852	0	3.07
3.08	65.00	RESPIRATORY THERAPY	RELATED PARTY	27,269	0	3.08
3.09	66.00	PHYSICAL THERAPY	RELATED PARTY	30,623	0	3.09
3.10	30.00	ADULTS & PEDIATRICS	RELATED PARTY	412,002	412,002	3.10
3.11	40.00	SUBPROVIDER - IPF	RELATED PARTY	97,160	97,160	3.11
3.12	50.00	OPERATING ROOM	RELATED PARTY	495,243	495,243	3.12
3.13	60.00	LABORATORY	RELATED PARTY	1,536,932	1,536,932	3.13
3.14	66.00	PHYSICAL THERAPY	RELATED PARTY	408,458	408,458	3.14
3.15	67.00	OCCUPATIONAL THERAPY	RELATED PARTY	74,718	74,718	3.15
3.16	68.00	SPEECH PATHOLOGY	RELATED PARTY	14,944	14,944	3.16
3.17	69.00	ELECTROCARDIOLOGY	RELATED PARTY	66,385	66,385	3.17
3.18	76.00	CARDIOPULMONARY	RELATED PARTY	168,025	168,025	3.18
3.19	90.01	FAMILY PRACTICE OF JAY COUNT	RELATED PARTY	250,575	250,575	3.19
3.20	90.02	JAY FAMILY MEDICINE	RELATED PARTY	472,149	472,149	3.20
3.21	90.05	JAY FAMILY FIRST HEALTH CARE	RELATED PARTY	347,089	347,089	3.21
3.22	91.00	EMERGENCY	RELATED PARTY	1,459,475	1,459,475	3.22
3.23	194.02	WEST JAY CLINIC	RELATED PARTY	342,389	342,389	3.23
3.24	194.03	JAY MERIDIAN URGENT CARE	RELATED PARTY	152,039	152,039	3.24
3.25	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	50,985	0	3.25
3.26	7.00	OPERATION OF PLANT	RELATED PARTY	61,862	61,862	3.26
3.27	15.00	PHARMACY	RELATED PARTY	95,357	95,357	3.27
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			20,648,279	8,109,426	5.00

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

				Related Organization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

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

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

6.00	B		0.00	IU HEALTH BALL	100.00	6.00
7.00	B		0.00	IU HEALTH	100.00	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 non-financial) specify:					100.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-1320	Period: From 03/01/2018 To 12/31/2018	Worksheet A-8-1 Date/Time Prepared: 5/24/2019 10:13 am

				Related Organization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	

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

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
B. Corporation, partnership, or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet A-8-1 | Date/Time Prepared: 5/24/2019 10:13 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	34,038	9		1.00
2.00	2,245,608	0		2.00
3.00	6,551,403	0		3.00
3.01	1,953,005	0		3.01
3.02	641,723	0		3.02
3.03	117,306	0		3.03
3.04	463,556	0		3.04
3.05	268,630	0		3.05
3.06	14,855	0		3.06
3.07	139,852	0		3.07
3.08	27,269	0		3.08
3.09	30,623	0		3.09
3.10	0	0		3.10
3.11	0	0		3.11
3.12	0	0		3.12
3.13	0	0		3.13
3.14	0	0		3.14
3.15	0	0		3.15
3.16	0	0		3.16
3.17	0	9		3.17
3.18	0	0		3.18
3.19	0	0		3.19
3.20	0	0		3.20
3.21	0	0		3.21
3.22	0	0		3.22
3.23	0	0		3.23
3.24	0	0		3.24
3.25	50,985	9		3.25
3.26	0	0		3.26
3.27	0	0		3.27
4.00	0	0		4.00
5.00	12,538,853			5.00

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

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:		

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

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

6.00	HOSPITAL		6.00
7.00	HOME OFFICE		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
B. Corporation, partnership, or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet A-8-2 | Date/Time Prepared: 5/24/2019 10:13 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	40.00	SUBPROVIDER - IPF	97,160	97,160	0	0	0	1.00
2.00	50.00	OPERATING ROOM	609,924	609,924	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	325	325	0	0	0	3.00
4.00	76.00	CARDIOPULMONARY	168,025	168,025	0	0	0	4.00
5.00	90.01	FAMILY PRACTICE OF JAY COUNTY	250,575	250,575	0	0	0	5.00
6.00	90.02	JAY FAMILY MEDICINE	472,149	472,149	0	0	0	6.00
7.00	90.04	OP ORTHO CLINIC	115,246	115,246	0	0	0	7.00
8.00	90.05	JAY FAMILY FIRST HEALTH CARE	347,089	347,089	0	0	0	8.00
9.00	91.00	EMERGENCY	1,457,894	1,201,742	256,152	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			3,518,387	3,262,235	256,152		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	3.00
4.00	76.00	CARDIOPULMONARY	0	0	0	0	0	4.00
5.00	90.01	FAMILY PRACTICE OF JAY COUNTY	0	0	0	0	0	5.00
6.00	90.02	JAY FAMILY MEDICINE	0	0	0	0	0	6.00
7.00	90.04	OP ORTHO CLINIC	0	0	0	0	0	7.00
8.00	90.05	JAY FAMILY FIRST HEALTH CARE	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	40.00	SUBPROVIDER - IPF	0	0	0	97,160		1.00
2.00	50.00	OPERATING ROOM	0	0	0	609,924		2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	325		3.00
4.00	76.00	CARDIOPULMONARY	0	0	0	168,025		4.00
5.00	90.01	FAMILY PRACTICE OF JAY COUNTY	0	0	0	250,575		5.00
6.00	90.02	JAY FAMILY MEDICINE	0	0	0	472,149		6.00
7.00	90.04	OP ORTHO CLINIC	0	0	0	115,246		7.00
8.00	90.05	JAY FAMILY FIRST HEALTH CARE	0	0	0	347,089		8.00
9.00	91.00	EMERGENCY	0	0	0	1,201,742		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	3,262,235		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet B Part I Date/Time Prepared: 5/24/2019 10:13 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	BLDG & FIXT-MOB	BLDG & FIXT-POB	BLDG & FIXT-WJ	
			0	1.00	1.01	1.02	1.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	716,974	716,974				1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MOB	0	0	0			1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT-POB	0	0	0	0		1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT-WJ	0	0	0	0	0	1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT-INTEREST	0	0	0	0	0	1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,306,125					2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB	20,004					2.01
2.02	00202	CAP REL COSTS-MVBLE EQUIP - POB	0					2.02
2.03	00203	CAP REL COSTS-MVBLE EQUIP - WJ	0					2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,262,191	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,701,094	75,624	0	0	0	5.00
7.00	00700	OPERATION OF PLANT	1,669,206	43,937	0	0	0	7.00
7.01	00701	OPERATION OF PLANT - MOB	56,043	461	0	0	0	7.01
7.02	00702	OPERATION OF PLANT - POB	7,606	950	0	0	0	7.02
7.03	00703	OPERATION OF PLANT - WJ	0	92	0	0	0	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	65,433	4,105	0	0	0	8.00
9.00	00900	HOUSEKEEPING	374,240	4,585	0	0	0	9.00
10.00	01000	DIETARY	192,084	13,367	0	0	0	10.00
11.00	01100	CAFETERIA	225,381	24,805	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,707,937	15,378	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	492,436	11,605	0	0	0	14.00
15.00	01500	PHARMACY	811,050	9,465	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	13,099	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,428,850	114,460	0	0	0	30.00
40.00	04000	SUBPROVIDER - IPF	803,729	41,659	0	0	0	40.00
43.00	04300	NURSERY	59,092	4,575	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,248,567	49,906	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	20,744	1,605	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,037,684	57,830	0	0	0	54.00
60.00	06000	LABORATORY	1,585,758	23,588	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	386,463	5,147	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	443,687	1,005	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	74,718	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	14,944	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	65,695	18,468	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	238,297	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	38,540	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,363,712	0	0	0	0	73.00
76.00	03160	CARDIOPULMONARY	99,301	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	552,527	0	0	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	723,998	79,702	0	0	0	90.02
90.03	09003	WOUND CLINIC	55,928	0	0	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0	0	0	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	347,485	35,681	0	0	0	90.05
90.06	09006	INFUSION CLINIC	57,503	0	0	0	0	90.06
91.00	09100	EMERGENCY	1,106,188	41,899	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	48,488	720	0	0	0	93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	32,409,702	693,718	0	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,358	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	20,727	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.02	07952	WEST JAY CLINIC	607,776	0	0	0	0	194.02
194.03	07953	JAY MERIDIAN URGENT CARE	311,001	14,898	0	0	0	194.03
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)	33,349,206	716,974	0	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet B Part I Date/Time Prepared: 5/24/2019 10:13 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT-INTEREST	MVBLE EQUIP	MVBLE EQUIP - MOB	MVBLE EQUIP - POB	MVBLE EQUIP - WJ	
			1.04	2.00	2.01	2.02	2.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MOB						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT-POB						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT-WJ						1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT-INTEREST	0					1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,306,125				2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB		0	20,004			2.01
2.02	00202	CAP REL COSTS-MVBLE EQUIP - POB		0	0	0		2.02
2.03	00203	CAP REL COSTS-MVBLE EQUIP - WJ		0	0	0	0	2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	137,766	3,514	0	0	5.00
7.00	00700	OPERATION OF PLANT	0	80,042	2,937	0	0	7.00
7.01	00701	OPERATION OF PLANT - MOB	0	840	0	0	0	7.01
7.02	00702	OPERATION OF PLANT - POB	0	1,731	0	0	0	7.02
7.03	00703	OPERATION OF PLANT - WJ	0	168	0	0	0	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	0	7,478	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	8,352	0	0	0	9.00
10.00	01000	DIETARY	0	24,350	0	0	0	10.00
11.00	01100	CAFETERIA	0	45,188	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	28,014	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	21,141	0	0	0	14.00
15.00	01500	PHARMACY	0	17,242	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	23,863	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	208,515	0	0	0	30.00
40.00	04000	SUBPROVIDER - IPF	0	75,891	0	0	0	40.00
43.00	04300	NURSERY	0	8,335	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	90,914	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,924	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	105,350	0	0	0	54.00
60.00	06000	LABORATORY	0	42,970	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	9,377	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,832	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	33,643	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	0	13,553	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0	145,194	0	0	0	90.02
90.03	09003	WOUND CLINIC	0	0	0	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0	0	0	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0	65,001	0	0	0	90.05
90.06	09006	INFUSION CLINIC	0	0	0	0	0	90.06
91.00	09100	EMERGENCY	0	76,328	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	0	1,311	0	0	0	93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,263,760	20,004	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	15,225	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.02	07952	WEST JAY CLINIC	0	0	0	0	0	194.02
194.03	07953	JAY MERIDIAN URGENT CARE	0	27,140	0	0	0	194.03
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)	0	1,306,125	20,004	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet B Part I Date/Time Prepared: 5/24/2019 10:13 am

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT - MOB	
			4.00	4A	5.00	7.00	7.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MOB						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT-POB						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT-WJ						1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT-INTEREST						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB						2.01
2.02	00202	CAP REL COSTS-MVBLE EQUIP - POB						2.02
2.03	00203	CAP REL COSTS-MVBLE EQUIP - WJ						2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,262,191					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	365,924	11,283,922	11,283,922			5.00
7.00	00700	OPERATION OF PLANT	42,337	1,838,459	940,166	2,778,625		7.00
7.01	00701	OPERATION OF PLANT - MOB	441	57,785	29,551	2,145	89,481	7.01
7.02	00702	OPERATION OF PLANT - POB	916	11,203	5,729	4,419	0	7.02
7.03	00703	OPERATION OF PLANT - WJ	90	350	179	429	0	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	5,014	82,030	41,949	19,093	0	8.00
9.00	00900	HOUSEKEEPING	56,274	443,451	226,776	21,324	0	9.00
10.00	01000	DIETARY	21,406	251,207	128,464	62,170	0	10.00
11.00	01100	CAFETERIA	39,707	335,081	171,356	115,372	0	11.00
13.00	01300	NURSING ADMINISTRATION	217,823	1,969,152	1,007,001	71,523	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	525,182	268,572	53,975	0	14.00
15.00	01500	PHARMACY	73,125	910,882	465,814	44,021	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	36,962	18,902	60,925	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	248,218	2,000,043	1,022,797	532,365	0	30.00
40.00	04000	SUBPROVIDER - IPF	140,700	1,061,979	543,083	193,760	0	40.00
43.00	04300	NURSERY	10,340	82,342	42,109	21,281	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	213,809	1,603,196	819,855	232,117	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,630	28,903	14,781	7,466	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	119,581	1,320,445	675,260	268,973	0	54.00
60.00	06000	LABORATORY	0	1,652,316	844,975	109,709	0	60.00
65.00	06500	RESPIRATORY THERAPY	59,650	460,637	235,564	23,941	0	65.00
66.00	06600	PHYSICAL THERAPY	77,343	523,867	267,899	4,677	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	14,148	88,866	45,445	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,830	17,774	9,089	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	117,806	60,245	85,896	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	238,297	121,862	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	38,540	19,709	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,363,712	697,386	0	0	73.00
76.00	03160	CARDIOPULMONARY	17,031	116,332	59,491	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	96,024	662,104	338,592	0	89,481	90.01
90.02	09002	JAY FAMILY MEDICINE	126,044	1,074,938	549,710	370,701	0	90.02
90.03	09003	WOUND CLINIC	9,630	65,558	33,526	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0	0	0	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	60,317	508,484	260,033	165,957	0	90.05
90.06	09006	INFUSION CLINIC	10,051	67,554	34,546	0	0	90.06
91.00	09100	EMERGENCY	149,365	1,373,780	702,535	194,875	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0				92.00
93.00	04950	OUTPATIENT PSYCH	8,132	58,651	29,993	3,347	0	93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,189,900	32,271,790	10,732,944	2,670,461	89,481	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	23,583	12,060	38,872	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	20,727	10,600	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.02	07952	WEST JAY CLINIC	44,599	652,375	333,617	0	0	194.02
194.03	07953	JAY MERIDIAN URGENT CARE	27,692	380,731	194,701	69,292	0	194.03
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)	2,262,191	33,349,206	11,283,922	2,778,625	89,481	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/24/2019 10:13 am

		Cost Center Description	OPERATION OF PLANT - POB	OPERATION OF PLANT - WJ	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			7.02	7.03	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MOB						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT-POB						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT-WJ						1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT-INTEREST						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB						2.01
2.02	00202	CAP REL COSTS-MVBLE EQUIP - POB						2.02
2.03	00203	CAP REL COSTS-MVBLE EQUIP - WJ						2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT - MOB						7.01
7.02	00702	OPERATION OF PLANT - POB	21,351					7.02
7.03	00703	OPERATION OF PLANT - WJ	0	958				7.03
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	143,072			8.00
9.00	00900	HOUSEKEEPING	0	0	17,325	708,876		9.00
10.00	01000	DIETARY	0	0	4,471	16,136	462,448	10.00
11.00	01100	CAFETERIA	0	0	0	29,944	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	18,563	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	14,009	0	14.00
15.00	01500	PHARMACY	0	0	0	11,425	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	15,813	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	65,590	138,174	316,769	30.00
40.00	04000	SUBPROVIDER - IPF	0	0	3,540	50,290	145,679	40.00
43.00	04300	NURSERY	0	0	2,593	5,523	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	21,351	0	14,903	60,245	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,938	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	11,364	69,811	0	54.00
60.00	06000	LABORATORY	0	0	0	28,474	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	6,214	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	931	1,214	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	2,981	22,294	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	0	0	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	0	96,214	0	90.02
90.03	09003	WOUND CLINIC	0	0	0	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0	0	0	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0	0	0	43,074	0	90.05
90.06	09006	INFUSION CLINIC	0	0	0	0	0	90.06
91.00	09100	EMERGENCY	0	0	19,374	50,579	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	0	0	0	869	0	93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	21,351	0	143,072	680,803	462,448	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	10,089	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.02	07952	WEST JAY CLINIC	0	958	0	0	0	194.02
194.03	07953	JAY MERIDIAN URGENT CARE	0	0	0	17,984	0	194.03
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)	21,351	958	143,072	708,876	462,448	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/24/2019 10:13 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MOB						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT-POB						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT-WJ						1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT-INTEREST						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB						2.01
2.02	00202	CAP REL COSTS-MVBLE EQUIP - POB						2.02
2.03	00203	CAP REL COSTS-MVBLE EQUIP - WJ						2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT - MOB						7.01
7.02	00702	OPERATION OF PLANT - POB						7.02
7.03	00703	OPERATION OF PLANT - WJ						7.03
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	651,753					11.00
13.00	01300	NURSING ADMINISTRATION	51,301	3,117,540				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	861,738			14.00
15.00	01500	PHARMACY	19,436	0	3,667	1,455,245		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	132,602	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	84,512	664,757	97,375	10,776	10,507	30.00
40.00	04000	SUBPROVIDER - IPF	49,124	363,659	5,177	0	3,449	40.00
43.00	04300	NURSERY	2,969	23,410	0	0	311	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	76,358	446,401	236,913	7,555	30,371	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,069	8,476	0	0	1,688	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	34,913	0	34,761	4,898	17,004	54.00
60.00	06000	LABORATORY	41,959	0	441	0	12,667	60.00
65.00	06500	RESPIRATORY THERAPY	19,515	0	16,635	0	1,386	65.00
66.00	06600	PHYSICAL THERAPY	21,098	0	3,270	0	1,955	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,988	0	513	0	425	67.00
68.00	06800	SPEECH PATHOLOGY	871	0	0	0	39	68.00
69.00	06900	ELECTROCARDIOLOGY	0	66,193	0	0	1,017	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	284,175	0	1,570	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	45,960	0	529	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,424,105	16,247	73.00
76.00	03160	CARDIOPULMONARY	5,898	1,614	3,053	0	2,710	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	59,178	394,738	26,358	0	2,022	90.01
90.02	09002	JAY FAMILY MEDICINE	71,924	519,052	13,793	0	1,775	90.02
90.03	09003	WOUND CLINIC	3,404	34,711	2,410	0	163	90.03
90.04	09004	OP ORTHO CLINIC	0	0	69	0	134	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	35,784	215,532	16,927	159	850	90.05
90.06	09006	INFUSION CLINIC	2,692	27,446	1,204	205	2,839	90.06
91.00	09100	EMERGENCY	45,047	351,551	67,922	7,547	22,708	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	4,354	0	5	0	236	93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	636,394	3,117,540	860,628	1,455,245	132,602	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.02	07952	WEST JAY CLINIC	0	0	1,110	0	0	194.02
194.03	07953	JAY MERIDIAN URGENT CARE	15,359	0	0	0	0	194.03
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)	651,753	3,117,540	861,738	1,455,245	132,602	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet B Part I Date/Time Prepared: 5/24/2019 10:13 am

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MOB						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT-POB						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT-WJ						1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT-INTEREST						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB						2.01
2.02	00202	CAP REL COSTS-MVBLE EQUIP - POB						2.02
2.03	00203	CAP REL COSTS-MVBLE EQUIP - WJ						2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT - MOB						7.01
7.02	00702	OPERATION OF PLANT - POB						7.02
7.03	00703	OPERATION OF PLANT - WJ						7.03
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	0					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	4,943,665	0	4,943,665		30.00
40.00	04000	SUBPROVIDER - IPF	0	2,419,740	0	2,419,740		40.00
43.00	04300	NURSERY	0	180,538	0	180,538		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,549,265	0	3,549,265		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	64,321	0	64,321		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,437,429	0	2,437,429		54.00
60.00	06000	LABORATORY	0	2,690,541	0	2,690,541		60.00
65.00	06500	RESPIRATORY THERAPY	0	763,892	0	763,892		65.00
66.00	06600	PHYSICAL THERAPY	0	824,911	0	824,911		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	140,237	0	140,237		67.00
68.00	06800	SPEECH PATHOLOGY	0	27,773	0	27,773		68.00
69.00	06900	ELECTROCARDIOLOGY	0	356,432	0	356,432		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	645,904	0	645,904		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	104,738	0	104,738		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,501,450	0	3,501,450		73.00
76.00	03160	CARDIOPULMONARY	0	189,098	0	189,098		76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0		90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	1,572,473	0	1,572,473		90.01
90.02	09002	JAY FAMILY MEDICINE	0	2,698,107	0	2,698,107		90.02
90.03	09003	WOUND CLINIC	0	139,772	0	139,772		90.03
90.04	09004	OP ORTHO CLINIC	0	203	0	203		90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0	1,246,800	0	1,246,800		90.05
90.06	09006	INFUSION CLINIC	0	136,486	0	136,486		90.06
91.00	09100	EMERGENCY	0	2,835,918	0	2,835,918		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
93.00	04950	OUTPATIENT PSYCH	0	97,455	0	97,455		93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	31,567,148	0	31,567,148		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	84,604	0	84,604		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	31,327	0	31,327		192.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194.00
194.02	07952	WEST JAY CLINIC	0	988,060	0	988,060		194.02
194.03	07953	JAY MERIDIAN URGENT CARE	0	678,067	0	678,067		194.03
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	33,349,206	0	33,349,206		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 5/24/2019 10:13 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	BLDG & FIXT-MOB	BLDG & FIXT-POB	BLDG & FIXT-WJ	
			0	1.00	1.01	1.02	1.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MOB						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT-POB						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT-WJ						1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT-INTEREST						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB						2.01
2.02	00202	CAP REL COSTS-MVBLE EQUIP - POB						2.02
2.03	00203	CAP REL COSTS-MVBLE EQUIP - WJ						2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	75,624	0	0	0	5.00
7.00	00700	OPERATION OF PLANT	0	43,937	0	0	0	7.00
7.01	00701	OPERATION OF PLANT - MOB	0	461	0	0	0	7.01
7.02	00702	OPERATION OF PLANT - POB	0	950	0	0	0	7.02
7.03	00703	OPERATION OF PLANT - WJ	0	92	0	0	0	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	0	4,105	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	4,585	0	0	0	9.00
10.00	01000	DIETARY	0	13,367	0	0	0	10.00
11.00	01100	CAFETERIA	0	24,805	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	15,378	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	11,605	0	0	0	14.00
15.00	01500	PHARMACY	0	9,465	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	13,099	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	114,460	0	0	0	30.00
40.00	04000	SUBPROVIDER - IPF	0	41,659	0	0	0	40.00
43.00	04300	NURSERY	0	4,575	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	49,906	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,605	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	57,830	0	0	0	54.00
60.00	06000	LABORATORY	0	23,588	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	5,147	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,005	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	18,468	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	0	0	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0	79,702	0	0	0	90.02
90.03	09003	WOUND CLINIC	0	0	0	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0	0	0	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0	35,681	0	0	0	90.05
90.06	09006	INFUSION CLINIC	0	0	0	0	0	90.06
91.00	09100	EMERGENCY	0	41,899	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	0	720	0	0	0	93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	693,718	0	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,358	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.02	07952	WEST JAY CLINIC	0	0	0	0	0	194.02
194.03	07953	JAY MERIDIAN URGENT CARE	0	14,898	0	0	0	194.03
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	716,974	0	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/24/2019 10:13 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT-INTEREST	MVBLE EQUIP	MVBLE EQUIP - MOB	MVBLE EQUIP - POB	MVBLE EQUIP - WJ	
			1.04	2.00	2.01	2.02	2.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MOB						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT-POB						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT-WJ						1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT-INTEREST						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB						2.01
2.02	00202	CAP REL COSTS-MVBLE EQUIP - POB						2.02
2.03	00203	CAP REL COSTS-MVBLE EQUIP - WJ						2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	137,766	3,514	0	0	5.00
7.00	00700	OPERATION OF PLANT	0	80,042	2,937	0	0	7.00
7.01	00701	OPERATION OF PLANT - MOB	0	840	0	0	0	7.01
7.02	00702	OPERATION OF PLANT - POB	0	1,731	0	0	0	7.02
7.03	00703	OPERATION OF PLANT - WJ	0	168	0	0	0	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	0	7,478	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	8,352	0	0	0	9.00
10.00	01000	DIETARY	0	24,350	0	0	0	10.00
11.00	01100	CAFETERIA	0	45,188	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	28,014	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	21,141	0	0	0	14.00
15.00	01500	PHARMACY	0	17,242	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	23,863	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	208,515	0	0	0	30.00
40.00	04000	SUBPROVIDER - IPF	0	75,891	0	0	0	40.00
43.00	04300	NURSERY	0	8,335	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	90,914	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,924	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	105,350	0	0	0	54.00
60.00	06000	LABORATORY	0	42,970	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	9,377	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,832	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	33,643	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	0	13,553	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0	145,194	0	0	0	90.02
90.03	09003	WOUND CLINIC	0	0	0	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0	0	0	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0	65,001	0	0	0	90.05
90.06	09006	INFUSION CLINIC	0	0	0	0	0	90.06
91.00	09100	EMERGENCY	0	76,328	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	0	1,311	0	0	0	93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,263,760	20,004	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	15,225	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.02	07952	WEST JAY CLINIC	0	0	0	0	0	194.02
194.03	07953	JAY MERIDIAN URGENT CARE	0	27,140	0	0	0	194.03
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)	0	1,306,125	20,004	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/24/2019 10:13 am

		Cost Center Description	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT - MOB	
			2A	4.00	5.00	7.00	7.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MOB						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT-POB						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT-WJ						1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT-INTEREST						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB						2.01
2.02	00202	CAP REL COSTS-MVBLE EQUIP - POB						2.02
2.03	00203	CAP REL COSTS-MVBLE EQUIP - WJ						2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	216,904	0	216,904			5.00
7.00	00700	OPERATION OF PLANT	126,916	0	18,072	144,988		7.00
7.01	00701	OPERATION OF PLANT - MOB	1,301	0	568	112	1,981	7.01
7.02	00702	OPERATION OF PLANT - POB	2,681	0	110	231	0	7.02
7.03	00703	OPERATION OF PLANT - WJ	260	0	3	22	0	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	11,583	0	806	996	0	8.00
9.00	00900	HOUSEKEEPING	12,937	0	4,359	1,113	0	9.00
10.00	01000	DIETARY	37,717	0	2,469	3,244	0	10.00
11.00	01100	CAFETERIA	69,993	0	3,294	6,020	0	11.00
13.00	01300	NURSING ADMINISTRATION	43,392	0	19,357	3,732	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	32,746	0	5,163	2,816	0	14.00
15.00	01500	PHARMACY	26,707	0	8,954	2,297	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	36,962	0	363	3,179	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	322,975	0	19,664	27,778	0	30.00
40.00	04000	SUBPROVIDER - IPF	117,550	0	10,439	10,110	0	40.00
43.00	04300	NURSERY	12,910	0	809	1,110	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	140,820	0	15,759	12,112	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,529	0	284	390	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	163,180	0	12,980	14,035	0	54.00
60.00	06000	LABORATORY	66,558	0	16,242	5,725	0	60.00
65.00	06500	RESPIRATORY THERAPY	14,524	0	4,528	1,249	0	65.00
66.00	06600	PHYSICAL THERAPY	2,837	0	5,150	244	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	874	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	175	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	52,111	0	1,158	4,482	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	2,342	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	379	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	13,405	0	0	73.00
76.00	03160	CARDIOPULMONARY	0	0	1,144	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	13,553	0	6,508	0	1,981	90.01
90.02	09002	JAY FAMILY MEDICINE	224,896	0	10,567	19,343	0	90.02
90.03	09003	WOUND CLINIC	0	0	644	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0	0	0	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	100,682	0	4,998	8,660	0	90.05
90.06	09006	INFUSION CLINIC	0	0	664	0	0	90.06
91.00	09100	EMERGENCY	118,227	0	13,504	10,169	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
93.00	04950	OUTPATIENT PSYCH	2,031	0	577	175	0	93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,977,482	0	206,312	139,344	1,981	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	23,583	0	232	2,028	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	204	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.02	07952	WEST JAY CLINIC	0	0	6,413	0	0	194.02
194.03	07953	JAY MERIDIAN URGENT CARE	42,038	0	3,743	3,616	0	194.03
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)	2,043,103	0	216,904	144,988	1,981	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/24/2019 10:13 am

		Cost Center Description	OPERATION OF PLANT - POB	OPERATION OF PLANT - WJ	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			7.02	7.03	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MOB						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT-POB						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT-WJ						1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT-INTEREST						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB						2.01
2.02	00202	CAP REL COSTS-MVBLE EQUIP - POB						2.02
2.03	00203	CAP REL COSTS-MVBLE EQUIP - WJ						2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT - MOB						7.01
7.02	00702	OPERATION OF PLANT - POB	3,022					7.02
7.03	00703	OPERATION OF PLANT - WJ	0	285				7.03
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	13,385			8.00
9.00	00900	HOUSEKEEPING	0	0	1,621	20,030		9.00
10.00	01000	DIETARY	0	0	418	456	44,304	10.00
11.00	01100	CAFETERIA	0	0	0	846	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	525	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	396	0	14.00
15.00	01500	PHARMACY	0	0	0	323	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	447	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	6,136	3,902	30,348	30.00
40.00	04000	SUBPROVIDER - IPF	0	0	331	1,421	13,956	40.00
43.00	04300	NURSERY	0	0	243	156	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,022	0	1,394	1,702	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	55	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	1,063	1,973	0	54.00
60.00	06000	LABORATORY	0	0	0	805	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	176	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	87	34	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	279	630	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	0	0	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	0	2,719	0	90.02
90.03	09003	WOUND CLINIC	0	0	0	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0	0	0	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0	0	0	1,217	0	90.05
90.06	09006	INFUSION CLINIC	0	0	0	0	0	90.06
91.00	09100	EMERGENCY	0	0	1,813	1,429	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	0	0	0	25	0	93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,022	0	13,385	19,237	44,304	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	285	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.02	07952	WEST JAY CLINIC	0	285	0	0	0	194.02
194.03	07953	JAY MERIDIAN URGENT CARE	0	0	0	508	0	194.03
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)	3,022	285	13,385	20,030	44,304	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/24/2019 10:13 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MOB						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT-POB						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT-WJ						1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT-INTEREST						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB						2.01
2.02	00202	CAP REL COSTS-MVBLE EQUIP - POB						2.02
2.03	00203	CAP REL COSTS-MVBLE EQUIP - WJ						2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT - MOB						7.01
7.02	00702	OPERATION OF PLANT - POB						7.02
7.03	00703	OPERATION OF PLANT - WJ						7.03
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	80,153					11.00
13.00	01300	NURSING ADMINISTRATION	6,309	73,315				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	41,121			14.00
15.00	01500	PHARMACY	2,390	0	175	40,846		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	40,951	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,394	15,633	4,647	302	3,247	30.00
40.00	04000	SUBPROVIDER - IPF	6,041	8,552	247	0	1,066	40.00
43.00	04300	NURSERY	365	551	0	0	96	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,391	10,498	11,305	212	9,362	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	131	199	0	0	522	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,294	0	1,659	137	5,255	54.00
60.00	06000	LABORATORY	5,160	0	21	0	3,914	60.00
65.00	06500	RESPIRATORY THERAPY	2,400	0	794	0	428	65.00
66.00	06600	PHYSICAL THERAPY	2,595	0	156	0	604	66.00
67.00	06700	OCCUPATIONAL THERAPY	613	0	24	0	131	67.00
68.00	06800	SPEECH PATHOLOGY	107	0	0	0	12	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,557	0	0	314	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	13,561	0	485	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	2,193	0	163	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	39,973	5,021	73.00
76.00	03160	CARDIOPULMONARY	725	38	146	0	837	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	7,278	9,283	1,258	0	625	90.01
90.02	09002	JAY FAMILY MEDICINE	8,845	12,207	658	0	548	90.02
90.03	09003	WOUND CLINIC	419	816	115	0	50	90.03
90.04	09004	OP ORTHO CLINIC	0	0	3	0	41	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	4,401	5,069	808	4	263	90.05
90.06	09006	INFUSION CLINIC	331	645	57	6	877	90.06
91.00	09100	EMERGENCY	5,540	8,267	3,241	212	7,017	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	535	0	0	0	73	93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	78,264	73,315	41,068	40,846	40,951	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.02	07952	WEST JAY CLINIC	0	0	53	0	0	194.02
194.03	07953	JAY MERIDIAN URGENT CARE	1,889	0	0	0	0	194.03
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)	80,153	73,315	41,121	40,846	40,951	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 5/24/2019 10:13 am

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MOB						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT-POB						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT-WJ						1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT-INTEREST						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB						2.01
2.02	00202	CAP REL COSTS-MVBLE EQUIP - POB						2.02
2.03	00203	CAP REL COSTS-MVBLE EQUIP - WJ						2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT - MOB						7.01
7.02	00702	OPERATION OF PLANT - POB						7.02
7.03	00703	OPERATION OF PLANT - WJ						7.03
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	0					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	445,026	0	445,026		30.00
40.00	04000	SUBPROVIDER - IPF	0	169,713	0	169,713		40.00
43.00	04300	NURSERY	0	16,240	0	16,240		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	215,577	0	215,577		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	6,110	0	6,110		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	204,576	0	204,576		54.00
60.00	06000	LABORATORY	0	98,425	0	98,425		60.00
65.00	06500	RESPIRATORY THERAPY	0	24,099	0	24,099		65.00
66.00	06600	PHYSICAL THERAPY	0	11,707	0	11,707		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,642	0	1,642		67.00
68.00	06800	SPEECH PATHOLOGY	0	294	0	294		68.00
69.00	06900	ELECTROCARDIOLOGY	0	60,531	0	60,531		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	16,388	0	16,388		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,735	0	2,735		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	58,399	0	58,399		73.00
76.00	03160	CARDIOPULMONARY	0	2,890	0	2,890		76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0		90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	40,486	0	40,486		90.01
90.02	09002	JAY FAMILY MEDICINE	0	279,783	0	279,783		90.02
90.03	09003	WOUND CLINIC	0	2,044	0	2,044		90.03
90.04	09004	OP ORTHO CLINIC	0	44	0	44		90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0	126,102	0	126,102		90.05
90.06	09006	INFUSION CLINIC	0	2,580	0	2,580		90.06
91.00	09100	EMERGENCY	0	169,419	0	169,419		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
93.00	04950	OUTPATIENT PSYCH	0	3,416	0	3,416		93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,958,226	0	1,958,226		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	26,128	0	26,128		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	204	0	204		192.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194.00
194.02	07952	WEST JAY CLINIC	0	6,751	0	6,751		194.02
194.03	07953	JAY MERIDIAN URGENT CARE	0	51,794	0	51,794		194.03
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,043,103	0	2,043,103		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/24/2019 10:13 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	BLDG & FIXT-MOB (SQUARE FEET-MOB)	BLDG & FIXT-POB (SQUARE FEET-POB)	BLDG & FIXT-WJ (SQUARE FEET-WJ)	BLDG & FIXT-INTEREST (SQUARE FEET)	
			1.00	1.01	1.02	1.03	1.04	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	77,723					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MOB	0	8,146				1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT-POB	0	0	10,501			1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT-WJ	0	0	0	3,300		1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT-INTEREST	0	0	0	0	77,723	1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB						2.01
2.02	00202	CAP REL COSTS-MVBLE EQUIP - POB						2.02
2.03	00203	CAP REL COSTS-MVBLE EQUIP - WJ						2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,198	1,431	873	0	8,198	5.00
7.00	00700	OPERATION OF PLANT	4,763	1,196	630	0	4,763	7.00
7.01	00701	OPERATION OF PLANT - MOB	50	0	0	0	50	7.01
7.02	00702	OPERATION OF PLANT - POB	103	0	0	0	103	7.02
7.03	00703	OPERATION OF PLANT - WJ	10	0	0	0	10	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	445	0	0	0	445	8.00
9.00	00900	HOUSEKEEPING	497	0	0	0	497	9.00
10.00	01000	DIETARY	1,449	0	0	0	1,449	10.00
11.00	01100	CAFETERIA	2,689	0	0	0	2,689	11.00
13.00	01300	NURSING ADMINISTRATION	1,667	0	0	0	1,667	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,258	0	0	0	1,258	14.00
15.00	01500	PHARMACY	1,026	0	0	0	1,026	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,420	0	0	0	1,420	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,408	0	0	0	12,408	30.00
40.00	04000	SUBPROVIDER - IPF	4,516	0	0	0	4,516	40.00
43.00	04300	NURSERY	496	0	0	0	496	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,410	0	8,998	0	5,410	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	174	0	0	0	174	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,269	0	0	0	6,269	54.00
60.00	06000	LABORATORY	2,557	0	0	0	2,557	60.00
65.00	06500	RESPIRATORY THERAPY	558	0	0	0	558	65.00
66.00	06600	PHYSICAL THERAPY	109	0	0	0	109	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,002	0	0	0	2,002	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	5,519	0	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	8,640	0	0	0	8,640	90.02
90.03	09003	WOUND CLINIC	0	0	0	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0	0	0	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	3,868	0	0	0	3,868	90.05
90.06	09006	INFUSION CLINIC	0	0	0	0	0	90.06
91.00	09100	EMERGENCY	4,542	0	0	0	4,542	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	78	0	0	0	78	93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	75,202	8,146	10,501	0	75,202	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	906	0	0	0	906	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.02	07952	WEST JAY CLINIC	0	0	0	3,300	0	194.02
194.03	07953	JAY MERIDIAN URGENT CARE	1,615	0	0	0	1,615	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	716,974	0	0	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.224734	0.000000	0.000000	0.000000	0.000000	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/24/2019 10:13 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	BLDG & FIXT-MOB (SQUARE FEET-MOB)	BLDG & FIXT-POB (SQUARE FEET-POB)	BLDG & FIXT-WJ (SQUARE FEET-WJ)	BLDG & FIXT-INTEREST (SQUARE FEET)	
			1.00	1.01	1.02	1.03	1.04	
204.00		Cost to be allocated (per Wkst. B, Part II)						204.00
205.00		Unit cost multiplier (Wkst. B, Part II)						205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/24/2019 10:13 am

		Cost Center Description	CAPITAL RELATED COSTS					
			MVBLE EQUIP (SQUARE FEET)	MVBLE EQUIP - MOB (SQUARE FEET-MOB)	MVBLE EQUIP - POB (SQUARE FEET-POB)	MVBLE EQUIP - WJ (SQUARE FEET-WJ)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
			2.00	2.01	2.02	2.03	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MOB						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT-POB						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT-WJ						1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT-INTEREST						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP	77,723					2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB	0	8,146				2.01
2.02	00202	CAP REL COSTS-MVBLE EQUIP - POB	0	0	10,501			2.02
2.03	00203	CAP REL COSTS-MVBLE EQUIP - WJ	0	0	0	3,300		2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	11,946,884	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,198	1,431	873	0	1,932,493	5.00
7.00	00700	OPERATION OF PLANT	4,763	1,196	630	0	223,588	7.00
7.01	00701	OPERATION OF PLANT - MOB	50	0	0	0	2,327	7.01
7.02	00702	OPERATION OF PLANT - POB	103	0	0	0	4,837	7.02
7.03	00703	OPERATION OF PLANT - WJ	10	0	0	0	475	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	445	0	0	0	26,477	8.00
9.00	00900	HOUSEKEEPING	497	0	0	0	297,191	9.00
10.00	01000	DIETARY	1,449	0	0	0	113,049	10.00
11.00	01100	CAFETERIA	2,689	0	0	0	209,697	11.00
13.00	01300	NURSING ADMINISTRATION	1,667	0	0	0	1,150,346	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,258	0	0	0	0	14.00
15.00	01500	PHARMACY	1,026	0	0	0	386,181	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,420	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,408	0	0	0	1,310,865	30.00
40.00	04000	SUBPROVIDER - IPF	4,516	0	0	0	743,051	40.00
43.00	04300	NURSERY	496	0	0	0	54,609	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,410	0	8,998	0	1,129,150	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	174	0	0	0	19,170	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,269	0	0	0	631,522	54.00
60.00	06000	LABORATORY	2,557	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	558	0	0	0	315,018	65.00
66.00	06600	PHYSICAL THERAPY	109	0	0	0	408,458	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	74,718	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	14,944	68.00
69.00	06900	ELECTROCARDIOLOGY	2,002	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03160	CARDIOPULMONARY	0	0	0	0	89,943	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	5,519	0	0	507,115	90.01
90.02	09002	JAY FAMILY MEDICINE	8,640	0	0	0	665,653	90.02
90.03	09003	WOUND CLINIC	0	0	0	0	50,855	90.03
90.04	09004	OP ORTHO CLINIC	0	0	0	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	3,868	0	0	0	318,543	90.05
90.06	09006	INFUSION CLINIC	0	0	0	0	53,079	90.06
91.00	09100	EMERGENCY	4,542	0	0	0	788,811	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	78	0	0	0	42,947	93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	75,202	8,146	10,501	0	11,565,112	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	906	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.02	07952	WEST JAY CLINIC	0	0	0	3,300	235,530	194.02
194.03	07953	JAY MERIDIAN URGENT CARE	1,615	0	0	0	146,242	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,306,125	20,004	0	0	2,262,191	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	16.804871	2.455684	0.000000	0.000000	0.189354	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/24/2019 10:13 am

		Cost Center Description	CAPITAL RELATED COSTS					
			MVBLE EQUIP (SQUARE FEET)	MVBLE EQUIP - MOB (SQUARE FEET-MOB)	MVBLE EQUIP - POB (SQUARE FEET-POB)	MVBLE EQUIP - WJ (SQUARE FEET-WJ)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
			2.00	2.01	2.02	2.03	4.00	
204.00		Cost to be allocated (per Wkst. B, Part II)					0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)					0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/24/2019 10:13 am

		Cost Center Description	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT - MOB (SQUARE FEET-MOB)	OPERATION OF PLANT - POB (SQUARE FEET-POB)	
			5A	5.00	7.00	7.01	7.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MOB						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT-POB						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT-WJ						1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT-INTEREST						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB						2.01
2.02	00202	CAP REL COSTS-MVBLE EQUIP - POB						2.02
2.03	00203	CAP REL COSTS-MVBLE EQUIP - WJ						2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-11,283,922	22,065,284				5.00
7.00	00700	OPERATION OF PLANT	0	1,838,459	64,762			7.00
7.01	00701	OPERATION OF PLANT - MOB	0	57,785	50	5,519		7.01
7.02	00702	OPERATION OF PLANT - POB	0	11,203	103	0	8,998	7.02
7.03	00703	OPERATION OF PLANT - WJ	0	350	10	0	0	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	0	82,030	445	0	0	8.00
9.00	00900	HOUSEKEEPING	0	443,451	497	0	0	9.00
10.00	01000	DIETARY	0	251,207	1,449	0	0	10.00
11.00	01100	CAFETERIA	0	335,081	2,689	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,969,152	1,667	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	525,182	1,258	0	0	14.00
15.00	01500	PHARMACY	0	910,882	1,026	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	36,962	1,420	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,000,043	12,408	0	0	30.00
40.00	04000	SUBPROVIDER - IPF	0	1,061,979	4,516	0	0	40.00
43.00	04300	NURSERY	0	82,342	496	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,603,196	5,410	0	8,998	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	28,903	174	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,320,445	6,269	0	0	54.00
60.00	06000	LABORATORY	0	1,652,316	2,557	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	460,637	558	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	523,867	109	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	88,866	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	17,774	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	117,806	2,002	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	238,297	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	38,540	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,363,712	0	0	0	73.00
76.00	03160	CARDIOPULMONARY	0	116,332	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	662,104	0	5,519	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0	1,074,938	8,640	0	0	90.02
90.03	09003	WOUND CLINIC	0	65,558	0	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0	0	0	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0	508,484	3,868	0	0	90.05
90.06	09006	INFUSION CLINIC	0	67,554	0	0	0	90.06
91.00	09100	EMERGENCY	0	1,373,780	4,542	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	0	58,651	78	0	0	93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-11,283,922	20,987,868	62,241	5,519	8,998	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	23,583	906	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	20,727	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.02	07952	WEST JAY CLINIC	0	652,375	0	0	0	194.02
194.03	07953	JAY MERIDIAN URGENT CARE	0	380,731	1,615	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)		11,283,922	2,778,625	89,481	21,351	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.511388	42.905176	16.213263	2.372861	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		216,904	144,988	1,981	3,022	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/24/2019 10:13 am

		Cost Center Description	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT - MOB (SQUARE FEET-MOB)	OPERATION OF PLANT - POB (SQUARE FEET-POB)	
			5A	5.00	7.00	7.01	7.02	
205.00		Unit cost multiplier (Wkst. B, Part II)		0.009830	2.238782	0.358942	0.335852	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/24/2019 10:13 am

		Cost Center Description	OPERATION OF PLANT - WJ (SQUARE FEET-WJ)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	
			7.03	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MOB						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT-POB						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT-WJ						1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT-INTEREST						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB						2.01
2.02	00202	CAP REL COSTS-MVBLE EQUIP - POB						2.02
2.03	00203	CAP REL COSTS-MVBLE EQUIP - WJ						2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT - MOB						7.01
7.02	00702	OPERATION OF PLANT - POB						7.02
7.03	00703	OPERATION OF PLANT - WJ	3,300					7.03
8.00	00800	LAUNDRY & LINEN SERVICE	0	46,080				8.00
9.00	00900	HOUSEKEEPING	0	5,580	63,657			9.00
10.00	01000	DIETARY	0	1,440	1,449	11,028		10.00
11.00	01100	CAFETERIA	0	0	2,689	0	16,465	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	1,667	0	1,296	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	1,258	0	0	14.00
15.00	01500	PHARMACY	0	0	1,026	0	491	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	1,420	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	21,125	12,408	7,554	2,135	30.00
40.00	04000	SUBPROVIDER - IPF	0	1,140	4,516	3,474	1,241	40.00
43.00	04300	NURSERY	0	835	496	0	75	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,800	5,410	0	1,929	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	174	0	27	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,660	6,269	0	882	54.00
60.00	06000	LABORATORY	0	0	2,557	0	1,060	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	558	0	493	65.00
66.00	06600	PHYSICAL THERAPY	0	300	109	0	533	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	126	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	22	68.00
69.00	06900	ELECTROCARDIOLOGY	0	960	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	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03160	CARDIOPULMONARY	0	0	0	0	149	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	0	0	0	1,495	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	8,640	0	1,817	90.02
90.03	09003	WOUND CLINIC	0	0	0	0	86	90.03
90.04	09004	OP ORTHO CLINIC	0	0	0	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0	0	3,868	0	904	90.05
90.06	09006	INFUSION CLINIC	0	0	0	0	68	90.06
91.00	09100	EMERGENCY	0	6,240	4,542	0	1,138	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	0	0	78	0	110	93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	46,080	61,136	11,028	16,077	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	906	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.02	07952	WEST JAY CLINIC	3,300	0	0	0	0	194.02
194.03	07953	JAY MERIDIAN URGENT CARE	0	0	1,615	0	388	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	958	143,072	708,876	462,448	651,753	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.290303	3.104861	11.135869	41.933986	39.584148	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	285	13,385	20,030	44,304	80,153	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/24/2019 10:13 am

		Cost Center Description	OPERATION OF PLANT - WJ (SQUARE FEET-WJ)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	
			7.03	8.00	9.00	10.00	11.00	
205.00		Unit cost multiplier (Wkst. B, Part II)	0.086364	0.290473	0.314655	4.017410	4.868084	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/24/2019 10:13 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MOB						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT-POB						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT-WJ						1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT-INTEREST						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB						2.01
2.02	00202	CAP REL COSTS-MVBLE EQUIP - POB						2.02
2.03	00203	CAP REL COSTS-MVBLE EQUIP - WJ						2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT - MOB						7.01
7.02	00702	OPERATION OF PLANT - POB						7.02
7.03	00703	OPERATION OF PLANT - WJ						7.03
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	7,724					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	722,615				14.00
15.00	01500	PHARMACY	0	3,075	1,393,530			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	76,720,481		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,647	81,654	10,319	6,080,687	0	30.00
40.00	04000	SUBPROVIDER - IPF	901	4,341	0	1,995,996	0	40.00
43.00	04300	NURSERY	58	0	0	179,798	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,106	198,665	7,235	17,559,973	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	21	0	0	976,922	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	29,149	4,690	9,840,429	0	54.00
60.00	06000	LABORATORY	0	370	0	7,330,241	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	13,949	0	801,873	0	65.00
66.00	06600	PHYSICAL THERAPY	0	2,742	0	1,131,634	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	430	0	245,782	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	22,427	0	68.00
69.00	06900	ELECTROCARDIOLOGY	164	0	0	588,377	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	238,297	0	908,325	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	38,540	0	306,000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,363,711	9,402,203	0	73.00
76.00	03160	CARDIOPULMONARY	4	2,560	0	1,568,060	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	978	22,103	0	1,170,050	0	90.01
90.02	09002	JAY FAMILY MEDICINE	1,286	11,566	0	1,027,091	0	90.02
90.03	09003	WOUND CLINIC	86	2,021	0	94,549	0	90.03
90.04	09004	OP ORTHO CLINIC	0	58	0	77,465	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	534	14,194	152	491,987	0	90.05
90.06	09006	INFUSION CLINIC	68	1,010	196	1,642,916	0	90.06
91.00	09100	EMERGENCY	871	56,956	7,227	13,140,972	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	0	4	0	136,724	0	93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,724	721,684	1,393,530	76,720,481	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.02	07952	WEST JAY CLINIC	0	931	0	0	0	194.02
194.03	07953	JAY MERIDIAN URGENT CARE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,117,540	861,738	1,455,245	132,602	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	403.617297	1.192527	1.044287	0.001728	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	73,315	41,121	40,846	40,951	0	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/24/2019 10:13 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	
			13.00	14.00	15.00	16.00	17.00	
205.00		Unit cost multiplier (Wkst. B, Part II)	9.491844	0.056906	0.029311	0.000534	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/24/2019 10:13 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,943,665		4,943,665	0	4,943,665	30.00
40.00	04000	SUBPROVIDER - IPF	2,419,740		2,419,740	0	2,419,740	40.00
43.00	04300	NURSERY	180,538		180,538	0	180,538	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,549,265		3,549,265	0	3,549,265	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	64,321		64,321	0	64,321	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,437,429		2,437,429	0	2,437,429	54.00
60.00	06000	LABORATORY	2,690,541		2,690,541	0	2,690,541	60.00
65.00	06500	RESPIRATORY THERAPY	763,892	0	763,892	0	763,892	65.00
66.00	06600	PHYSICAL THERAPY	824,911	0	824,911	0	824,911	66.00
67.00	06700	OCCUPATIONAL THERAPY	140,237	0	140,237	0	140,237	67.00
68.00	06800	SPEECH PATHOLOGY	27,773	0	27,773	0	27,773	68.00
69.00	06900	ELECTROCARDIOLOGY	356,432		356,432	0	356,432	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	645,904		645,904	0	645,904	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	104,738		104,738	0	104,738	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,501,450		3,501,450	0	3,501,450	73.00
76.00	03160	CARDIOPULMONARY	189,098		189,098	0	189,098	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1,572,473		1,572,473	0	1,572,473	90.01
90.02	09002	JAY FAMILY MEDICINE	2,698,107		2,698,107	0	2,698,107	90.02
90.03	09003	WOUND CLINIC	139,772		139,772	0	139,772	90.03
90.04	09004	OP ORTHO CLINIC	203		203	0	203	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	1,246,800		1,246,800	0	1,246,800	90.05
90.06	09006	INFUSION CLINIC	136,486		136,486	0	136,486	90.06
91.00	09100	EMERGENCY	2,835,918		2,835,918	0	2,835,918	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,398,102		1,398,102		1,398,102	92.00
93.00	04950	OUTPATIENT PSYCH	97,455		97,455	0	97,455	93.00
200.00		Subtotal (see instructions)	32,965,250	0	32,965,250	0	32,965,250	200.00
201.00		Less Observation Beds	1,398,102		1,398,102		1,398,102	201.00
202.00		Total (see instructions)	31,567,148	0	31,567,148	0	31,567,148	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/24/2019 10:13 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,211,609		3,211,609			30.00
40.00	04000	SUBPROVIDER - IPF	1,995,996		1,995,996			40.00
43.00	04300	NURSERY	179,798		179,798			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,435,507	13,124,466	17,559,973	0.202122	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	553,931	422,991	976,922	0.065840	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	603,491	9,236,938	9,840,429	0.247695	0.000000	54.00
60.00	06000	LABORATORY	1,372,906	5,957,335	7,330,241	0.367047	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	364,931	436,942	801,873	0.952635	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	185,282	946,352	1,131,634	0.728956	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	118,777	127,005	245,782	0.570575	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	8,145	14,282	22,427	1.238373	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	80,485	507,892	588,377	0.605788	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	467,140	441,185	908,325	0.711093	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	33,760	272,240	306,000	0.342281	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,096,579	7,305,624	9,402,203	0.372407	0.000000	73.00
76.00	03160	CARDIOPULMONARY	262,464	1,305,596	1,568,060	0.120594	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	738	1,169,312	1,170,050	1.343937	0.000000	90.01
90.02	09002	JAY FAMILY MEDICINE	138	1,026,953	1,027,091	2.626941	0.000000	90.02
90.03	09003	WOUND CLINIC	0	94,549	94,549	1.478302	0.000000	90.03
90.04	09004	OP ORTHO CLINIC	0	77,465	77,465	0.002621	0.000000	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	681	491,306	491,987	2.534213	0.000000	90.05
90.06	09006	INFUSION CLINIC	0	1,642,916	1,642,916	0.083075	0.000000	90.06
91.00	09100	EMERGENCY	506,948	12,634,024	13,140,972	0.215807	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	49,271	2,819,807	2,869,078	0.487300	0.000000	92.00
93.00	04950	OUTPATIENT PSYCH	0	136,724	136,724	0.712786	0.000000	93.00
200.00		Subtotal (see instructions)	16,528,577	60,191,904	76,720,481			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	16,528,577	60,191,904	76,720,481			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/24/2019 10:13 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.202122		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.065840		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.247695		54.00
60.00	06000	LABORATORY	0.367047		60.00
65.00	06500	RESPIRATORY THERAPY	0.952635		65.00
66.00	06600	PHYSICAL THERAPY	0.728956		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.570575		67.00
68.00	06800	SPEECH PATHOLOGY	1.238373		68.00
69.00	06900	ELECTROCARDIOLOGY	0.605788		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.711093		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.342281		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.372407		73.00
76.00	03160	CARDIOPULMONARY	0.120594		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1.343937		90.01
90.02	09002	JAY FAMILY MEDICINE	2.626941		90.02
90.03	09003	WOUND CLINIC	1.478302		90.03
90.04	09004	OP ORTHO CLINIC	0.002621		90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	2.534213		90.05
90.06	09006	INFUSION CLINIC	0.083075		90.06
91.00	09100	EMERGENCY	0.215807		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.487300		92.00
93.00	04950	OUTPATIENT PSYCH	0.712786		93.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/24/2019 10:13 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,943,665		4,943,665	0	4,943,665	30.00
40.00	04000	SUBPROVIDER - IPF	2,419,740		2,419,740	0	2,419,740	40.00
43.00	04300	NURSERY	180,538		180,538	0	180,538	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,549,265		3,549,265	0	3,549,265	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	64,321		64,321	0	64,321	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,437,429		2,437,429	0	2,437,429	54.00
60.00	06000	LABORATORY	2,690,541		2,690,541	0	2,690,541	60.00
65.00	06500	RESPIRATORY THERAPY	763,892	0	763,892	0	763,892	65.00
66.00	06600	PHYSICAL THERAPY	824,911	0	824,911	0	824,911	66.00
67.00	06700	OCCUPATIONAL THERAPY	140,237	0	140,237	0	140,237	67.00
68.00	06800	SPEECH PATHOLOGY	27,773	0	27,773	0	27,773	68.00
69.00	06900	ELECTROCARDIOLOGY	356,432		356,432	0	356,432	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	645,904		645,904	0	645,904	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	104,738		104,738	0	104,738	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,501,450		3,501,450	0	3,501,450	73.00
76.00	03160	CARDIOPULMONARY	189,098		189,098	0	189,098	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1,572,473		1,572,473	0	1,572,473	90.01
90.02	09002	JAY FAMILY MEDICINE	2,698,107		2,698,107	0	2,698,107	90.02
90.03	09003	WOUND CLINIC	139,772		139,772	0	139,772	90.03
90.04	09004	OP ORTHO CLINIC	203		203	0	203	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	1,246,800		1,246,800	0	1,246,800	90.05
90.06	09006	INFUSION CLINIC	136,486		136,486	0	136,486	90.06
91.00	09100	EMERGENCY	2,835,918		2,835,918	0	2,835,918	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,398,102		1,398,102		1,398,102	92.00
93.00	04950	OUTPATIENT PSYCH	97,455		97,455	0	97,455	93.00
200.00		Subtotal (see instructions)	32,965,250	0	32,965,250	0	32,965,250	200.00
201.00		Less Observation Beds	1,398,102		1,398,102		1,398,102	201.00
202.00		Total (see instructions)	31,567,148	0	31,567,148	0	31,567,148	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/24/2019 10:13 am

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,211,609		3,211,609			30.00
40.00	04000	SUBPROVIDER - IPF	1,995,996		1,995,996			40.00
43.00	04300	NURSERY	179,798		179,798			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,435,507	13,124,466	17,559,973	0.202122	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	553,931	422,991	976,922	0.065840	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	603,491	9,236,938	9,840,429	0.247695	0.000000	54.00
60.00	06000	LABORATORY	1,372,906	5,957,335	7,330,241	0.367047	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	364,931	436,942	801,873	0.952635	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	185,282	946,352	1,131,634	0.728956	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	118,777	127,005	245,782	0.570575	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	8,145	14,282	22,427	1.238373	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	80,485	507,892	588,377	0.605788	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	467,140	441,185	908,325	0.711093	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	33,760	272,240	306,000	0.342281	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,096,579	7,305,624	9,402,203	0.372407	0.000000	73.00
76.00	03160	CARDIOPULMONARY	262,464	1,305,596	1,568,060	0.120594	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	738	1,169,312	1,170,050	1.343937	0.000000	90.01
90.02	09002	JAY FAMILY MEDICINE	138	1,026,953	1,027,091	2.626941	0.000000	90.02
90.03	09003	WOUND CLINIC	0	94,549	94,549	1.478302	0.000000	90.03
90.04	09004	OP ORTHO CLINIC	0	77,465	77,465	0.002621	0.000000	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	681	491,306	491,987	2.534213	0.000000	90.05
90.06	09006	INFUSION CLINIC	0	1,642,916	1,642,916	0.083075	0.000000	90.06
91.00	09100	EMERGENCY	506,948	12,634,024	13,140,972	0.215807	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	49,271	2,819,807	2,869,078	0.487300	0.000000	92.00
93.00	04950	OUTPATIENT PSYCH	0	136,724	136,724	0.712786	0.000000	93.00
200.00		Subtotal (see instructions)	16,528,577	60,191,904	76,720,481			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	16,528,577	60,191,904	76,720,481			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/24/2019 10:13 am

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.202122		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.065840		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.247695		54.00
60.00	06000	LABORATORY	0.367047		60.00
65.00	06500	RESPIRATORY THERAPY	0.952635		65.00
66.00	06600	PHYSICAL THERAPY	0.728956		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.570575		67.00
68.00	06800	SPEECH PATHOLOGY	1.238373		68.00
69.00	06900	ELECTROCARDIOLOGY	0.605788		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.711093		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.342281		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.372407		73.00
76.00	03160	CARDIOPULMONARY	0.120594		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1.343937		90.01
90.02	09002	JAY FAMILY MEDICINE	2.626941		90.02
90.03	09003	WOUND CLINIC	1.478302		90.03
90.04	09004	OP ORTHO CLINIC	0.002621		90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	2.534213		90.05
90.06	09006	INFUSION CLINIC	0.083075		90.06
91.00	09100	EMERGENCY	0.215807		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.487300		92.00
93.00	04950	OUTPATIENT PSYCH	0.712786		93.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet C Part II | Date/Time Prepared: 5/24/2019 10:13 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,549,265	215,577	3,333,688	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	64,321	6,110	58,211	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,437,429	204,576	2,232,853	0	0	54.00
60.00	06000	LABORATORY	2,690,541	98,425	2,592,116	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	763,892	24,099	739,793	0	0	65.00
66.00	06600	PHYSICAL THERAPY	824,911	11,707	813,204	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	140,237	1,642	138,595	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	27,773	294	27,479	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	356,432	60,531	295,901	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	645,904	16,388	629,516	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	104,738	2,735	102,003	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,501,450	58,399	3,443,051	0	0	73.00
76.00	03160	CARDIOPULMONARY	189,098	2,890	186,208	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1,572,473	40,486	1,531,987	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	2,698,107	279,783	2,418,324	0	0	90.02
90.03	09003	WOUND CLINIC	139,772	2,044	137,728	0	0	90.03
90.04	09004	OP ORTHO CLINIC	203	44	159	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	1,246,800	126,102	1,120,698	0	0	90.05
90.06	09006	INFUSION CLINIC	136,486	2,580	133,906	0	0	90.06
91.00	09100	EMERGENCY	2,835,918	169,419	2,666,499	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,398,102	125,856	1,272,246	0	0	92.00
93.00	04950	OUTPATIENT PSYCH	97,455	3,416	94,039	0	0	93.00
200.00		Subtotal (sum of lines 50 thru 199)	25,421,307	1,453,103	23,968,204	0	0	200.00
201.00		Less Observation Beds	1,398,102	125,856	1,272,246	0	0	201.00
202.00		Total (line 200 minus line 201)	24,023,205	1,327,247	22,695,958	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet C Part II Date/Time Prepared: 5/24/2019 10:13 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	3,549,265	17,559,973	0.202122		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	64,321	976,922	0.065840		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,437,429	9,840,429	0.247695		54.00
60.00	06000	LABORATORY	2,690,541	7,330,241	0.367047		60.00
65.00	06500	RESPIRATORY THERAPY	763,892	801,873	0.952635		65.00
66.00	06600	PHYSICAL THERAPY	824,911	1,131,634	0.728956		66.00
67.00	06700	OCCUPATIONAL THERAPY	140,237	245,782	0.570575		67.00
68.00	06800	SPEECH PATHOLOGY	27,773	22,427	1.238373		68.00
69.00	06900	ELECTROCARDIOLOGY	356,432	588,377	0.605788		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	645,904	908,325	0.711093		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	104,738	306,000	0.342281		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,501,450	9,402,203	0.372407		73.00
76.00	03160	CARDIOPULMONARY	189,098	1,568,060	0.120594		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0.000000		90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1,572,473	1,170,050	1.343937		90.01
90.02	09002	JAY FAMILY MEDICINE	2,698,107	1,027,091	2.626941		90.02
90.03	09003	WOUND CLINIC	139,772	94,549	1.478302		90.03
90.04	09004	OP ORTHO CLINIC	203	77,465	0.002621		90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	1,246,800	491,987	2.534213		90.05
90.06	09006	INFUSION CLINIC	136,486	1,642,916	0.083075		90.06
91.00	09100	EMERGENCY	2,835,918	13,140,972	0.215807		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,398,102	2,869,078	0.487300		92.00
93.00	04950	OUTPATIENT PSYCH	97,455	136,724	0.712786		93.00
200.00		Subtotal (sum of lines 50 thru 199)	25,421,307	71,333,078			200.00
201.00		Less Observation Beds	1,398,102	0			201.00
202.00		Total (line 200 minus line 201)	24,023,205	71,333,078			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet D Part II Date/Time Prepared: 5/24/2019 10:13 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	215,577	17,559,973	0.012277	1,253,650	15,391	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,110	976,922	0.006254	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	204,576	9,840,429	0.020789	219,225	4,557	54.00
60.00	06000	LABORATORY	98,425	7,330,241	0.013427	437,495	5,874	60.00
65.00	06500	RESPIRATORY THERAPY	24,099	801,873	0.030053	168,195	5,055	65.00
66.00	06600	PHYSICAL THERAPY	11,707	1,131,634	0.010345	76,730	794	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,642	245,782	0.006681	49,440	330	67.00
68.00	06800	SPEECH PATHOLOGY	294	22,427	0.013109	3,441	45	68.00
69.00	06900	ELECTROCARDIOLOGY	60,531	588,377	0.102878	13,632	1,402	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,388	908,325	0.018042	140,826	2,541	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,735	306,000	0.008938	3,361	30	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	58,399	9,402,203	0.006211	676,131	4,199	73.00
76.00	03160	CARDIOPULMONARY	2,890	1,568,060	0.001843	157,638	291	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	40,486	1,170,050	0.034602	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	279,783	1,027,091	0.272403	0	0	90.02
90.03	09003	WOUND CLINIC	2,044	94,549	0.021618	0	0	90.03
90.04	09004	OP ORTHO CLINIC	44	77,465	0.000568	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	126,102	491,987	0.256312	0	0	90.05
90.06	09006	INFUSION CLINIC	2,580	1,642,916	0.001570	0	0	90.06
91.00	09100	EMERGENCY	169,419	13,140,972	0.012892	21,583	278	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	125,856	2,869,078	0.043866	980	43	92.00
93.00	04950	OUTPATIENT PSYCH	3,416	136,724	0.024985	0	0	93.00
200.00		Total (lines 50 through 199)	1,453,103	71,333,078		3,222,327	40,830	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/24/2019 10:13 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	0	0	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	0	0	0	90.02
90.03	09003	WOUND CLINIC	0	0	0	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0	0	0	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0	0	0	0	0	90.05
90.06	09006	INFUSION CLINIC	0	0	0	0	0	90.06
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
93.00	04950	OUTPATIENT PSYCH	0	0	0	0	0	93.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/24/2019 10:13 am

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	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	0	0	0	17,559,973	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	976,922	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	9,840,429	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	7,330,241	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	801,873	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,131,634	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	245,782	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	22,427	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	588,377	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	908,325	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	306,000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,402,203	0.000000	73.00
76.00	03160	CARDIOPULMONARY	0	0	0	1,568,060	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	0	0	1,170,050	0.000000	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	0	1,027,091	0.000000	90.02
90.03	09003	WOUND CLINIC	0	0	0	94,549	0.000000	90.03
90.04	09004	OP ORTHO CLINIC	0	0	0	77,465	0.000000	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0	0	0	491,987	0.000000	90.05
90.06	09006	INFUSION CLINIC	0	0	0	1,642,916	0.000000	90.06
91.00	09100	EMERGENCY	0	0	0	13,140,972	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	2,869,078	0.000000	92.00
93.00	04950	OUTPATIENT PSYCH	0	0	0	136,724	0.000000	93.00
200.00		Total (lines 50 through 199)	0	0	0	71,333,078		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/24/2019 10:13 am

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	1,253,650	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	219,225	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	437,495	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	168,195	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	76,730	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	49,440	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	3,441	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	13,632	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	140,826	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	3,361	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	676,131	0	0	0	73.00
76.00	03160	CARDIOPULMONARY	0.000000	157,638	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0.000000	0	0	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0.000000	0	0	0	0	90.02
90.03	09003	WOUND CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0.000000	0	0	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0.000000	0	0	0	0	90.05
90.06	09006	INFUSION CLINIC	0.000000	0	0	0	0	90.06
91.00	09100	EMERGENCY	0.000000	21,583	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	980	0	0	0	92.00
93.00	04950	OUTPATIENT PSYCH	0.000000	0	0	0	0	93.00
200.00		Total (lines 50 through 199)		3,222,327	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/24/2019 10:13 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.202122	0	3,244,094	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.065840	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.247695	0	2,653,349	0	0	54.00
60.00	06000	LABORATORY	0.367047	0	1,689,282	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.952635	0	116,575	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.728956	0	385,534	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.570575	0	28,866	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.238373	0	8,559	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.605788	0	156,444	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.711093	0	93,416	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.342281	0	54,148	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.372407	0	2,708,650	83,924	0	73.00
76.00	03160	CARDIOPULMONARY	0.120594	0	511,867	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1.343937	0	254,659	24,148	0	90.01
90.02	09002	JAY FAMILY MEDICINE	2.626941	0	478,606	32,506	0	90.02
90.03	09003	WOUND CLINIC	1.478302	0	33,416	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0.002621	0	34,972	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	2.534213	0	109,909	5,006	0	90.05
90.06	09006	INFUSION CLINIC	0.083075	0	898,866	0	0	90.06
91.00	09100	EMERGENCY	0.215807	0	2,695,733	6,051	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.487300	0	1,107,049	216	0	92.00
93.00	04950	OUTPATIENT PSYCH	0.712786	0	29,214	0	0	93.00
200.00		Subtotal (see instructions)		0	17,293,208	151,851	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	17,293,208	151,851	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/24/2019 10:13 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	655,703	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	657,221	0		54.00
60.00	06000	LABORATORY	620,046	0		60.00
65.00	06500	RESPIRATORY THERAPY	111,053	0		65.00
66.00	06600	PHYSICAL THERAPY	281,037	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	16,470	0		67.00
68.00	06800	SPEECH PATHOLOGY	10,599	0		68.00
69.00	06900	ELECTROCARDIOLOGY	94,772	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	66,427	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,534	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,008,720	31,254		73.00
76.00	03160	CARDIOPULMONARY	61,728	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	342,246	32,453		90.01
90.02	09002	JAY FAMILY MEDICINE	1,257,270	85,391		90.02
90.03	09003	WOUND CLINIC	49,399	0		90.03
90.04	09004	OP ORTHO CLINIC	92	0		90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	278,533	12,686		90.05
90.06	09006	INFUSION CLINIC	74,673	0		90.06
91.00	09100	EMERGENCY	581,758	1,306		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	539,465	105		92.00
93.00	04950	OUTPATIENT PSYCH	20,823	0		93.00
200.00		Subtotal (see instructions)	6,746,569	163,195		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	6,746,569	163,195		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-1320 | Component CCN: 15-M320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet D Part II Date/Time Prepared: 5/24/2019 10:13 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	215,577	17,559,973	0.012277	185	2	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,110	976,922	0.006254	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	204,576	9,840,429	0.020789	15,304	318	54.00
60.00	06000	LABORATORY	98,425	7,330,241	0.013427	92,480	1,242	60.00
65.00	06500	RESPIRATORY THERAPY	24,099	801,873	0.030053	6,427	193	65.00
66.00	06600	PHYSICAL THERAPY	11,707	1,131,634	0.010345	8,690	90	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,642	245,782	0.006681	5,350	36	67.00
68.00	06800	SPEECH PATHOLOGY	294	22,427	0.013109	532	7	68.00
69.00	06900	ELECTROCARDIOLOGY	60,531	588,377	0.102878	13,845	1,424	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,388	908,325	0.018042	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,735	306,000	0.008938	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	58,399	9,402,203	0.006211	150,637	936	73.00
76.00	03160	CARDIOPULMONARY	2,890	1,568,060	0.001843	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	40,486	1,170,050	0.034602	138	5	90.01
90.02	09002	JAY FAMILY MEDICINE	279,783	1,027,091	0.272403	0	0	90.02
90.03	09003	WOUND CLINIC	2,044	94,549	0.021618	0	0	90.03
90.04	09004	OP ORTHO CLINIC	44	77,465	0.000568	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	126,102	491,987	0.256312	185	47	90.05
90.06	09006	INFUSION CLINIC	2,580	1,642,916	0.001570	0	0	90.06
91.00	09100	EMERGENCY	169,419	13,140,972	0.012892	40,530	523	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,869,078	0.000000	2,310	0	92.00
93.00	04950	OUTPATIENT PSYCH	3,416	136,724	0.024985	0	0	93.00
200.00		Total (lines 50 through 199)	1,327,247	71,333,078		336,613	4,823	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1320 | Component CCN: 15-M320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/24/2019 10:13 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	0	0	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	0	0	0	90.02
90.03	09003	WOUND CLINIC	0	0	0	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0	0	0	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0	0	0	0	0	90.05
90.06	09006	INFUSION CLINIC	0	0	0	0	0	90.06
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
93.00	04950	OUTPATIENT PSYCH	0	0	0	0	0	93.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1320 | Component CCN: 15-M320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/24/2019 10:13 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	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	0	0	0	17,559,973	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	976,922	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	9,840,429	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	7,330,241	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	801,873	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,131,634	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	245,782	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	22,427	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	588,377	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	908,325	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	306,000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,402,203	0.000000	73.00
76.00	03160	CARDIOPULMONARY	0	0	0	1,568,060	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	0	0	1,170,050	0.000000	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	0	1,027,091	0.000000	90.02
90.03	09003	WOUND CLINIC	0	0	0	94,549	0.000000	90.03
90.04	09004	OP ORTHO CLINIC	0	0	0	77,465	0.000000	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0	0	0	491,987	0.000000	90.05
90.06	09006	INFUSION CLINIC	0	0	0	1,642,916	0.000000	90.06
91.00	09100	EMERGENCY	0	0	0	13,140,972	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	2,869,078	0.000000	92.00
93.00	04950	OUTPATIENT PSYCH	0	0	0	136,724	0.000000	93.00
200.00		Total (lines 50 through 199)	0	0	0	71,333,078		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1320 | Component CCN: 15-M320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/24/2019 10:13 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	185	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	15,304	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	92,480	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	6,427	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	8,690	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	5,350	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	532	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	13,845	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	150,637	0	0	0	73.00
76.00	03160	CARDIOPULMONARY	0.000000	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0.000000	138	0	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0.000000	0	0	0	0	90.02
90.03	09003	WOUND CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0.000000	0	0	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0.000000	185	0	0	0	90.05
90.06	09006	INFUSION CLINIC	0.000000	0	0	0	0	90.06
91.00	09100	EMERGENCY	0.000000	40,530	0	160	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	2,310	0	0	0	92.00
93.00	04950	OUTPATIENT PSYCH	0.000000	0	0	0	0	93.00
200.00		Total (lines 50 through 199)		336,613	0	160	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1320 | Component CCN: 15-M320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet D Part V | Date/Time Prepared: 5/24/2019 10:13 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.202122	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.065840	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.247695	0	0	0	0	54.00
60.00	06000	LABORATORY	0.367047	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.952635	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.728956	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.570575	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.238373	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.605788	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.711093	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.342281	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.372407	0	0	491	0	73.00
76.00	03160	CARDIOPULMONARY	0.120594	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1.343937	0	0	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	2.626941	0	0	0	0	90.02
90.03	09003	WOUND CLINIC	1.478302	0	0	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0.002621	0	0	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	2.534213	0	0	0	0	90.05
90.06	09006	INFUSION CLINIC	0.083075	0	0	0	0	90.06
91.00	09100	EMERGENCY	0.215807	160	0	0	35	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.487300	0	0	0	0	92.00
93.00	04950	OUTPATIENT PSYCH	0.712786	0	0	0	0	93.00
200.00		Subtotal (see instructions)		160	0	491	35	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		160	0	491	35	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1320 | Component CCN: 15-M320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet D Part V | Date/Time Prepared: 5/24/2019 10:13 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	183		73.00
76.00	03160	CARDIOPULMONARY	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	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
90.03	09003	WOUND CLINIC	0	0		90.03
90.04	09004	OP ORTHO CLINIC	0	0		90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0	0		90.05
90.06	09006	INFUSION CLINIC	0	0		90.06
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
93.00	04950	OUTPATIENT PSYCH	0	0		93.00
200.00		Subtotal (see instructions)	0	183		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	183		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1320 | Component CCN: 15-Z320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/24/2019 10:13 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.202122	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.065840	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.247695	0	0	0	0	54.00
60.00	06000	LABORATORY	0.367047	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.952635	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.728956	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.570575	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.238373	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.605788	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.711093	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.342281	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.372407	0	0	0	0	73.00
76.00	03160	CARDIOPULMONARY	0.120594	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1.343937	0	0	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	2.626941	0	0	0	0	90.02
90.03	09003	WOUND CLINIC	1.478302	0	0	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0.002621	0	0	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	2.534213	0	0	0	0	90.05
90.06	09006	INFUSION CLINIC	0.083075	0	0	0	0	90.06
91.00	09100	EMERGENCY	0.215807	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.487300	0	0	0	0	92.00
93.00	04950	OUTPATIENT PSYCH	0.712786	0	0	0	0	93.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1320 | Component CCN: 15-Z320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet D Part V | Date/Time Prepared: 5/24/2019 10:13 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03160	CARDIOPULMONARY	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	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
90.03	09003	WOUND CLINIC	0	0		90.03
90.04	09004	OP ORTHO CLINIC	0	0		90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0	0		90.05
90.06	09006	INFUSION CLINIC	0	0		90.06
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
93.00	04950	OUTPATIENT PSYCH	0	0		93.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet D Part I Date/Time Prepared: 5/24/2019 10:13 am

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	445,026	26,701	418,325	2,330	179.54	30.00
40.00	SUBPROVIDER - IPF	169,713	0	169,713	1,158	146.56	40.00
43.00	NURSERY	16,240		16,240	144	112.78	43.00
200.00	Total (lines 30 through 199)	630,979		604,278	3,632		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)		
		6.00	7.00		
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	22	3,950		30.00
40.00	SUBPROVIDER - IPF	23	3,371		40.00
43.00	NURSERY	4	451		43.00
200.00	Total (lines 30 through 199)	49	7,772		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet D Part II Date/Time Prepared: 5/24/2019 10:13 am

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	215,577	17,559,973	0.012277	39,611	486	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,110	976,922	0.006254	8,555	54	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	204,576	9,840,429	0.020789	8,387	174	54.00
60.00	06000	LABORATORY	98,425	7,330,241	0.013427	13,604	183	60.00
65.00	06500	RESPIRATORY THERAPY	24,099	801,873	0.030053	3,591	108	65.00
66.00	06600	PHYSICAL THERAPY	11,707	1,131,634	0.010345	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,642	245,782	0.006681	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	294	22,427	0.013109	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	60,531	588,377	0.102878	639	66	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,388	908,325	0.018042	1,935	35	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,735	306,000	0.008938	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	58,399	9,402,203	0.006211	43,073	268	73.00
76.00	03160	CARDIOPULMONARY	2,890	1,568,060	0.001843	2,918	5	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	40,486	1,170,050	0.034602	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	279,783	1,027,091	0.272403	138	38	90.02
90.03	09003	WOUND CLINIC	2,044	94,549	0.021618	0	0	90.03
90.04	09004	OP ORTHO CLINIC	44	77,465	0.000568	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	126,102	491,987	0.256312	81	21	90.05
90.06	09006	INFUSION CLINIC	2,580	1,642,916	0.001570	0	0	90.06
91.00	09100	EMERGENCY	169,419	13,140,972	0.012892	21,089	272	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	125,856	2,869,078	0.043866	0	0	92.00
93.00	04950	OUTPATIENT PSYCH	3,416	136,724	0.024985	0	0	93.00
200.00		Total (lines 50 through 199)	1,453,103	71,333,078		143,621	1,710	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet D Part III Date/Time Prepared: 5/24/2019 10:13 am

Title XIX | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	2,330	0.00	22	30.00
40.00	04000	SUBPROVIDER - IPF	0	0	1,158	0.00	23	40.00
43.00	04300	NURSERY		0	144	0.00	4	43.00
200.00		Total (lines 30 through 199)		0	3,632		49	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
40.00	04000	SUBPROVIDER - IPF	0	40.00
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/24/2019 10:13 am

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	0	0	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	0	0	0	90.02
90.03	09003	WOUND CLINIC	0	0	0	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0	0	0	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0	0	0	0	0	90.05
90.06	09006	INFUSION CLINIC	0	0	0	0	0	90.06
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
93.00	04950	OUTPATIENT PSYCH	0	0	0	0	0	93.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/24/2019 10:13 am

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	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	0	0	0	17,559,973	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	976,922	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	9,840,429	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	7,330,241	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	801,873	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,131,634	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	245,782	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	22,427	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	588,377	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	908,325	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	306,000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,402,203	0.000000	73.00
76.00	03160	CARDIOPULMONARY	0	0	0	1,568,060	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	0	0	1,170,050	0.000000	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	0	1,027,091	0.000000	90.02
90.03	09003	WOUND CLINIC	0	0	0	94,549	0.000000	90.03
90.04	09004	OP ORTHO CLINIC	0	0	0	77,465	0.000000	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0	0	0	491,987	0.000000	90.05
90.06	09006	INFUSION CLINIC	0	0	0	1,642,916	0.000000	90.06
91.00	09100	EMERGENCY	0	0	0	13,140,972	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	2,869,078	0.000000	92.00
93.00	04950	OUTPATIENT PSYCH	0	0	0	136,724	0.000000	93.00
200.00		Total (lines 50 through 199)	0	0	0	71,333,078		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/24/2019 10:13 am

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	39,611	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	8,555	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	8,387	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	13,604	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	3,591	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	639	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	1,935	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	43,073	0	0	0	73.00
76.00	03160	CARDIOPULMONARY	0.000000	2,918	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0.000000	0	0	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0.000000	138	0	0	0	90.02
90.03	09003	WOUND CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0.000000	0	0	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0.000000	81	0	0	0	90.05
90.06	09006	INFUSION CLINIC	0.000000	0	0	0	0	90.06
91.00	09100	EMERGENCY	0.000000	21,089	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
93.00	04950	OUTPATIENT PSYCH	0.000000	0	0	0	0	93.00
200.00		Total (lines 50 through 199)		143,621	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/24/2019 10:13 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,518	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,330	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,629	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	146	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	42	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	759	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	146	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	129.14	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,943,665	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	5,424	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	296,612	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,647,053	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,647,053	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 per diem (see instructions)	1,994.44	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,513,780	39.00
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)	1,513,780	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/24/2019 10:13 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,102,393	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,616,173	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
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 medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	291,188	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	291,188	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	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	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	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	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	701	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,994.44	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,398,102	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/24/2019 10:13 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	445,026	4,943,665	0.090019	1,398,102	125,856	90.00
91.00	Nursing School cost	0	4,943,665	0.000000	1,398,102	0	91.00
92.00	Allied health cost	0	4,943,665	0.000000	1,398,102	0	92.00
93.00	All other Medical Education	0	4,943,665	0.000000	1,398,102	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1320 Component CCN: 15-M320	Period: From 03/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/24/2019 10:13 am
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,158	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,158	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,158	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	405	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,419,740	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
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)	2,419,740	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,419,740	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 per diem (see instructions)	2,089.59	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	846,284	39.00
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)	846,284	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1320 | Component CCN: 15-M320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/24/2019 10:13 am

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	128,955	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	975,239	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	4,823	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	4,823	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	970,416	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
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	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	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	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	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	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-1320 | Component CCN: 15-M320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/24/2019 10:13 am

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	0	2,419,740	0.000000	0	0	90.00
91.00	Nursing School cost	0	2,419,740	0.000000	0	0	91.00
92.00	Allied health cost	0	2,419,740	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,419,740	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/24/2019 10:13 am

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,518	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,330	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,629	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	146	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	42	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	22	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	144	15.00
16.00	Nursery days (title V or XIX only)	4	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	129.14	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,943,665	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	5,424	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	296,612	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,647,053	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,647,053	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 per diem (see instructions)	1,994.44	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	43,878	39.00
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)	43,878	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/24/2019 10:13 am

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	180,538	144	1,253.74	4	5,015	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	42,335	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	91,228	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	4,401	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	1,710	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	6,111	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	85,117	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
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	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	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	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	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	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	701	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,994.44	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,398,102	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/24/2019 10:13 am

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	445,026	4,943,665	0.090019	1,398,102	125,856	90.00
91.00	Nursing School cost	0	4,943,665	0.000000	1,398,102	0	91.00
92.00	Allied health cost	0	4,943,665	0.000000	1,398,102	0	92.00
93.00	All other Medical Education	0	4,943,665	0.000000	1,398,102	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1320 Component CCN: 15-M320	Period: From 03/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/24/2019 10:13 am
	Title XIX	Subprovider - IPF	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,158	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,158	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,158	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	23	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	144	15.00
16.00	Nursery days (title V or XIX only)	4	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	129.14	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,419,740	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
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)	2,419,740	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,419,740	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 per diem (see instructions)	2,089.59	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	48,061	39.00
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)	48,061	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1320 | Component CCN: 15-M320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/24/2019 10:13 am

Title XIX | Subprovider - IPF | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	6,741	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	54,802	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
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 medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
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	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	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	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	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	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-1320 | Component CCN: 15-M320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/24/2019 10:13 am

Title XIX | Subprovider - IPF | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	169,713	2,419,740	0.070137	0	0	90.00
91.00	Nursing School cost	0	2,419,740	0.000000	0	0	91.00
92.00	Allied health cost	0	2,419,740	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,419,740	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/24/2019 10:13 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,324,059		30.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.202122	1,253,650	253,390	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.065840	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.247695	219,225	54,301	54.00
60.00	06000	LABORATORY	0.367047	437,495	160,581	60.00
65.00	06500	RESPIRATORY THERAPY	0.952635	168,195	160,228	65.00
66.00	06600	PHYSICAL THERAPY	0.728956	76,730	55,933	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.570575	49,440	28,209	67.00
68.00	06800	SPEECH PATHOLOGY	1.238373	3,441	4,261	68.00
69.00	06900	ELECTROCARDIOLOGY	0.605788	13,632	8,258	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.711093	140,826	100,140	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.342281	3,361	1,150	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.372407	676,131	251,796	73.00
76.00	03160	CARDIOPULMONARY	0.120594	157,638	19,010	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1.343937	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	2.626941	0	0	90.02
90.03	09003	WOUND CLINIC	1.478302	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0.002621	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	2.534213	0	0	90.05
90.06	09006	INFUSION CLINIC	0.083075	0	0	90.06
91.00	09100	EMERGENCY	0.215807	21,583	4,658	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.487300	980	478	92.00
93.00	04950	OUTPATIENT PSYCH	0.712786	0	0	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		3,222,327	1,102,393	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)		3,222,327		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1320 | Component CCN: 15-M320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/24/2019 10:13 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
40.00	04000	SUBPROVIDER - IPF		693,046		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.202122	185	37	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.065840	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.247695	15,304	3,791	54.00
60.00	06000	LABORATORY	0.367047	92,480	33,945	60.00
65.00	06500	RESPIRATORY THERAPY	0.952635	6,427	6,123	65.00
66.00	06600	PHYSICAL THERAPY	0.728956	8,690	6,335	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.570575	5,350	3,053	67.00
68.00	06800	SPEECH PATHOLOGY	1.238373	532	659	68.00
69.00	06900	ELECTROCARDIOLOGY	0.605788	13,845	8,387	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.711093	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.342281	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.372407	150,637	56,098	73.00
76.00	03160	CARDIOPULMONARY	0.120594	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1.343937	138	185	90.01
90.02	09002	JAY FAMILY MEDICINE	2.626941	0	0	90.02
90.03	09003	WOUND CLINIC	1.478302	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0.002621	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	2.534213	185	469	90.05
90.06	09006	INFUSION CLINIC	0.083075	0	0	90.06
91.00	09100	EMERGENCY	0.215807	40,530	8,747	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.487300	2,310	1,126	92.00
93.00	04950	OUTPATIENT PSYCH	0.712786	0	0	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		336,613	128,955	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)		336,613		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet D-3

Component CCN: 15-Z320 | Date/Time Prepared: 5/24/2019 10:13 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.202122	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.065840	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.247695	7,549	1,870	54.00
60.00	06000	LABORATORY	0.367047	22,107	8,114	60.00
65.00	06500	RESPIRATORY THERAPY	0.952635	36,628	34,893	65.00
66.00	06600	PHYSICAL THERAPY	0.728956	54,593	39,796	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.570575	37,339	21,305	67.00
68.00	06800	SPEECH PATHOLOGY	1.238373	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.605788	426	258	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.711093	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.342281	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.372407	69,211	25,775	73.00
76.00	03160	CARDIOPULMONARY	0.120594	2,918	352	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1.343937	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	2.626941	0	0	90.02
90.03	09003	WOUND CLINIC	1.478302	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0.002621	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	2.534213	0	0	90.05
90.06	09006	INFUSION CLINIC	0.083075	0	0	90.06
91.00	09100	EMERGENCY	0.215807	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.487300	0	0	92.00
93.00	04950	OUTPATIENT PSYCH	0.712786	0	0	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		230,771	132,363	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)		230,771		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/24/2019 10:13 am

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		40,417		30.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY		4,687		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.202122	39,611	8,006	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.065840	8,555	563	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.247695	8,387	2,077	54.00
60.00	06000	LABORATORY	0.367047	13,604	4,993	60.00
65.00	06500	RESPIRATORY THERAPY	0.952635	3,591	3,421	65.00
66.00	06600	PHYSICAL THERAPY	0.728956	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.570575	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.238373	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.605788	639	387	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.711093	1,935	1,376	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.342281	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.372407	43,073	16,041	73.00
76.00	03160	CARDIOPULMONARY	0.120594	2,918	352	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1.343937	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	2.626941	138	363	90.02
90.03	09003	WOUND CLINIC	1.478302	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0.002621	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	2.534213	81	205	90.05
90.06	09006	INFUSION CLINIC	0.083075	0	0	90.06
91.00	09100	EMERGENCY	0.215807	21,089	4,551	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.487300	0	0	92.00
93.00	04950	OUTPATIENT PSYCH	0.712786	0	0	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		143,621	42,335	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)		143,621		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1320 | Component CCN: 15-M320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/24/2019 10:13 am

Title XIX | Subprovider - IPF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
40.00	04000	SUBPROVIDER - IPF		46,344		40.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.202122	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.065840	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.247695	300	74	54.00
60.00	06000	LABORATORY	0.367047	9,753	3,580	60.00
65.00	06500	RESPIRATORY THERAPY	0.952635	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.728956	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.570575	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.238373	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.605788	1,278	774	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.711093	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.342281	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.372407	4,588	1,709	73.00
76.00	03160	CARDIOPULMONARY	0.120594	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1.343937	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	2.626941	0	0	90.02
90.03	09003	WOUND CLINIC	1.478302	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0.002621	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	2.534213	0	0	90.05
90.06	09006	INFUSION CLINIC	0.083075	0	0	90.06
91.00	09100	EMERGENCY	0.215807	2,801	604	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.487300	0	0	92.00
93.00	04950	OUTPATIENT PSYCH	0.712786	0	0	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		18,720	6,741	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)		18,720		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1320	Period: From 03/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/24/2019 10:13 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,909,764	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	6,909,764	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	6,978,862	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	38,598	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	3,107,824	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	3,832,440	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	3,832,440	30.00
31.00	Primary payer payments	78	31.00
32.00	Subtotal (line 30 minus line 31)	3,832,362	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	76,212	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	49,538	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	76,212	36.00
37.00	Subtotal (see instructions)	3,881,900	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		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)	3,881,900	40.00
40.01	Sequestration adjustment (see instructions)	77,638	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	897,337	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	2,906,925	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	263,527	44.00
	TO BE COMPLETED BY CONTRACTOR		
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
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1320 Component CCN: 15-M320	Period: From 03/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/24/2019 10:13 am
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	183	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	35	2.00
3.00	OPPS payments	65	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	183	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	491	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	491	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	491	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	308	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	183	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	65	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	0	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	248	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	248	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	248	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	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)	248	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		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)	248	40.00
40.01	Sequestration adjustment (see instructions)	5	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	160	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	83	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
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
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet E-1 Part I Date/Time Prepared: 5/24/2019 10:13 am

Title XVIII | Hospital | 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		1,620,368		897,337	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	09/11/2018	87,500		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		87,500		0	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)		1,707,868		897,337	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		647,260		2,906,925	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,355,128		3,804,262	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1320 | Component CCN: 15-M320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 5/24/2019 10:13 am

Title XVIII | Subprovider - IPF | PPS

		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		748,269		160	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	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)		748,269		160	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		1,712		83	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		749,981		243	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1320 | Component CCN: 15-Z320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 5/24/2019 10:13 am

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		286,908		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	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)		286,908		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		132,323		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		419,231		0	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1320	Period: From 03/01/2018 To 12/31/2018	Worksheet E-1 Part II Date/Time Prepared: 5/24/2019 10:13 am
	Title XVIII	Hospital	Cost

			1.00
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12		2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12		4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168		7.00
8.00	Calculation of the HIT incentive payment (see instructions)		8.00
9.00	Sequestration adjustment amount (see instructions)		9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)		30.00
31.00	Other Adjustment (specify)		31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-1320 Component CCN: 15-Z320	Period: From 03/01/2018 To 12/31/2018	Worksheet E-2 Date/Time Prepared: 5/24/2019 10:13 am
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	294,100	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	133,687	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	146	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	427,787	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	427,787	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	427,787	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	427,787	0	15.00
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) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	427,787	0	19.00
19.01	Sequestration adjustment (see instructions)	8,556	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	286,908	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	132,323	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	16,164	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			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 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1320	Period: From 03/01/2018 To 12/31/2018	Worksheet E-3 Part V Date/Time Prepared: 5/24/2019 10:13 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	2,616,173	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	2,616,173	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,642,335	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	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	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	2,642,335	19.00
20.00	Deductibles (exclude professional component)	243,880	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	2,398,455	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	2,398,455	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	7,287	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	4,737	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	7,287	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	2,403,192	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	2,403,192	30.00
30.01	Sequestration adjustment (see instructions)	48,064	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	1,707,868	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	647,260	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	99,834	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1320 Component CCN: 15-M320	Period: From 03/01/2018 To 12/31/2018	Worksheet E-3 Part II Date/Time Prepared: 5/24/2019 10:13 am
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	391,666	1.00
2.00	Net IPF PPS Outlier Payments	421,459	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 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 program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	3.784314	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
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)	813,125	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	813,125	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	813,125	18.00
19.00	Deductibles	49,580	19.00
20.00	Subtotal (line 18 minus line 19)	763,545	20.00
21.00	Coinsurance	0	21.00
22.00	Subtotal (line 20 minus line 21)	763,545	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	2,680	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	1,742	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	2,680	25.00
26.00	Subtotal (sum of lines 22 and 24)	765,287	26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	27.00
28.00	Other pass through costs (see instructions)	0	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	30.99
31.00	Total amount payable to the provider (see instructions)	765,287	31.00
31.01	Sequestration adjustment (see instructions)	15,306	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	31.02
32.00	Interim payments	748,269	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)	1,712	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	7	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	421,459	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet G | Date/Time Prepared: 5/24/2019 10:13 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	6,153,629	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	4,290,341	0	0	0	4.00
5.00	Other receivable	-1,866,165	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	516,943	0	0	0	7.00
8.00	Prepaid expenses	283,140	0	0	0	8.00
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)	9,377,888	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,006,948	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	19,125,052	0	0	0	15.00
16.00	Accumulated depreciation	-1,072,112	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	8,604,553	0	0	0	23.00
24.00	Accumulated depreciation	-1,250,698	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	26,413,743	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
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)	35,791,631	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	11,460,261	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,194,167	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	105,414	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	12,759,842	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	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)	12,759,842	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	23,031,789				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	23,031,789	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	35,791,631	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet G-1 | Date/Time Prepared: 5/24/2019 10:13 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		23,061,100				2.00
3.00	Total (sum of line 1 and line 2)		23,061,100		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		23,061,100		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	ROUNDING	0		0		0	13.00
14.00	NET INTERCOMPANY TRANSACTIONS	29,311		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		29,311		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		23,031,789		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00	ROUNDING		0		13.00
14.00	NET INTERCOMPANY TRANSACTIONS		0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-1320 | Period: From 03/01/2018 To 12/31/2018 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/24/2019 10:13 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,238,751		3,238,751	1.00
2.00	SUBPROVIDER - IPF	1,995,996		1,995,996	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	152,656		152,656	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	5,387,403		5,387,403	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	5,387,403		5,387,403	17.00
18.00	Ancillary services	10,583,398	40,098,848	50,682,246	18.00
19.00	Outpatient services	557,776	20,093,056	20,650,832	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	16,528,577	60,191,904	76,720,481	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		31,628,883		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		31,628,883		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-1320	Period: From 03/01/2018 To 12/31/2018	Worksheet G-3 Date/Time Prepared: 5/24/2019 10:13 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	76,720,481	1.00
2.00	Less contractual allowances and discounts on patients' accounts	55,074,798	2.00
3.00	Net patient revenues (line 1 minus line 2)	21,645,683	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	31,628,883	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-9,983,200	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER (MISCELLANEOUS INCOME)	33,044,300	24.00
25.00	Total other income (sum of lines 6-24)	33,044,300	25.00
26.00	Total (line 5 plus line 25)	23,061,100	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	23,061,100	29.00