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 09-30-2025

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-1320	Period: From 01/01/2022 To 12/31/2022	Worksheet S Parts I-III Date/Time Prepared: 5/26/2023 12:02 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/26/2023 Time: 12:02 pm
2. [ ] Manually prepared 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, "L" for low, or "N" for no.

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 BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

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 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 01/01/2022 and ending 12/31/2022 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.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1		2		
1	Jon Vanator		Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Jon Vanator			2
3	Signatory Title	CFO			3
4	Date	(Dated when report is electronica			4

		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	66,537	386,781	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	123,817	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
200.00	TOTAL	0	190,354	386,781	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 number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 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 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Prepared: 5/26/2023 12:02 pm

	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									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	IU HEALTH JAY SWING BED	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)	01/01/2022	12/31/2022	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 UCPs, including supplemental UCPs, 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 a final UCP 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
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? 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.				22.04
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1320	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Prepared: 5/26/2023 12:02 pm

		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
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? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	N			56.00
57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, 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. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.				57.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1320	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Prepared: 5/26/2023 12:02 pm

		V	XVIII	XIX	
		1.00	2.00	3.00	
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 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	N			60.00

		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

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1320 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2023 12:02 pm

		1.00	
	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)		
68.00	For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)?	N	68.00

		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.	N			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	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

		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

		Approved for Permanent Adjustment (Y/N)	Number of Approved Permanent Adjustments	
		1.00	2.00	
88.00	Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.		0	88.00

		Wkst. A Line No.	Effective Date	Approved Permanent Adjustment Amount Per Discharge	
		1.00	2.00	3.00	
89.00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.	0.00		0	89.00

		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

		V	XIX	
		1.00	2.00	
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	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	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

		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	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N			112.00
113.00	Did this hospital participate in the Community Health Access and Rural Transformation (CHART) model for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no.				113.00
	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.	2			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	53,130	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
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.			123.00
	Certified Transplant Center Information			
125.00	Does this facility operate a Medicare-certified 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 program, 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 program, 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 program, 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 program, 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 program, 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 program, 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 program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based 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

	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.	N		146.00

		1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N	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)		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)	N	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)			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	43	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1320 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part II Date/Time Prepared: 5/26/2023 12:02 pm

		Y/N	Date	
		1.00	2.00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE			
	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)	N		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		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 a nursing program? Column 2: If yes, is the provider 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 programs 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 coinsurance amounts 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	04/04/2023	Y	04/04/2022	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 01/01/2022 To 12/31/2022 | Worksheet S-2 Part II Date/Time Prepared: 5/26/2023 12:02 pm

		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	Were 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 01/01/2022 To 12/31/2022	Worksheet S-2 Part II Date/Time Prepared: 5/26/2023 12:02 pm

		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 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I | Date/Time Prepared: 5/26/2023 12:02 pm

	Component	Worksheet A Line No.	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	
	PART I - STATISTICAL DATA						
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	21	7,665	33,096.00	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)		21	7,665	33,096.00	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)		21	7,665	33,096.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	0	0		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)		21				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
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0		0	34.00

	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	
	PART I - STATISTICAL DATA						
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)	576	17	1,379			1.00
2.00	HMO and other (see instructions)	425	127				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	266	0	266			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	252			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	842	17	1,897			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		0	0			13.00
14.00	Total (see instructions)	842	17	1,897	0.00	193.02	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	0	0	0	0.00	0.00	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)			10			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	193.02	27.00
28.00	Observation Bed Days		13	606			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
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1320 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I | Date/Time Prepared: 5/26/2023 12:02 pm

	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	
	PART I - STATISTICAL DATA						
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	173	4	400	1.00
2.00	HMO and other (see instructions)			102	41		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation 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	173	4	400	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	0	0	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)						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
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1320 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-10 | Date/Time Prepared: 5/26/2023 12:02 pm

		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)	0.424025	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	3,267,120	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		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	19,959,436	6.00
7.00	Medicaid cost (line 1 times line 6)	8,463,300	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)	5,196,180	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)	4,606	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	95,172	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	40,355	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)	35,749	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)	5,231,929	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)	1,884,950	69,999	1,954,949	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	799,266	69,999	869,265	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)	799,266	69,999	869,265	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)	1,974,535	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	322,973	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	496,882	27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,477,653	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	800,471	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,669,736	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	6,901,665	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1320 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A | Date/Time Prepared: 5/26/2023 12:02 pm

		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	1,185,903	1,185,903	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MOB		0	0	75,227	75,227	1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT-POB		0	0	35,030	35,030	1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT-WJ		0	0	9,433	9,433	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		0	0	1,389,472	1,389,472	2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB		0	0	29,787	29,787	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	10,428	21,990	32,418	2,975,886	3,008,304	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	967,492	9,870,807	10,838,299	-812,470	10,025,829	5.00
7.00	00700	OPERATION OF PLANT	539,413	3,679,416	4,218,829	-1,318,264	2,900,565	7.00
7.01	00701	OPERATION OF PLANT - MOB	0	118,573	118,573	-75,329	43,244	7.01
7.02	00702	OPERATION OF PLANT - POB	0	86,271	86,271	-35,060	51,211	7.02
7.03	00703	OPERATION OF PLANT - WJ	0	0	0	0	0	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	37,607	-25,368	12,239	64,524	76,763	8.00
9.00	00900	HOUSEKEEPING	444,751	503,076	947,827	-115,928	831,899	9.00
10.00	01000	DIETARY	364,028	446,015	810,043	-498,613	311,430	10.00
11.00	01100	CAFETERIA	0	0	0	337,225	337,225	11.00
13.00	01300	NURSING ADMINISTRATION	1,319,378	628,651	1,948,029	-369,018	1,579,011	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,417	2,417	131,501	133,918	14.00
15.00	01500	PHARMACY	554,662	1,786,381	2,341,043	-1,348,007	993,036	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	1,741,250	1,461,689	3,202,939	-205,905	2,997,034	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
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	893,141	1,469,179	2,362,320	-617,851	1,744,469	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	1,034,417	1,141,733	2,176,150	-921,795	1,254,355	54.00
60.00	06000	LABORATORY	630	2,357,816	2,358,446	-520	2,357,926	60.00
65.00	06500	RESPIRATORY THERAPY	471,592	219,701	691,293	-72,251	619,042	65.00
66.00	06600	PHYSICAL THERAPY	513,525	64,193	577,718	-734	576,984	66.00
67.00	06700	OCCUPATIONAL THERAPY	93,938	0	93,938	0	93,938	67.00
68.00	06800	SPEECH PATHOLOGY	18,788	0	18,788	0	18,788	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,885	3,885	-2,688	1,197	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	65,063	65,063	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	23,421	23,421	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,693,462	1,693,462	73.00
76.00	03160	CARDIOPULMONARY	151,108	165,811	316,919	-73,778	243,141	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	692,816	662,920	1,355,736	-404,673	951,063	90.01
90.02	09002	JAY FAMILY MEDICINE	831,355	660,885	1,492,240	-436,095	1,056,145	90.02
90.03	09003	WOUND CLINIC	0	668	668	-667	1	90.03
90.04	09004	OP ORTHO CLINIC	0	627	627	0	627	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	338,101	277,563	615,664	-211,150	404,514	90.05
90.06	09006	INFUSION CLINIC	94,046	34,323	128,369	-8,084	120,285	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	286,345	145,695	432,040	-95,558	336,482	90.07
91.00	09100	EMERGENCY	1,394,565	2,047,036	3,441,601	-283,240	3,158,361	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	92,012	61,146	153,158	-44,069	109,089	93.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,885,388	27,893,099	40,778,487	64,187	40,842,674	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	124,399	92,440	216,839	-64,187	152,652	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT	0	-30	-30	0	-30	194.00
194.02	07952	WEST JAY CLINIC	0	0	0	0	0	194.02
194.03	07953	JAY MERIDIAN URGENT CARE	0	0	0	0	0	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	13,009,787	27,985,509	40,995,296	0	40,995,296	200.00

		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	-369,550	816,353	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MOB	-75,227	0	1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT-POB	-62,070	-27,040	1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT-WJ	-9,433	0	1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT-INTEREST	0	0	1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP	321,000	1,710,472	2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB	0	29,787	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	-961,181	2,047,123	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,277,813	8,748,016	5.00
7.00	00700	OPERATION OF PLANT	-88,495	2,812,070	7.00
7.01	00701	OPERATION OF PLANT - MOB	0	43,244	7.01
7.02	00702	OPERATION OF PLANT - POB	0	51,211	7.02
7.03	00703	OPERATION OF PLANT - WJ	0	0	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	0	76,763	8.00
9.00	00900	HOUSEKEEPING	0	831,899	9.00
10.00	01000	DIETARY	9,012	320,442	10.00
11.00	01100	CAFETERIA	-105	337,120	11.00
13.00	01300	NURSING ADMINISTRATION	142,927	1,721,938	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	133,918	14.00
15.00	01500	PHARMACY	49,465	1,042,501	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	-751,671	2,245,363	30.00
40.00	04000	SUBPROVIDER - IPF	0	0	40.00
43.00	04300	NURSERY	0	0	43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	-319,269	1,425,200	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	58,116	1,312,471	54.00
60.00	06000	LABORATORY	0	2,357,926	60.00
65.00	06500	RESPIRATORY THERAPY	15,663	634,705	65.00
66.00	06600	PHYSICAL THERAPY	-10,370	566,614	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	93,938	67.00
68.00	06800	SPEECH PATHOLOGY	0	18,788	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,197	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	65,063	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	23,421	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,693,462	73.00
76.00	03160	CARDIOPULMONARY	28,813	271,954	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	-33,180	917,883	90.01
90.02	09002	JAY FAMILY MEDICINE	-88,479	967,666	90.02
90.03	09003	WOUND CLINIC	0	1	90.03
90.04	09004	OP ORTHO CLINIC	0	627	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	-16,590	387,924	90.05
90.06	09006	INFUSION CLINIC	0	120,285	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	336,482	90.07
91.00	09100	EMERGENCY	-8,884	3,149,477	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
93.00	04950	OUTPATIENT PSYCH	0	109,089	93.00
		OTHER REIMBURSABLE COST CENTERS			
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	102.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-3,447,321	37,395,353	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-130	152,522	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	VACANT	0	-30	194.00
194.02	07952	WEST JAY CLINIC	0	0	194.02
194.03	07953	JAY MERIDIAN URGENT CARE	0	0	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-3,447,451	37,547,845	200.00

RECLASSIFICATIONS | Provider CCN: 15-1320 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-6 | Date/Time Prepared: 5/26/2023 12:02 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA				
1.00	CAFETERIA	11.00	190,522	146,703	1.00
	0		190,522	146,703	
	B - DRUGS RECLASS				
1.00	PHARMACY	15.00	0	82,012	1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,693,462	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
	0		0	1,775,474	
	C - SUPPLIES/IMPLANTS				
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	131,504	1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	65,063	2.00
3.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	23,421	3.00
4.00	ADMINISTRATIVE & GENERAL	5.00	0	12,711	4.00
5.00	HOUSEKEEPING	9.00	0	1,208	5.00
6.00	DIETARY	10.00	0	94	6.00
7.00	NURSING ADMINISTRATION	13.00	0	50	7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	614	8.00
9.00	CARDIOPULMONARY	76.00	0	118	9.00
10.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	28	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
	0		0	234,811	
	D - LAUNDRY				
1.00	LAUNDRY & LINEN SERVICE	8.00	0	75,076	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
	0		0	75,076	
	E - DEPRECIATION				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,154,745	1.00
2.00	CAP REL COSTS-BLDG & FIXT-MOB	1.01	0	75,227	2.00
3.00	CAP REL COSTS-BLDG & FIXT-POB	1.02	0	35,030	3.00
4.00	CAP REL COSTS-BLDG & FIXT-WJ	1.03	0	9,433	4.00
5.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,383,944	5.00
6.00	CAP REL COSTS-MVBLE EQUIP - MOB	2.01	0	29,787	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

RECLASSIFICATIONS | Provider CCN: 15-1320 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-6 | Date/Time Prepared: 5/26/2023 12:02 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
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
	0		0	2,688,166	
	G - PROPERTY INSURANCE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	31,158	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	5,528	2.00
	0		0	36,686	
	H - HOUSEKEEPING SUPPLIES				
1.00	HOUSEKEEPING	9.00	0	2,755	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
	0		0	2,755	
	J - EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,987,374	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
	0		0	2,987,374	
	O - PREMIUM WAGES				
1.00	ADULTS & PEDIATRICS	30.00	121,463	9,262	1.00
2.00	RESPIRATORY THERAPY	65.00	21,485	1,638	2.00
	0		142,948	10,900	
	P - EMPLOYEE BONUS				
1.00	ADULTS & PEDIATRICS	30.00	127,000	9,716	1.00
2.00	OPERATING ROOM	50.00	129,000	9,869	2.00
3.00	RESPIRATORY THERAPY	65.00	48,000	3,672	3.00
4.00	FAMILY PRACTICE OF JAY COUNTY	90.01	16,000	1,224	4.00
5.00	JAY FAMILY MEDICINE	90.02	38,000	2,907	5.00
6.00	JAY FAMILY FIRST HEALTH CARE	90.05	10,000	765	6.00
7.00	INFUSION CLINIC	90.06	16,000	1,224	7.00
8.00	HEALTH BEGINNINGS PROGRAM	90.07	28,000	2,142	8.00
9.00	EMERGENCY	91.00	154,000	11,780	9.00
	TOTALS		566,000	43,299	
500.00	Grand Total: Increases		899,470	8,001,244	500.00

	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	190,522	146,703	0	1.00
	0		190,522	146,703		
	B - DRUGS RECLASS					
1.00	PHARMACY	15.00	0	1,208,085	0	1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	9,046	0	2.00
3.00	HOUSEKEEPING	9.00	0	7	0	3.00
4.00	DIETARY	10.00	0	6	0	4.00
5.00	NURSING ADMINISTRATION	13.00	0	79	0	5.00
6.00	ADULTS & PEDIATRICS	30.00	0	17,929	0	6.00
7.00	OPERATING ROOM	50.00	0	22,994	0	7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	84,857	0	8.00
9.00	RESPIRATORY THERAPY	65.00	0	156	0	9.00
10.00	PHYSICAL THERAPY	66.00	0	33	0	10.00
11.00	CARDIOPULMONARY	76.00	0	6,344	0	11.00
12.00	FAMILY PRACTICE OF JAY COUNTY	90.01	0	147,584	0	12.00
13.00	JAY FAMILY MEDICINE	90.02	0	136,043	0	13.00
14.00	JAY FAMILY FIRST HEALTH CARE	90.05	0	76,093	0	14.00
15.00	INFUSION CLINIC	90.06	0	7,889	0	15.00
16.00	HEALTH BEGINNINGS PROGRAM	90.07	0	407	0	16.00
17.00	EMERGENCY	91.00	0	57,922	0	17.00
	0		0	1,775,474		
	C - SUPPLIES/IMPLANTS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	134	0	1.00
2.00	OPERATION OF PLANT	7.00	0	4,207	0	2.00
3.00	OPERATION OF PLANT - MOB	7.01	0	102	0	3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	0	39	0	4.00
5.00	PHARMACY	15.00	0	898	0	5.00
6.00	ADULTS & PEDIATRICS	30.00	0	39,519	0	6.00
7.00	OPERATING ROOM	50.00	0	92,399	0	7.00
8.00	LABORATORY	60.00	0	418	0	8.00
9.00	RESPIRATORY THERAPY	65.00	0	13,392	0	9.00
10.00	PHYSICAL THERAPY	66.00	0	63	0	10.00
11.00	ELECTROCARDIOLOGY	69.00	0	2,688	0	11.00
12.00	FAMILY PRACTICE OF JAY COUNTY	90.01	0	7,792	0	12.00
13.00	JAY FAMILY MEDICINE	90.02	0	3,578	0	13.00
14.00	WOUND CLINIC	90.03	0	76	0	14.00
15.00	JAY FAMILY FIRST HEALTH CARE	90.05	0	6,813	0	15.00
16.00	INFUSION CLINIC	90.06	0	3,490	0	16.00
17.00	HEALTH BEGINNINGS PROGRAM	90.07	0	230	0	17.00
18.00	EMERGENCY	91.00	0	58,945	0	18.00
19.00	OUTPATIENT PSYCH	93.00	0	28	0	19.00
	0		0	234,811		
	D - LAUNDRY					
1.00	OPERATION OF PLANT - POB	7.02	0	30	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	0	24,524	0	2.00
3.00	OPERATING ROOM	50.00	0	16,993	0	3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	10,615	0	4.00
5.00	PHYSICAL THERAPY	66.00	0	624	0	5.00
6.00	FAMILY PRACTICE OF JAY COUNTY	90.01	0	1,260	0	6.00
7.00	JAY FAMILY MEDICINE	90.02	0	297	0	7.00
8.00	JAY FAMILY FIRST HEALTH CARE	90.05	0	443	0	8.00
9.00	EMERGENCY	91.00	0	20,032	0	9.00
10.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	258	0	10.00
	0		0	75,076		
	E - DEPRECIATION					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,308	9	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	66,456	9	2.00
3.00	OPERATION OF PLANT	7.00	0	1,173,403	9	3.00
4.00	OPERATION OF PLANT - MOB	7.01	0	75,227	9	4.00
5.00	OPERATION OF PLANT - POB	7.02	0	35,030	9	5.00
6.00	DIETARY	10.00	0	17,362	9	6.00
7.00	PHARMACY	15.00	0	86,023	0	7.00
8.00	ADULTS & PEDIATRICS	30.00	0	85,772	0	8.00
9.00	OPERATING ROOM	50.00	0	373,694	0	9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	600,666	0	10.00
11.00	RESPIRATORY THERAPY	65.00	0	21,889	0	11.00
12.00	CARDIOPULMONARY	76.00	0	23,512	0	12.00
13.00	FAMILY PRACTICE OF JAY COUNTY	90.01	0	6,275	0	13.00
14.00	WOUND CLINIC	90.03	0	591	0	14.00

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
15.00	JAY FAMILY FIRST HEALTH CARE	90.05	0	1,579	0		15.00
16.00	INFUSION CLINIC	90.06	0	445	0		16.00
17.00	HEALTH BEGINNINGS PROGRAM	90.07	0	28,978	0		17.00
18.00	EMERGENCY	91.00	0	66,366	0		18.00
19.00	OUTPATIENT PSYCH	93.00	0	13,158	0		19.00
20.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	9,432	0		20.00
	0		0	2,688,166			
	G - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	36,686	12		1.00
2.00		0.00	0	0	12		2.00
	0		0	36,686			
	H - HOUSEKEEPING SUPPLIES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	43	0		1.00
2.00	OPERATION OF PLANT	7.00	0	7	0		2.00
3.00	DIETARY	10.00	0	18	0		3.00
4.00	NURSING ADMINISTRATION	13.00	0	2	0		4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	3	0		5.00
6.00	PHARMACY	15.00	0	403	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	797	0		7.00
8.00	OPERATING ROOM	50.00	0	391	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	51	0		9.00
10.00	LABORATORY	60.00	0	5	0		10.00
11.00	RESPIRATORY THERAPY	65.00	0	4	0		11.00
12.00	PHYSICAL THERAPY	66.00	0	14	0		12.00
13.00	CARDIOPULMONARY	76.00	0	9	0		13.00
14.00	FAMILY PRACTICE OF JAY COUNTY	90.01	0	118	0		14.00
15.00	JAY FAMILY MEDICINE	90.02	0	217	0		15.00
16.00	JAY FAMILY FIRST HEALTH CARE	90.05	0	36	0		16.00
17.00	INFUSION CLINIC	90.06	0	34	0		17.00
18.00	HEALTH BEGINNINGS PROGRAM	90.07	0	2	0		18.00
19.00	EMERGENCY	91.00	0	601	0		19.00
	0		0	2,755			
	J - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	112,697	0		1.00
2.00	OPERATION OF PLANT	7.00	0	140,647	0		2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	10,513	0		3.00
4.00	HOUSEKEEPING	9.00	0	119,884	0		4.00
5.00	DIETARY	10.00	0	144,096	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	215,139	0		6.00
7.00	PHARMACY	15.00	0	134,610	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	304,805	0		8.00
9.00	OPERATING ROOM	50.00	0	250,249	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	226,220	0		10.00
11.00	LABORATORY	60.00	0	97	0		11.00
12.00	RESPIRATORY THERAPY	65.00	0	111,605	0		12.00
13.00	CARDIOPULMONARY	76.00	0	44,031	0		13.00
14.00	FAMILY PRACTICE OF JAY COUNTY	90.01	0	258,868	0		14.00
15.00	JAY FAMILY MEDICINE	90.02	0	336,867	0		15.00
16.00	JAY FAMILY FIRST HEALTH CARE	90.05	0	136,951	0		16.00
17.00	INFUSION CLINIC	90.06	0	13,450	0		17.00
18.00	HEALTH BEGINNINGS PROGRAM	90.07	0	96,083	0		18.00
19.00	EMERGENCY	91.00	0	245,154	0		19.00
20.00	OUTPATIENT PSYCH	93.00	0	30,883	0		20.00
21.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	54,525	0		21.00
	0		0	2,987,374			
	O - PREMIUM WAGES						
1.00	NURSING ADMINISTRATION	13.00	142,948	10,900	0		1.00
2.00		0.00	0	0	0		2.00
	0		142,948	10,900			
	P - EMPLOYEE BONUS						
1.00	ADMINISTRATIVE & GENERAL	5.00	566,000	43,299	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
	TOTALS		566,000	43,299			
500.00	Grand Total: Decreases		899,470	8,001,244			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1320 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part I | Date/Time Prepared: 5/26/2023 12:02 pm

		Beginning Balances	Acquisitions Purchases	Donation	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	989,148	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	18,977,852	0	0	0	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	9,871,745	109,271	0	109,271	157,785	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	29,838,745	109,271	0	109,271	157,785	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	29,838,745	109,271	0	109,271	157,785	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	989,148	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	18,977,852	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	9,823,231	1,519,909	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	29,790,231	1,519,909	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	29,790,231	1,519,909	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1320 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part II Date/Time Prepared: 5/26/2023 12:02 pm

	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	0	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)	0	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	0	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	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1320 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part III | Date/Time Prepared: 5/26/2023 12:02 pm

	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	29,790,231	0	29,790,231	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)	29,790,231	0	29,790,231	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	785,195	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	-27,040	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	1,704,944	0	2.00
2.01	CAP REL COSTS-MVBLE EQUIP - MOB	0	0	0	29,787	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	2,492,886	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	31,158	0	0	816,353	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	-27,040	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	5,528	0	0	1,710,472	2.00
2.01	CAP REL COSTS-MVBLE EQUIP - MOB	0	0	0	0	29,787	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	36,686	0	0	2,529,572	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1320 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8 | Date/Time Prepared: 5/26/2023 12:02 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	50,422	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)	B	-35,315	CAP REL COSTS-BLDG & FIXT	1.00	9	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	-143,416			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	2,682,543			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-105	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

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1320 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8 | Date/Time Prepared: 5/26/2023 12:02 pm

	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	
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
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	-2,987,461	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
33.01	HOSPITAL ASSESSMENT FEES	A	-1,493,959	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	MISCELLANEOUS INCOME	B	4,994	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	MISCELLANEOUS INCOME	B	-641	PHARMACY	15.00	0	33.03
33.04	CONTRACTED HOSPITALIST	A	-751,671	ADULTS & PEDIATRICS	30.00	0	33.04
33.05	CONTRACTED CRNA	A	-322,010	OPERATING ROOM	50.00	0	33.05
33.06	MEDICARE DEPRECIATION EXPENSE	A	-480,199	CAP REL COSTS-BLDG & FIXT	1.00	9	33.06
33.07	MEDICARE DEPRECIATION EXPENSE	A	-75,227	CAP REL COSTS-BLDG & FIXT-MOB	1.01	9	33.07
33.08	MEDICARE DEPRECIATION EXPENSE	A	-35,030	CAP REL COSTS-BLDG & FIXT-POB	1.02	9	33.08
33.09	MEDICARE DEPRECIATION EXPENSE	A	-9,433	CAP REL COSTS-BLDG & FIXT-WJ	1.03	9	33.09
33.10	MEDICARE DEPRECIATION EXPENSE	A	188,906	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.10
33.11	MEDICARE DEPRECIATION EXPENSE	A	0	CAP REL COSTS-MVBLE EQUIP - MOB	2.01	9	33.11
33.12	MISCELLANEOUS INCOME	B	-976	EMERGENCY	91.00	0	33.12
33.13	MISCELLANEOUS INCOME	B	0	LABORATORY	60.00	0	33.13
33.14	MISCELLANEOUS INCOME	B	-27,040	CAP REL COSTS-BLDG & FIXT-POB	1.02	9	33.14
33.15	MISC NON-ALLOWABLE	A	-482	PHYSICAL THERAPY	66.00	0	33.15
33.16	MISC NON-ALLOWABLE	A	-130	PHYSICIANS' PRIVATE OFFICES	192.00	0	33.16
33.17	MISC NON-ALLOWABLE	A	-11,761	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	MISC NON-ALLOWABLE	A	-319	DIETARY	10.00	0	33.18
33.19	MISCELLANEOUS INCOME	B	0	OUTPATIENT PSYCH	93.00	0	33.19
33.20	MISCELLANEOUS INCOME	B	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.20
33.21	MISCELLANEOUS INCOME	B	0	JAY FAMILY MEDICINE	90.02	0	33.21
33.22	MISC NON-ALLOWABLE	A	-141	CARDIOPULMONARY	76.00	0	33.22
33.23	MISC NON-ALLOWABLE	A	1,000	NURSING ADMINISTRATION	13.00	0	33.23

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1320 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8 | Date/Time Prepared: 5/26/2023 12:02 pm

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		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.)		-3,447,451				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 01/01/2022 To 12/31/2022 | Worksheet A-8-1 | Date/Time Prepared: 5/26/2023 12:02 pm

	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	95,542	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	132,094	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	1,966,772	0	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	5,764,402	5,855,224	3.01
4.00	7.00	OPERATION OF PLANT	HOME OFFICE	0	29,008	4.00
4.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	RELATED PARTY	59,508	0	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	RELATED PARTY	750,376	436,641	4.02
4.03	7.00	OPERATION OF PLANT	RELATED PARTY	110,217	169,704	4.03
4.04	10.00	DIETARY	RELATED PARTY	9,331	0	4.04
4.05	13.00	NURSING ADMINISTRATION	RELATED PARTY	354,758	212,831	4.05
4.06	15.00	PHARMACY	RELATED PARTY	206,799	156,693	4.06
4.07	54.00	RADIOLOGY-DIAGNOSTIC	RELATED PARTY	151,432	93,316	4.07
4.08	65.00	RESPIRATORY THERAPY	RELATED PARTY	37,113	21,450	4.08
4.09	66.00	PHYSICAL THERAPY	RELATED PARTY	39,611	49,499	4.09
4.10	76.00	CARDIOPULMONARY	RELATED PARTY	51,202	22,248	4.10
4.11	4.00	EMPLOYEE BENEFITS DEPARTMENT	SHARED EMPLOYEES	13,510	13,510	4.11
4.12	5.00	ADMINISTRATIVE & GENERAL	SHARED EMPLOYEES	6,962	6,962	4.12
4.13	10.00	DIETARY	SHARED EMPLOYEES	38,353	38,353	4.13
4.14	13.00	NURSING ADMINISTRATION	SHARED EMPLOYEES	39,214	39,214	4.14
4.15	15.00	PHARMACY	SHARED EMPLOYEES	106,695	106,695	4.15
4.16	30.00	ADULTS & PEDIATRICS	SHARED EMPLOYEES	764,726	764,726	4.16
4.17	50.00	OPERATING ROOM	SHARED EMPLOYEES	18,745	18,745	4.17
4.18	60.00	LABORATORY	SHARED EMPLOYEES	2,075,412	2,075,412	4.18
4.19	66.00	PHYSICAL THERAPY	SHARED EMPLOYEES	513,525	513,525	4.19
4.20	67.00	OCCUPATIONAL THERAPY	SHARED EMPLOYEES	93,938	93,938	4.20
4.21	68.00	SPEECH PATHOLOGY	SHARED EMPLOYEES	18,788	18,788	4.21
4.22	76.00	CARDIOPULMONARY	SHARED EMPLOYEES	25,996	25,996	4.22
4.23	90.01	FAMILY PRACTICE OF JAY COUNT	SHARED EMPLOYEES	33,180	33,180	4.23
4.24	90.02	JAY FAMILY MEDICINE	SHARED EMPLOYEES	88,479	88,479	4.24
4.25	90.05	JAY FAMILY FIRST HEALTH CARE	SHARED EMPLOYEES	16,590	16,590	4.25
4.26	91.00	EMERGENCY	SHARED EMPLOYEES	1,393,555	1,393,555	4.26
4.27	0.00			0	0	4.27
4.28	0.00			0	0	4.28
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			14,976,825	12,294,282	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.

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

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.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-1320	Period: From 01/01/2022 To 12/31/2022	Worksheet A-8-1 Date/Time Prepared: 5/26/2023 12:02 pm

				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 01/01/2022 To 12/31/2022 | Worksheet A-8-1 | Date/Time Prepared: 5/26/2023 12:02 pm

	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	95,542	9		1.00
2.00	132,094	9		2.00
3.00	1,966,772	0		3.00
3.01	-90,822	0		3.01
4.00	-29,008	0		4.00
4.01	59,508	0		4.01
4.02	313,735	0		4.02
4.03	-59,487	0		4.03
4.04	9,331	0		4.04
4.05	141,927	0		4.05
4.06	50,106	0		4.06
4.07	58,116	0		4.07
4.08	15,663	0		4.08
4.09	-9,888	0		4.09
4.10	28,954	0		4.10
4.11	0	0		4.11
4.12	0	0		4.12
4.13	0	0		4.13
4.14	0	0		4.14
4.15	0	0		4.15
4.16	0	0		4.16
4.17	0	0		4.17
4.18	0	0		4.18
4.19	0	0		4.19
4.20	0	0		4.20
4.21	0	0		4.21
4.22	0	0		4.22
4.23	0	0		4.23
4.24	0	0		4.24
4.25	0	0		4.25
4.26	0	0		4.26
4.27	0	0		4.27
4.28	0	0		4.28
5.00	2,682,543			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 01/01/2022 To 12/31/2022 | Worksheet A-8-2 Date/Time Prepared: 5/26/2023 12:02 pm

	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	50.00	OPERATING ROOM	-2,741	-2,741	0	0	0	1.00
2.00	90.01	FAMILY PRACTICE OF JAY COUNTY	33,180	33,180	0	0	0	2.00
3.00	90.02	JAY FAMILY MEDICINE	88,479	88,479	0	0	0	3.00
4.00	90.05	JAY FAMILY FIRST HEALTH CARE	16,590	16,590	0	0	0	4.00
5.00	91.00	EMERGENCY	1,273,293	7,908	1,265,385	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,408,801	143,416	1,265,385		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	50.00	OPERATING ROOM	0	0	0	0	0	1.00
2.00	90.01	FAMILY PRACTICE OF JAY COUNTY	0	0	0	0	0	2.00
3.00	90.02	JAY FAMILY MEDICINE	0	0	0	0	0	3.00
4.00	90.05	JAY FAMILY FIRST HEALTH CARE	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			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	50.00	OPERATING ROOM	0	0	0	-2,741	1.00
2.00	90.01	FAMILY PRACTICE OF JAY COUNTY	0	0	0	33,180	2.00
3.00	90.02	JAY FAMILY MEDICINE	0	0	0	88,479	3.00
4.00	90.05	JAY FAMILY FIRST HEALTH CARE	0	0	0	16,590	4.00
5.00	91.00	EMERGENCY	0	0	0	7,908	5.00
6.00	0.00		0	0	0	0	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	0	0	143,416	200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1320 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I Date/Time Prepared: 5/26/2023 12:02 pm

		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	816,353	816,353				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	-27,040	0	0	-27,040		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	1,710,472					2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB	29,787					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	2,047,123	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,748,016	93,164	0	0	0	5.00
7.00	00700	OPERATION OF PLANT	2,812,070	185,083	0	0	0	7.00
7.01	00701	OPERATION OF PLANT - MOB	43,244	0	0	0	0	7.01
7.02	00702	OPERATION OF PLANT - POB	51,211	0	0	0	0	7.02
7.03	00703	OPERATION OF PLANT - WJ	0	0	0	0	0	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	76,763	5,913	0	0	0	8.00
9.00	00900	HOUSEKEEPING	831,899	5,993	0	0	0	9.00
10.00	01000	DIETARY	320,442	20,267	0	0	0	10.00
11.00	01100	CAFETERIA	337,120	22,258	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,721,938	9,258	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	133,918	0	0	0	0	14.00
15.00	01500	PHARMACY	1,042,501	9,954	0	0	0	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	2,245,363	98,101	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
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,425,200	39,738	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	1,312,471	48,398	0	0	0	54.00
60.00	06000	LABORATORY	2,357,926	26,031	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	634,705	7,277	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	566,614	32,969	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	93,938	5,146	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	18,788	119	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,197	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	65,063	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	23,421	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,693,462	0	0	0	0	73.00
76.00	03160	CARDIOPULMONARY	271,954	0	0	0	0	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	917,883	0	0	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	967,666	0	0	0	0	90.02
90.03	09003	WOUND CLINIC	1	0	0	0	0	90.03
90.04	09004	OP ORTHO CLINIC	627	0	0	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	387,924	50,817	0	0	0	90.05
90.06	09006	INFUSION CLINIC	120,285	6,152	0	0	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	336,482	37,011	0	0	0	90.07
91.00	09100	EMERGENCY	3,149,477	47,483	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	109,089	15,638	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	37,395,353	766,770	0	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7,675	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	152,522	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT	-30	25,931	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	15,977	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1320 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 5/26/2023 12:02 pm

	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	
201.00	Negative Cost Centers		0	0	-27,040	0	201.00
202.00	TOTAL (sum lines 118 through 201)	37,547,845	816,353	0	-27,040	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1320 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I Date/Time Prepared: 5/26/2023 12:02 pm

		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		1,710,472				2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB		0	29,787			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	195,202	1,943	0	0	5.00
7.00	00700	OPERATION OF PLANT	0	387,795	0	0	0	7.00
7.01	00701	OPERATION OF PLANT - MOB	0	0	679	0	0	7.01
7.02	00702	OPERATION OF PLANT - POB	0	0	0	0	0	7.02
7.03	00703	OPERATION OF PLANT - WJ	0	0	0	0	0	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	0	12,389	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	12,556	0	0	0	9.00
10.00	01000	DIETARY	0	42,465	0	0	0	10.00
11.00	01100	CAFETERIA	0	46,637	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	19,397	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	20,857	0	0	0	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	0	205,547	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
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	83,262	1,253	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	101,407	0	0	0	54.00
60.00	06000	LABORATORY	0	54,541	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	15,247	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	69,079	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	10,783	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	250	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	2,076	0	0	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		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	11,958	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	11,689	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	106,476	189	0	0	90.05
90.06	09006	INFUSION CLINIC	0	12,890	0	0	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	77,547	0	0	0	90.07
91.00	09100	EMERGENCY	0	99,488	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	0	32,767	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,606,582	29,787	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	16,081	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	VACANT	0	54,333	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	33,476	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	1,710,472	29,787	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1320 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 5/26/2023 12:02 pm

		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	2,047,123					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	63,227	9,101,552	9,101,552			5.00
7.00	00700	OPERATION OF PLANT	84,946	3,469,894	1,109,159	4,579,053		7.00
7.01	00701	OPERATION OF PLANT - MOB	0	43,923	14,040	25,910	83,873	7.01
7.02	00702	OPERATION OF PLANT - POB	0	51,211	16,370	32,126	0	7.02
7.03	00703	OPERATION OF PLANT - WJ	0	0	0	0	0	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	5,922	100,987	32,281	31,029	0	8.00
9.00	00900	HOUSEKEEPING	70,039	920,487	294,236	31,447	0	9.00
10.00	01000	DIETARY	27,324	410,498	131,217	106,355	0	10.00
11.00	01100	CAFETERIA	30,003	436,018	139,374	116,802	0	11.00
13.00	01300	NURSING ADMINISTRATION	185,263	1,935,856	618,800	48,581	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	133,918	42,807	0	0	14.00
15.00	01500	PHARMACY	87,348	1,160,660	371,007	52,237	0	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	313,335	2,862,346	914,955	514,797	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
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	160,966	1,710,419	546,739	590,745	3,869	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	162,899	1,625,175	519,490	253,977	0	54.00
60.00	06000	LABORATORY	99	2,438,597	779,502	136,600	0	60.00
65.00	06500	RESPIRATORY THERAPY	85,208	742,437	237,321	38,185	0	65.00
66.00	06600	PHYSICAL THERAPY	80,869	749,531	239,589	173,009	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	14,793	124,660	39,848	27,007	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,959	22,116	7,069	627	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,197	383	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	65,063	20,798	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	23,421	7,487	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,693,462	541,319	0	0	73.00
76.00	03160	CARDIOPULMONARY	23,796	297,826	95,201	79,191	6,409	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	111,624	1,041,465	332,906	456,187	36,923	90.01
90.02	09002	JAY FAMILY MEDICINE	136,905	1,116,260	356,815	445,896	36,089	90.02
90.03	09003	WOUND CLINIC	0	1	0	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0	627	200	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	54,819	600,225	191,863	273,984	583	90.05
90.06	09006	INFUSION CLINIC	17,330	156,657	50,076	32,283	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	49,503	500,543	160,000	194,218	0	90.07
91.00	09100	EMERGENCY	243,866	3,540,314	1,131,660	249,171	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0				92.00
93.00	04950	OUTPATIENT PSYCH	14,490	171,984	54,975	82,065	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,027,533	37,249,330	8,997,487	3,992,429	83,873	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	23,756	7,594	40,275	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	19,590	172,112	55,016	326,430	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT	0	80,234	25,647	136,078	0	194.00
194.02	07952	WEST JAY CLINIC	0	0	0	0	0	194.02
194.03	07953	JAY MERIDIAN URGENT CARE	0	49,453	15,808	83,841	0	194.03
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	-27,040	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,047,123	37,547,845	9,101,552	4,579,053	83,873	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1320 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I Date/Time Prepared: 5/26/2023 12:02 pm

		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	99,707					7.02
7.03	00703	OPERATION OF PLANT - WJ	0	0				7.03
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	164,297			8.00
9.00	00900	HOUSEKEEPING	0	0	0	1,246,170		9.00
10.00	01000	DIETARY	0	0	0	29,726	677,796	10.00
11.00	01100	CAFETERIA	0	0	0	32,646	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	13,578	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	14,600	0	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	0	0	164,297	143,887	677,796	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
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	71,537	0	0	165,116	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	70,987	0	54.00
60.00	06000	LABORATORY	0	0	0	38,180	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	10,673	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	48,356	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	7,548	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	175	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	22,134	0	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
	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	127,505	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	0	124,629	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	76,579	0	90.05
90.06	09006	INFUSION CLINIC	0	0	0	9,023	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	0	0	54,284	0	90.07
91.00	09100	EMERGENCY	0	0	0	69,644	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	0	0	0	22,937	0	93.00
	OTHER REIMBURSABLE COST CENTERS							
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	71,537	0	164,297	1,082,207	677,796	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	11,257	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	28,170	0	0	91,238	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT	0	0	0	38,034	0	194.00
194.02	07952	WEST JAY CLINIC	0	0	0	0	0	194.02
194.03	07953	JAY MERIDIAN URGENT CARE	0	0	0	23,434	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)	99,707	0	164,297	1,246,170	677,796	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1320 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I Date/Time Prepared: 5/26/2023 12:02 pm

		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	724,840					11.00
13.00	01300	NURSING ADMINISTRATION	55,352	2,672,167				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	176,725			14.00
15.00	01500	PHARMACY	28,399	0	1,231	1,628,134		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	103,801	787,065	27,251	11,885	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
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	51,761	424,905	21,276	7,181	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	57,030	0	3,820	5,029	0	54.00
60.00	06000	LABORATORY	56,284	0	289	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	25,507	0	9,619	0	0	65.00
66.00	06600	PHYSICAL THERAPY	18,699	0	120	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,275	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,026	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	1,843	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	44,582	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	16,049	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,552,997	0	73.00
76.00	03160	CARDIOPULMONARY	9,699	4,954	156	126	0	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	74,471	203,096	5,423	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	84,496	273,546	2,830	0	0	90.02
90.03	09003	WOUND CLINIC	0	0	52	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	35,067	72,652	5,006	0	0	90.05
90.06	09006	INFUSION CLINIC	4,756	56,140	2,218	6,141	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	21,637	150,808	174	373	0	90.07
91.00	09100	EMERGENCY	65,424	698,451	34,726	44,402	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	10,819	0	59	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	711,503	2,671,617	176,724	1,628,134	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	13,337	550	1	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT	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	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)	724,840	2,672,167	176,725	1,628,134	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1320 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 5/26/2023 12:02 pm

		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	6,208,080	0	6,208,080		30.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0		40.00
43.00	04300	NURSERY	0	0	0	0		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,593,548	0	3,593,548		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,535,508	0	2,535,508		54.00
60.00	06000	LABORATORY	0	3,449,452	0	3,449,452		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,063,742	0	1,063,742		65.00
66.00	06600	PHYSICAL THERAPY	0	1,229,304	0	1,229,304		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	206,338	0	206,338		67.00
68.00	06800	SPEECH PATHOLOGY	0	31,013	0	31,013		68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,423	0	3,423		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	130,443	0	130,443		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	46,957	0	46,957		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,787,778	0	3,787,778		73.00
76.00	03160	CARDIOPULMONARY	0	515,696	0	515,696		76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0		90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	2,277,976	0	2,277,976		90.01
90.02	09002	JAY FAMILY MEDICINE	0	2,440,561	0	2,440,561		90.02
90.03	09003	WOUND CLINIC	0	53	0	53		90.03
90.04	09004	OP ORTHO CLINIC	0	827	0	827		90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0	1,255,959	0	1,255,959		90.05
90.06	09006	INFUSION CLINIC	0	317,294	0	317,294		90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	1,082,037	0	1,082,037		90.07
91.00	09100	EMERGENCY	0	5,833,792	0	5,833,792		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
93.00	04950	OUTPATIENT PSYCH	0	342,839	0	342,839		93.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0		102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	36,352,620	0	36,352,620		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	82,882	0	82,882		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	686,854	0	686,854		192.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
194.00	07950	VACANT	0	279,993	0	279,993		194.00
194.02	07952	WEST JAY CLINIC	0	0	0	0		194.02
194.03	07953	JAY MERIDIAN URGENT CARE	0	172,536	0	172,536		194.03
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	-27,040	0	-27,040		201.00
202.00		TOTAL (sum lines 118 through 201)	0	37,547,845	0	37,547,845		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1320 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II Date/Time Prepared: 5/26/2023 12:02 pm

		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	93,164	0	0	0	5.00
7.00	00700	OPERATION OF PLANT	0	185,083	0	0	0	7.00
7.01	00701	OPERATION OF PLANT - MOB	0	0	0	0	0	7.01
7.02	00702	OPERATION OF PLANT - POB	0	0	0	0	0	7.02
7.03	00703	OPERATION OF PLANT - WJ	0	0	0	0	0	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	0	5,913	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	5,993	0	0	0	9.00
10.00	01000	DIETARY	0	20,267	0	0	0	10.00
11.00	01100	CAFETERIA	0	22,258	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	9,258	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	9,954	0	0	0	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	0	98,101	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
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	39,738	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	48,398	0	0	0	54.00
60.00	06000	LABORATORY	0	26,031	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	7,277	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	32,969	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5,146	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	119	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
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		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	50,817	0	0	0	90.05
90.06	09006	INFUSION CLINIC	0	6,152	0	0	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	37,011	0	0	0	90.07
91.00	09100	EMERGENCY	0	47,483	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	0	15,638	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	766,770	0	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7,675	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	VACANT	0	25,931	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	15,977	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	-27,040	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1320 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II Date/Time Prepared: 5/26/2023 12:02 pm

	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	
202.00	TOTAL (sum lines 118 through 201)	0	816,353	0	-27,040	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1320 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II | Date/Time Prepared: 5/26/2023 12:02 pm

		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	195,202	1,943	0	0	5.00
7.00	00700	OPERATION OF PLANT	0	387,795	0	0	0	7.00
7.01	00701	OPERATION OF PLANT - MOB	0	0	679	0	0	7.01
7.02	00702	OPERATION OF PLANT - POB	0	0	0	0	0	7.02
7.03	00703	OPERATION OF PLANT - WJ	0	0	0	0	0	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	0	12,389	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	12,556	0	0	0	9.00
10.00	01000	DIETARY	0	42,465	0	0	0	10.00
11.00	01100	CAFETERIA	0	46,637	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	19,397	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	20,857	0	0	0	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	0	205,547	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
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	83,262	1,253	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	101,407	0	0	0	54.00
60.00	06000	LABORATORY	0	54,541	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	15,247	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	69,079	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	10,783	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	250	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	2,076	0	0	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		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	11,958	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	11,689	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	106,476	189	0	0	90.05
90.06	09006	INFUSION CLINIC	0	12,890	0	0	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	77,547	0	0	0	90.07
91.00	09100	EMERGENCY	0	99,488	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	0	32,767	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,606,582	29,787	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	16,081	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	VACANT	0	54,333	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	33,476	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	1,710,472	29,787	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1320 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II | Date/Time Prepared: 5/26/2023 12:02 pm

		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	290,309	0	290,309			5.00
7.00	00700	OPERATION OF PLANT	572,878	0	35,379	608,257		7.00
7.01	00701	OPERATION OF PLANT - MOB	679	0	448	3,442	4,569	7.01
7.02	00702	OPERATION OF PLANT - POB	0	0	522	4,267	0	7.02
7.03	00703	OPERATION OF PLANT - WJ	0	0	0	0	0	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	18,302	0	1,030	4,122	0	8.00
9.00	00900	HOUSEKEEPING	18,549	0	9,385	4,177	0	9.00
10.00	01000	DIETARY	62,732	0	4,185	14,128	0	10.00
11.00	01100	CAFETERIA	68,895	0	4,446	15,515	0	11.00
13.00	01300	NURSING ADMINISTRATION	28,655	0	19,738	6,453	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	1,365	0	0	14.00
15.00	01500	PHARMACY	30,811	0	11,834	6,939	0	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	303,648	0	29,184	68,383	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
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	124,253	0	17,439	78,473	211	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	149,805	0	16,570	33,737	0	54.00
60.00	06000	LABORATORY	80,572	0	24,864	18,145	0	60.00
65.00	06500	RESPIRATORY THERAPY	22,524	0	7,570	5,072	0	65.00
66.00	06600	PHYSICAL THERAPY	102,048	0	7,642	22,982	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	15,929	0	1,271	3,587	0	67.00
68.00	06800	SPEECH PATHOLOGY	369	0	225	83	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	12	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	663	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	239	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	17,267	0	0	73.00
76.00	03160	CARDIOPULMONARY	2,076	0	3,037	10,519	349	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	11,958	0	10,619	60,597	2,011	90.01
90.02	09002	JAY FAMILY MEDICINE	11,689	0	11,381	59,230	1,966	90.02
90.03	09003	WOUND CLINIC	0	0	0	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0	0	6	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	157,482	0	6,120	36,395	32	90.05
90.06	09006	INFUSION CLINIC	19,042	0	1,597	4,288	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	114,558	0	5,104	25,799	0	90.07
91.00	09100	EMERGENCY	146,971	0	36,094	33,099	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
93.00	04950	OUTPATIENT PSYCH	48,405	0	1,754	10,901	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,403,139	0	286,990	530,333	4,569	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	23,756	0	242	5,350	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	1,755	43,361	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT	80,264	0	818	18,076	0	194.00
194.02	07952	WEST JAY CLINIC	0	0	0	0	0	194.02
194.03	07953	JAY MERIDIAN URGENT CARE	49,453	0	504	11,137	0	194.03
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	-27,040	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,529,572	0	290,309	608,257	4,569	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1320 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II Date/Time Prepared: 5/26/2023 12:02 pm

		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	4,789					7.02
7.03	00703	OPERATION OF PLANT - WJ	0	0				7.03
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	23,454			8.00
9.00	00900	HOUSEKEEPING	0	0	0	32,111		9.00
10.00	01000	DIETARY	0	0	0	766	81,811	10.00
11.00	01100	CAFETERIA	0	0	0	841	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	350	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	376	0	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	0	0	23,454	3,708	81,811	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
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,436	0	0	4,253	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	1,829	0	54.00
60.00	06000	LABORATORY	0	0	0	984	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	275	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,246	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	195	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	5	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	570	0	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		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	3,286	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	0	3,211	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	1,973	0	90.05
90.06	09006	INFUSION CLINIC	0	0	0	233	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	0	0	1,399	0	90.07
91.00	09100	EMERGENCY	0	0	0	1,795	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	0	0	0	591	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,436	0	23,454	27,886	81,811	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	290	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,353	0	0	2,351	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT	0	0	0	980	0	194.00
194.02	07952	WEST JAY CLINIC	0	0	0	0	0	194.02
194.03	07953	JAY MERIDIAN URGENT CARE	0	0	0	604	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)	4,789	0	23,454	32,111	81,811	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1320 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II Date/Time Prepared: 5/26/2023 12:02 pm

		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	89,697					11.00
13.00	01300	NURSING ADMINISTRATION	6,850	62,046				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	1,365			14.00
15.00	01500	PHARMACY	3,514	0	10	53,484		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	12,846	18,273	210	390	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
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,405	9,866	164	236	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	7,057	0	30	165	0	54.00
60.00	06000	LABORATORY	6,965	0	2	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,156	0	74	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,314	0	1	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	900	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	127	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	14	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	346	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	124	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	51,016	0	73.00
76.00	03160	CARDIOPULMONARY	1,200	115	1	4	0	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	9,216	4,716	42	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	10,456	6,352	22	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	4,339	1,687	39	0	0	90.05
90.06	09006	INFUSION CLINIC	589	1,304	17	202	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	2,678	3,502	1	12	0	90.07
91.00	09100	EMERGENCY	8,096	16,218	268	1,459	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	1,339	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	88,047	62,033	1,365	53,484	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	1,650	13	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT	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	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)	89,697	62,046	1,365	53,484	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1320 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II Date/Time Prepared: 5/26/2023 12:02 pm

		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	541,907	0	541,907		30.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0		40.00
43.00	04300	NURSERY	0	0	0	0		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	244,736	0	244,736		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	209,193	0	209,193		54.00
60.00	06000	LABORATORY	0	131,532	0	131,532		60.00
65.00	06500	RESPIRATORY THERAPY	0	38,671	0	38,671		65.00
66.00	06600	PHYSICAL THERAPY	0	136,233	0	136,233		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	21,882	0	21,882		67.00
68.00	06800	SPEECH PATHOLOGY	0	809	0	809		68.00
69.00	06900	ELECTROCARDIOLOGY	0	26	0	26		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,009	0	1,009		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	363	0	363		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	68,283	0	68,283		73.00
76.00	03160	CARDIOPULMONARY	0	17,871	0	17,871		76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0		90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	102,445	0	102,445		90.01
90.02	09002	JAY FAMILY MEDICINE	0	104,307	0	104,307		90.02
90.03	09003	WOUND CLINIC	0	0	0	0		90.03
90.04	09004	OP ORTHO CLINIC	0	6	0	6		90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0	208,067	0	208,067		90.05
90.06	09006	INFUSION CLINIC	0	27,272	0	27,272		90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	153,053	0	153,053		90.07
91.00	09100	EMERGENCY	0	244,000	0	244,000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
93.00	04950	OUTPATIENT PSYCH	0	62,990	0	62,990		93.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0		102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,314,655	0	2,314,655		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	29,638	0	29,638		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	50,483	0	50,483		192.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
194.00	07950	VACANT	0	100,138	0	100,138		194.00
194.02	07952	WEST JAY CLINIC	0	0	0	0		194.02
194.03	07953	JAY MERIDIAN URGENT CARE	0	61,698	0	61,698		194.03
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	-27,040	0	-27,040		201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,529,572	0	2,529,572		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1320 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/26/2023 12:02 pm

		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	82,009					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MOB	0	21,753				1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT-POB	0	0	9,538			1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT-WJ	0	0	0	3,728		1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT-INTEREST	0	0	0	0	82,009	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	9,359	1,419	0	0	9,359	5.00
7.00	00700	OPERATION OF PLANT	18,593	0	0	0	18,593	7.00
7.01	00701	OPERATION OF PLANT - MOB	0	496	0	0	0	7.01
7.02	00702	OPERATION OF PLANT - POB	0	0	615	0	0	7.02
7.03	00703	OPERATION OF PLANT - WJ	0	0	0	0	0	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	594	0	0	0	594	8.00
9.00	00900	HOUSEKEEPING	602	0	0	0	602	9.00
10.00	01000	DIETARY	2,036	0	0	0	2,036	10.00
11.00	01100	CAFETERIA	2,236	0	0	0	2,236	11.00
13.00	01300	NURSING ADMINISTRATION	930	0	0	0	930	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	1,000	0	0	0	1,000	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	9,855	0	0	0	9,855	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
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,992	915	6,402	0	3,992	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	4,862	0	0	0	4,862	54.00
60.00	06000	LABORATORY	2,615	0	0	0	2,615	60.00
65.00	06500	RESPIRATORY THERAPY	731	0	0	0	731	65.00
66.00	06600	PHYSICAL THERAPY	3,312	0	0	0	3,312	66.00
67.00	06700	OCCUPATIONAL THERAPY	517	0	0	0	517	67.00
68.00	06800	SPEECH PATHOLOGY	12	0	0	0	12	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	1,516	0	0	0	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	8,733	0	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0	8,536	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	5,105	138	0	0	5,105	90.05
90.06	09006	INFUSION CLINIC	618	0	0	0	618	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	3,718	0	0	0	3,718	90.07
91.00	09100	EMERGENCY	4,770	0	0	0	4,770	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	1,571	0	0	0	1,571	93.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	77,028	21,753	7,017	0	77,028	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	771	0	0	0	771	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	2,521	3,728	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT	2,605	0	0	0	2,605	194.00
194.02	07952	WEST JAY CLINIC	0	0	0	0	0	194.02
194.03	07953	JAY MERIDIAN URGENT CARE	1,605	0	0	0	1,605	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1320 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/26/2023 12:02 pm

		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	
202.00		Cost to be allocated (per Wkst. B, Part I)	816,353	0	-27,040	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.954432	0.000000	0.000000	0.000000	0.000000	203.00
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 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/26/2023 12:02 pm

		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	82,009					2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB	0	21,753				2.01
2.02	00202	CAP REL COSTS-MVBLE EQUIP - POB	0	0	9,538			2.02
2.03	00203	CAP REL COSTS-MVBLE EQUIP - WJ	0	0	0	3,728		2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	12,999,359	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,359	1,419	0	0	401,492	5.00
7.00	00700	OPERATION OF PLANT	18,593	0	0	0	539,413	7.00
7.01	00701	OPERATION OF PLANT - MOB	0	496	0	0	0	7.01
7.02	00702	OPERATION OF PLANT - POB	0	0	615	0	0	7.02
7.03	00703	OPERATION OF PLANT - WJ	0	0	0	0	0	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	594	0	0	0	37,607	8.00
9.00	00900	HOUSEKEEPING	602	0	0	0	444,751	9.00
10.00	01000	DIETARY	2,036	0	0	0	173,506	10.00
11.00	01100	CAFETERIA	2,236	0	0	0	190,522	11.00
13.00	01300	NURSING ADMINISTRATION	930	0	0	0	1,176,430	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	1,000	0	0	0	554,662	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	9,855	0	0	0	1,989,713	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
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,992	915	6,402	0	1,022,141	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	4,862	0	0	0	1,034,417	54.00
60.00	06000	LABORATORY	2,615	0	0	0	630	60.00
65.00	06500	RESPIRATORY THERAPY	731	0	0	0	541,077	65.00
66.00	06600	PHYSICAL THERAPY	3,312	0	0	0	513,525	66.00
67.00	06700	OCCUPATIONAL THERAPY	517	0	0	0	93,938	67.00
68.00	06800	SPEECH PATHOLOGY	12	0	0	0	18,788	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	1,516	0	0	151,108	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	8,733	0	0	708,816	90.01
90.02	09002	JAY FAMILY MEDICINE	0	8,536	0	0	869,355	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	5,105	138	0	0	348,101	90.05
90.06	09006	INFUSION CLINIC	618	0	0	0	110,046	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	3,718	0	0	0	314,345	90.07
91.00	09100	EMERGENCY	4,770	0	0	0	1,548,565	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	1,571	0	0	0	92,012	93.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	77,028	21,753	7,017	0	12,874,960	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	771	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	2,521	3,728	124,399	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT	2,605	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	1,605	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1320 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/26/2023 12:02 pm

		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	
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,710,472	29,787	0	0	2,047,123	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	20.857125	1.369328	0.000000	0.000000	0.157479	203.00
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 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/26/2023 12:02 pm

		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	-9,101,552	28,473,333				5.00
7.00	00700	OPERATION OF PLANT	0	3,469,894	87,659			7.00
7.01	00701	OPERATION OF PLANT - MOB	0	43,923	496	19,838		7.01
7.02	00702	OPERATION OF PLANT - POB	0	51,211	615	0	8,923	7.02
7.03	00703	OPERATION OF PLANT - WJ	0	0	0	0	0	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	0	100,987	594	0	0	8.00
9.00	00900	HOUSEKEEPING	0	920,487	602	0	0	9.00
10.00	01000	DIETARY	0	410,498	2,036	0	0	10.00
11.00	01100	CAFETERIA	0	436,018	2,236	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,935,856	930	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	133,918	0	0	0	14.00
15.00	01500	PHARMACY	0	1,160,660	1,000	0	0	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	0	2,862,346	9,855	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
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,710,419	11,309	915	6,402	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	1,625,175	4,862	0	0	54.00
60.00	06000	LABORATORY	0	2,438,597	2,615	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	742,437	731	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	749,531	3,312	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	124,660	517	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	22,116	12	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,197	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	65,063	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	23,421	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,693,462	0	0	0	73.00
76.00	03160	CARDIOPULMONARY	0	297,826	1,516	1,516	0	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	1,041,465	8,733	8,733	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0	1,116,260	8,536	8,536	0	90.02
90.03	09003	WOUND CLINIC	0	1	0	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0	627	0	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0	600,225	5,245	138	0	90.05
90.06	09006	INFUSION CLINIC	0	156,657	618	0	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	500,543	3,718	0	0	90.07
91.00	09100	EMERGENCY	0	3,540,314	4,770	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	0	171,984	1,571	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-9,101,552	28,147,778	76,429	19,838	6,402	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	23,756	771	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	172,112	6,249	0	2,521	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT	0	80,234	2,605	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	49,453	1,605	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)		9,101,552	4,579,053	83,873	99,707	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1320 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/26/2023 12:02 pm

	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	
203.00	Unit cost multiplier (Wkst. B, Part I)		0.319652	52.237112	4.227896	11.174157	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)		290,309	608,257	4,569	4,789	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)		0.010196	6.938900	0.230316	0.536703	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 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/26/2023 12:02 pm

		Cost Center Description	OPERATION OF PLANT - WJ (SQUARE FEET-WJ)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	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	3,728					7.03
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,379				8.00
9.00	00900	HOUSEKEEPING	0	0	85,352			9.00
10.00	01000	DIETARY	0	0	2,036	8,520		10.00
11.00	01100	CAFETERIA	0	0	2,236	0	15,544	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	930	0	1,187	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	1,000	0	609	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	0	1,379	9,855	8,520	2,226	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
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	11,309	0	1,110	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	4,862	0	1,223	54.00
60.00	06000	LABORATORY	0	0	2,615	0	1,207	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	731	0	547	65.00
66.00	06600	PHYSICAL THERAPY	0	0	3,312	0	401	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	517	0	156	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	12	0	22	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	1,516	0	208	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		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	8,733	0	1,597	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	8,536	0	1,812	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	5,245	0	752	90.05
90.06	09006	INFUSION CLINIC	0	0	618	0	102	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	0	3,718	0	464	90.07
91.00	09100	EMERGENCY	0	0	4,770	0	1,403	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	0	0	1,571	0	232	93.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,379	74,122	8,520	15,258	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	771	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,728	0	6,249	0	286	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT	0	0	2,605	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	0	1,605	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)	0	164,297	1,246,170	677,796	724,840	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1320 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/26/2023 12:02 pm

	Cost Center Description	OPERATION OF PLANT - WJ (SQUARE FEET-WJ)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	
		7.03	8.00	9.00	10.00	11.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000000	119.142132	14.600361	79.553521	46.631498	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	0	23,454	32,111	81,811	89,697	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	17.007977	0.376218	9.602230	5.770522	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 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/26/2023 12:02 pm

		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	4,855					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	257,905				14.00
15.00	01500	PHARMACY	0	1,796	1,775,395			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	85,732,275		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,430	39,769	12,960	7,642,151	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
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	772	31,049	7,831	7,984,254	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	5,575	5,484	14,061,419	0	54.00
60.00	06000	LABORATORY	0	422	0	9,725,655	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	14,037	0	2,380,446	0	65.00
66.00	06600	PHYSICAL THERAPY	0	175	0	1,610,010	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	325,129	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	23,952	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,689	0	145,500	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	65,063	0	221,834	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	23,421	0	195,990	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,693,462	11,872,058	0	73.00
76.00	03160	CARDIOPULMONARY	9	227	137	2,003,151	0	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	369	7,914	0	1,015,606	0	90.01
90.02	09002	JAY FAMILY MEDICINE	497	4,130	0	1,076,479	0	90.02
90.03	09003	WOUND CLINIC	0	76	0	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0	0	0	265	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	132	7,306	0	370,097	0	90.05
90.06	09006	INFUSION CLINIC	102	3,237	6,696	1,851,282	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	274	254	407	54,082	0	90.07
91.00	09100	EMERGENCY	1,269	50,677	48,418	22,658,054	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	0	86	0	514,861	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,854	257,903	1,775,395	85,732,275	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	1	2	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT	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	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1320 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/26/2023 12:02 pm

		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	
202.00		Cost to be allocated (per Wkst. B, Part I)	2,672,167	176,725	1,628,134	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	550.394851	0.685233	0.917055	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	62,046	1,365	53,484	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	12.779815	0.005293	0.030125	0.000000	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 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/26/2023 12:02 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	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	6,208,080		6,208,080	0	0	30.00
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	40.00
43.00	04300	NURSERY	0		0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,593,548		3,593,548	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,535,508		2,535,508	0	0	54.00
60.00	06000	LABORATORY	3,449,452		3,449,452	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,063,742	0	1,063,742	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,229,304	0	1,229,304	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	206,338	0	206,338	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	31,013	0	31,013	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,423		3,423	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	130,443		130,443	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	46,957		46,957	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,787,778		3,787,778	0	0	73.00
76.00	03160	CARDIOPULMONARY	515,696		515,696	0	0	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	2,277,976		2,277,976	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	2,440,561		2,440,561	0	0	90.02
90.03	09003	WOUND CLINIC	53		53	0	0	90.03
90.04	09004	OP ORTHO CLINIC	827		827	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	1,255,959		1,255,959	0	0	90.05
90.06	09006	INFUSION CLINIC	317,294		317,294	0	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	1,082,037		1,082,037	0	0	90.07
91.00	09100	EMERGENCY	5,833,792		5,833,792	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,654,307		1,654,307		0	92.00
93.00	04950	OUTPATIENT PSYCH	342,839		342,839	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
200.00		Subtotal (see instructions)	38,006,927	0	38,006,927	0	0	200.00
201.00		Less Observation Beds	1,654,307		1,654,307		0	201.00
202.00		Total (see instructions)	36,352,620	0	36,352,620	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1320 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/26/2023 12:02 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	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	3,921,652		3,921,652			30.00
40.00	04000	SUBPROVIDER - IPF	0		0			40.00
43.00	04300	NURSERY	0		0			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,492	7,976,762	7,984,254	0.450079	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	515,063	13,546,356	14,061,419	0.180317	0.000000	54.00
60.00	06000	LABORATORY	835,029	8,890,626	9,725,655	0.354676	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	829,969	1,550,477	2,380,446	0.446867	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	263,740	1,346,270	1,610,010	0.763538	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	168,624	156,505	325,129	0.634634	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	16,836	7,116	23,952	1.294798	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	145,500	145,500	0.023526	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	25,505	196,329	221,834	0.588021	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	195,990	195,990	0.239589	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,931,082	9,940,976	11,872,058	0.319050	0.000000	73.00
76.00	03160	CARDIOPULMONARY	128,977	1,874,174	2,003,151	0.257442	0.000000	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00
		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	0	1,015,606	1,015,606	2.242972	0.000000	90.01
90.02	09002	JAY FAMILY MEDICINE	0	1,076,479	1,076,479	2.267170	0.000000	90.02
90.03	09003	WOUND CLINIC	0	0	0	0.000000	0.000000	90.03
90.04	09004	OP ORTHO CLINIC	0	265	265	3.120755	0.000000	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0	370,097	370,097	3.393594	0.000000	90.05
90.06	09006	INFUSION CLINIC	0	1,851,282	1,851,282	0.171392	0.000000	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	54,082	54,082	20.007341	0.000000	90.07
91.00	09100	EMERGENCY	626,364	22,031,690	22,658,054	0.257471	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	11,727	3,708,772	3,720,499	0.444647	0.000000	92.00
93.00	04950	OUTPATIENT PSYCH	0	514,861	514,861	0.665887	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
200.00		Subtotal (see instructions)	9,282,060	76,450,215	85,732,275			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	9,282,060	76,450,215	85,732,275			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1320 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/26/2023 12:02 pm

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	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.00	03160	CARDIOPULMONARY	0.000000	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0.000000	90.01
90.02	09002	JAY FAMILY MEDICINE	0.000000	90.02
90.03	09003	WOUND CLINIC	0.000000	90.03
90.04	09004	OP ORTHO CLINIC	0.000000	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0.000000	90.05
90.06	09006	INFUSION CLINIC	0.000000	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0.000000	90.07
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
93.00	04950	OUTPATIENT PSYCH	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS		
102.00	10200	OPIOID TREATMENT PROGRAM		102.00
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 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/26/2023 12:02 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	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	6,208,080		6,208,080	0	6,208,080	30.00
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	40.00
43.00	04300	NURSERY	0		0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,593,548		3,593,548	0	3,593,548	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,535,508		2,535,508	0	2,535,508	54.00
60.00	06000	LABORATORY	3,449,452		3,449,452	0	3,449,452	60.00
65.00	06500	RESPIRATORY THERAPY	1,063,742	0	1,063,742	0	1,063,742	65.00
66.00	06600	PHYSICAL THERAPY	1,229,304	0	1,229,304	0	1,229,304	66.00
67.00	06700	OCCUPATIONAL THERAPY	206,338	0	206,338	0	206,338	67.00
68.00	06800	SPEECH PATHOLOGY	31,013	0	31,013	0	31,013	68.00
69.00	06900	ELECTROCARDIOLOGY	3,423		3,423	0	3,423	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	130,443		130,443	0	130,443	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	46,957		46,957	0	46,957	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,787,778		3,787,778	0	3,787,778	73.00
76.00	03160	CARDIOPULMONARY	515,696		515,696	0	515,696	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	2,277,976		2,277,976	0	2,277,976	90.01
90.02	09002	JAY FAMILY MEDICINE	2,440,561		2,440,561	0	2,440,561	90.02
90.03	09003	WOUND CLINIC	53		53	0	53	90.03
90.04	09004	OP ORTHO CLINIC	827		827	0	827	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	1,255,959		1,255,959	0	1,255,959	90.05
90.06	09006	INFUSION CLINIC	317,294		317,294	0	317,294	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	1,082,037		1,082,037	0	1,082,037	90.07
91.00	09100	EMERGENCY	5,833,792		5,833,792	0	5,833,792	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,654,307		1,654,307		1,654,307	92.00
93.00	04950	OUTPATIENT PSYCH	342,839		342,839	0	342,839	93.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
200.00		Subtotal (see instructions)	38,006,927	0	38,006,927	0	38,006,927	200.00
201.00		Less Observation Beds	1,654,307		1,654,307		1,654,307	201.00
202.00		Total (see instructions)	36,352,620	0	36,352,620	0	36,352,620	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1320 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I | Date/Time Prepared: 5/26/2023 12:02 pm

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	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	3,921,652		3,921,652			30.00
40.00	04000	SUBPROVIDER - IPF	0		0			40.00
43.00	04300	NURSERY	0		0			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,492	7,976,762	7,984,254	0.450079	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	515,063	13,546,356	14,061,419	0.180317	0.000000	54.00
60.00	06000	LABORATORY	835,029	8,890,626	9,725,655	0.354676	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	829,969	1,550,477	2,380,446	0.446867	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	263,740	1,346,270	1,610,010	0.763538	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	168,624	156,505	325,129	0.634634	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	16,836	7,116	23,952	1.294798	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	145,500	145,500	0.023526	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	25,505	196,329	221,834	0.588021	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	195,990	195,990	0.239589	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,931,082	9,940,976	11,872,058	0.319050	0.000000	73.00
76.00	03160	CARDIOPULMONARY	128,977	1,874,174	2,003,151	0.257442	0.000000	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00
		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	0	1,015,606	1,015,606	2.242972	0.000000	90.01
90.02	09002	JAY FAMILY MEDICINE	0	1,076,479	1,076,479	2.267170	0.000000	90.02
90.03	09003	WOUND CLINIC	0	0	0	0.000000	0.000000	90.03
90.04	09004	OP ORTHO CLINIC	0	265	265	3.120755	0.000000	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0	370,097	370,097	3.393594	0.000000	90.05
90.06	09006	INFUSION CLINIC	0	1,851,282	1,851,282	0.171392	0.000000	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	54,082	54,082	20.007341	0.000000	90.07
91.00	09100	EMERGENCY	626,364	22,031,690	22,658,054	0.257471	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	11,727	3,708,772	3,720,499	0.444647	0.000000	92.00
93.00	04950	OUTPATIENT PSYCH	0	514,861	514,861	0.665887	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
200.00		Subtotal (see instructions)	9,282,060	76,450,215	85,732,275			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	9,282,060	76,450,215	85,732,275			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-1320	Period: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Prepared: 5/26/2023 12:02 pm
	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	0.450079	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.180317	54.00
60.00	06000	LABORATORY	0.354676	60.00
65.00	06500	RESPIRATORY THERAPY	0.446867	65.00
66.00	06600	PHYSICAL THERAPY	0.763538	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.634634	67.00
68.00	06800	SPEECH PATHOLOGY	1.294798	68.00
69.00	06900	ELECTROCARDIOLOGY	0.023526	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.588021	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.239589	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.319050	73.00
76.00	03160	CARDIOPULMONARY	0.257442	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	2.242972	90.01
90.02	09002	JAY FAMILY MEDICINE	2.267170	90.02
90.03	09003	WOUND CLINIC	0.000000	90.03
90.04	09004	OP ORTHO CLINIC	3.120755	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	3.393594	90.05
90.06	09006	INFUSION CLINIC	0.171392	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	20.007341	90.07
91.00	09100	EMERGENCY	0.257471	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.444647	92.00
93.00	04950	OUTPATIENT PSYCH	0.665887	93.00
		OTHER REIMBURSABLE COST CENTERS		
102.00	10200	OPIOID TREATMENT PROGRAM		102.00
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 01/01/2022 To 12/31/2022 | Worksheet C Part II | Date/Time Prepared: 5/26/2023 12:02 pm

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	3,593,548	244,736	3,348,812	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	2,535,508	209,193	2,326,315	0	0	54.00
60.00	06000	LABORATORY	3,449,452	131,532	3,317,920	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,063,742	38,671	1,025,071	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,229,304	136,233	1,093,071	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	206,338	21,882	184,456	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	31,013	809	30,204	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,423	26	3,397	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	130,443	1,009	129,434	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	46,957	363	46,594	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,787,778	68,283	3,719,495	0	0	73.00
76.00	03160	CARDIOPULMONARY	515,696	17,871	497,825	0	0	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	2,277,976	102,445	2,175,531	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	2,440,561	104,307	2,336,254	0	0	90.02
90.03	09003	WOUND CLINIC	53	0	53	0	0	90.03
90.04	09004	OP ORTHO CLINIC	827	6	821	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	1,255,959	208,067	1,047,892	0	0	90.05
90.06	09006	INFUSION CLINIC	317,294	27,272	290,022	0	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	1,082,037	153,053	928,984	0	0	90.07
91.00	09100	EMERGENCY	5,833,792	244,000	5,589,792	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,654,307	144,406	1,509,901	0	0	92.00
93.00	04950	OUTPATIENT PSYCH	342,839	62,990	279,849	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
200.00		Subtotal (sum of lines 50 thru 199)	31,798,847	1,917,154	29,881,693	0	0	200.00
201.00		Less Observation Beds	1,654,307	144,406	1,509,901	0	0	201.00
202.00		Total (line 200 minus line 201)	30,144,540	1,772,748	28,371,792	0	0	202.00

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

Provider CCN: 15-1320 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part II | Date/Time Prepared: 5/26/2023 12:02 pm

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	3,593,548	7,984,254	0.450079	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,535,508	14,061,419	0.180317	54.00
60.00	06000	LABORATORY	3,449,452	9,725,655	0.354676	60.00
65.00	06500	RESPIRATORY THERAPY	1,063,742	2,380,446	0.446867	65.00
66.00	06600	PHYSICAL THERAPY	1,229,304	1,610,010	0.763538	66.00
67.00	06700	OCCUPATIONAL THERAPY	206,338	325,129	0.634634	67.00
68.00	06800	SPEECH PATHOLOGY	31,013	23,952	1.294798	68.00
69.00	06900	ELECTROCARDIOLOGY	3,423	145,500	0.023526	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	130,443	221,834	0.588021	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	46,957	195,990	0.239589	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,787,778	11,872,058	0.319050	73.00
76.00	03160	CARDIOPULMONARY	515,696	2,003,151	0.257442	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0	0.000000	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	2,277,976	1,015,606	2.242972	90.01
90.02	09002	JAY FAMILY MEDICINE	2,440,561	1,076,479	2.267170	90.02
90.03	09003	WOUND CLINIC	53	0	0.000000	90.03
90.04	09004	OP ORTHO CLINIC	827	265	3.120755	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	1,255,959	370,097	3.393594	90.05
90.06	09006	INFUSION CLINIC	317,294	1,851,282	0.171392	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	1,082,037	54,082	20.007341	90.07
91.00	09100	EMERGENCY	5,833,792	22,658,054	0.257471	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,654,307	3,720,499	0.444647	92.00
93.00	04950	OUTPATIENT PSYCH	342,839	514,861	0.665887	93.00
		OTHER REIMBURSABLE COST CENTERS				
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0.000000	102.00
200.00		Subtotal (sum of lines 50 thru 199)	31,798,847	81,810,623		200.00
201.00		Less Observation Beds	1,654,307	0		201.00
202.00		Total (line 200 minus line 201)	30,144,540	81,810,623		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1320 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part II Date/Time Prepared: 5/26/2023 12:02 pm

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	244,736	7,984,254	0.030652	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	209,193	14,061,419	0.014877	143,363	2,133	54.00
60.00	06000	LABORATORY	131,532	9,725,655	0.013524	306,727	4,148	60.00
65.00	06500	RESPIRATORY THERAPY	38,671	2,380,446	0.016245	273,392	4,441	65.00
66.00	06600	PHYSICAL THERAPY	136,233	1,610,010	0.084616	58,950	4,988	66.00
67.00	06700	OCCUPATIONAL THERAPY	21,882	325,129	0.067303	28,346	1,908	67.00
68.00	06800	SPEECH PATHOLOGY	809	23,952	0.033776	10,948	370	68.00
69.00	06900	ELECTROCARDIOLOGY	26	145,500	0.000179	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,009	221,834	0.004548	6,466	29	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	363	195,990	0.001852	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	68,283	11,872,058	0.005752	692,519	3,983	73.00
76.00	03160	CARDIOPULMONARY	17,871	2,003,151	0.008921	68,239	609	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	102,445	1,015,606	0.100871	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	104,307	1,076,479	0.096896	0	0	90.02
90.03	09003	WOUND CLINIC	0	0	0.000000	0	0	90.03
90.04	09004	OP ORTHO CLINIC	6	265	0.022642	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	208,067	370,097	0.562196	0	0	90.05
90.06	09006	INFUSION CLINIC	27,272	1,851,282	0.014731	0	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	153,053	54,082	2.830017	0	0	90.07
91.00	09100	EMERGENCY	244,000	22,658,054	0.010769	24,180	260	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	144,406	3,720,499	0.038814	1,190	46	92.00
93.00	04950	OUTPATIENT PSYCH	62,990	514,861	0.122344	0	0	93.00
200.00		Total (lines 50 through 199)	1,917,154	81,810,623		1,614,320	22,915	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1320 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV | Date/Time Prepared: 5/26/2023 12:02 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	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
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		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
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	0	0	0	0	90.07
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 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Prepared: 5/26/2023 12:02 pm
	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) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	7,984,254	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	14,061,419	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	9,725,655	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,380,446	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,610,010	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	325,129	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	23,952	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	145,500	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	221,834	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	195,990	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	11,872,058	0.000000	73.00
76.00	03160	CARDIOPULMONARY	0	0	0	2,003,151	0.000000	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
		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	1,015,606	0.000000	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	0	1,076,479	0.000000	90.02
90.03	09003	WOUND CLINIC	0	0	0	0	0.000000	90.03
90.04	09004	OP ORTHO CLINIC	0	0	0	265	0.000000	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0	0	0	370,097	0.000000	90.05
90.06	09006	INFUSION CLINIC	0	0	0	1,851,282	0.000000	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	0	0	54,082	0.000000	90.07
91.00	09100	EMERGENCY	0	0	0	22,658,054	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,720,499	0.000000	92.00
93.00	04950	OUTPATIENT PSYCH	0	0	0	514,861	0.000000	93.00
200.00		Total (lines 50 through 199)	0	0	0	81,810,623		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1320 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV | Date/Time Prepared: 5/26/2023 12:02 pm

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	0	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	143,363	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	306,727	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	273,392	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	58,950	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	28,346	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	10,948	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	6,466	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	692,519	0	0	0	73.00
76.00	03160	CARDIOPULMONARY	0.000000	68,239	0	0	0	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
		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
90.07	09007	HEALTH BEGINNINGS PROGRAM	0.000000	0	0	0	0	90.07
91.00	09100	EMERGENCY	0.000000	24,180	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	1,190	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)		1,614,320	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1320 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V Date/Time Prepared: 5/26/2023 12:02 pm

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	0.450079	0	1,492,475	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	0.180317	0	2,547,482	0	0	54.00
60.00	06000	LABORATORY	0.354676	0	1,659,341	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.446867	0	277,233	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.763538	0	321,222	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.634634	0	18,183	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.294798	0	129	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.023526	0	13,157	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.588021	0	18,352	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.239589	0	19,242	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.319050	0	1,764,003	133,017	0	73.00
76.00	03160	CARDIOPULMONARY	0.257442	0	685,009	0	0	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	2.242972	0	266,461	71,816	0	90.01
90.02	09002	JAY FAMILY MEDICINE	2.267170	0	457,384	77,664	0	90.02
90.03	09003	WOUND CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	OP ORTHO CLINIC	3.120755	0	265	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	3.393594	0	87,136	23,169	0	90.05
90.06	09006	INFUSION CLINIC	0.171392	0	365,710	0	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	20.007341	0	0	0	0	90.07
91.00	09100	EMERGENCY	0.257471	0	3,222,508	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.444647	0	789,818	750	0	92.00
93.00	04950	OUTPATIENT PSYCH	0.665887	0	38,218	0	0	93.00
200.00		Subtotal (see instructions)		0	14,043,328	306,416	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	14,043,328	306,416	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1320 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V Date/Time Prepared: 5/26/2023 12:02 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	671,732	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	459,354	0	54.00
60.00	06000	LABORATORY	588,528	0	60.00
65.00	06500	RESPIRATORY THERAPY	123,886	0	65.00
66.00	06600	PHYSICAL THERAPY	245,265	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	11,540	0	67.00
68.00	06800	SPEECH PATHOLOGY	167	0	68.00
69.00	06900	ELECTROCARDIOLOGY	310	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,791	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,610	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	562,805	42,439	73.00
76.00	03160	CARDIOPULMONARY	176,350	0	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	597,665	161,081	90.01
90.02	09002	JAY FAMILY MEDICINE	1,036,967	176,077	90.02
90.03	09003	WOUND CLINIC	0	0	90.03
90.04	09004	OP ORTHO CLINIC	827	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	295,704	78,626	90.05
90.06	09006	INFUSION CLINIC	62,680	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	0	90.07
91.00	09100	EMERGENCY	829,702	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	351,190	333	92.00
93.00	04950	OUTPATIENT PSYCH	25,449	0	93.00
200.00		Subtotal (see instructions)	6,055,522	458,556	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	6,055,522	458,556	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-1320 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part I Date/Time Prepared: 5/26/2023 12:02 pm

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	541,907	64,037	477,870	1,985	240.74	30.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00
43.00	NURSERY	0		0	0	0.00	43.00
200.00	Total (lines 30 through 199)	541,907		477,870	1,985		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	17	4,093	30.00
40.00	SUBPROVIDER - IPF	0	0	40.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30 through 199)	17	4,093	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1320 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part II | Date/Time Prepared: 5/26/2023 12:02 pm

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	244,736	7,984,254	0.030652	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	209,193	14,061,419	0.014877	5,373	80	54.00
60.00	06000	LABORATORY	131,532	9,725,655	0.013524	4,990	67	60.00
65.00	06500	RESPIRATORY THERAPY	38,671	2,380,446	0.016245	11,736	191	65.00
66.00	06600	PHYSICAL THERAPY	136,233	1,610,010	0.084616	1,334	113	66.00
67.00	06700	OCCUPATIONAL THERAPY	21,882	325,129	0.067303	1,037	70	67.00
68.00	06800	SPEECH PATHOLOGY	809	23,952	0.033776	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	26	145,500	0.000179	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,009	221,834	0.004548	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	363	195,990	0.001852	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	68,283	11,872,058	0.005752	15,965	92	73.00
76.00	03160	CARDIOPULMONARY	17,871	2,003,151	0.008921	0	0	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	102,445	1,015,606	0.100871	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	104,307	1,076,479	0.096896	0	0	90.02
90.03	09003	WOUND CLINIC	0	0	0.000000	0	0	90.03
90.04	09004	OP ORTHO CLINIC	6	265	0.022642	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	208,067	370,097	0.562196	0	0	90.05
90.06	09006	INFUSION CLINIC	27,272	1,851,282	0.014731	0	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	153,053	54,082	2.830017	0	0	90.07
91.00	09100	EMERGENCY	244,000	22,658,054	0.010769	9,064	98	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	144,406	3,720,499	0.038814	0	0	92.00
93.00	04950	OUTPATIENT PSYCH	62,990	514,861	0.122344	0	0	93.00
200.00		Total (lines 50 through 199)	1,917,154	81,810,623		49,499	711	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1320 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part III Date/Time Prepared: 5/26/2023 12:02 pm

Title XIX | Hospital | PPS

		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	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	1,985	0.00	17	30.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0.00	0	40.00
43.00	04300	NURSERY		0	0	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	1,985		17	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 01/01/2022 To 12/31/2022 | Worksheet D Part IV | Date/Time Prepared: 5/26/2023 12:02 pm

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	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
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		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
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	0	0	0	0	90.07
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 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 5/26/2023 12:02 pm

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) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	7,984,254	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	14,061,419	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	9,725,655	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,380,446	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,610,010	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	325,129	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	23,952	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	145,500	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	221,834	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	195,990	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	11,872,058	0.000000	73.00
76.00	03160	CARDIOPULMONARY	0	0	0	2,003,151	0.000000	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
		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	1,015,606	0.000000	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	0	1,076,479	0.000000	90.02
90.03	09003	WOUND CLINIC	0	0	0	0	0.000000	90.03
90.04	09004	OP ORTHO CLINIC	0	0	0	265	0.000000	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0	0	0	370,097	0.000000	90.05
90.06	09006	INFUSION CLINIC	0	0	0	1,851,282	0.000000	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	0	0	54,082	0.000000	90.07
91.00	09100	EMERGENCY	0	0	0	22,658,054	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,720,499	0.000000	92.00
93.00	04950	OUTPATIENT PSYCH	0	0	0	514,861	0.000000	93.00
200.00		Total (lines 50 through 199)	0	0	0	81,810,623		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1320 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 5/26/2023 12:02 pm

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	0	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	5,373	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	4,990	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	11,736	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,334	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	1,037	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	15,965	0	0	0	73.00
76.00	03160	CARDIOPULMONARY	0.000000	0	0	0	0	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
		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
90.07	09007	HEALTH BEGINNINGS PROGRAM	0.000000	0	0	0	0	90.07
91.00	09100	EMERGENCY	0.000000	9,064	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)		49,499	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1320 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/26/2023 12:02 pm

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)	2,503	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,985	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)	1,379	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	266	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	252	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) (see instructions)	576	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)	266	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	250.44	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)	6,208,080	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)	63,111	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)	789,259	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,418,821	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)	5,418,821	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)	2,729.88	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,572,411	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)	1,572,411	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-1320 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/26/2023 12:02 pm

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)	583,058	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	2,155,469	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
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	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	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 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)	726,148	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	726,148	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)	606	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,729.88	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1320	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/26/2023 12:02 pm
	Title XVIII	Hospital	Cost

	Cost Center Description	1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,654,307	89.00

	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	541,907	6,208,080	0.087291	1,654,307	144,406	90.00
91.00	Nursing Program cost	0	6,208,080	0.000000	1,654,307	0	91.00
92.00	Allied health cost	0	6,208,080	0.000000	1,654,307	0	92.00
93.00	All other Medical Education	0	6,208,080	0.000000	1,654,307	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1320	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/26/2023 12:02 pm
	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)	2,503	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,985	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)	1,379	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	266	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	252	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) (see instructions)	17	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)	6,208,080	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)	733,607	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,474,473	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)	5,474,473	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)	2,757.92	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	46,885	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)	46,885	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1320 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/26/2023 12:02 pm

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)	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)	17,088	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	63,973	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)	4,093	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	711	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	4,804	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	59,169	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	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	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 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)	606	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,757.92	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1320	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/26/2023 12:02 pm
	Title XIX	Hospital	PPS

	Cost Center Description	1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,671,300	89.00

	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	541,907	6,208,080	0.087291	1,671,300	145,889	90.00
91.00	Nursing Program cost	0	6,208,080	0.000000	1,671,300	0	91.00
92.00	Allied health cost	0	6,208,080	0.000000	1,671,300	0	92.00
93.00	All other Medical Education	0	6,208,080	0.000000	1,671,300	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1320 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3 | Date/Time Prepared: 5/26/2023 12:02 pm

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		1,399,663		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	0.450079	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.180317	143,363	25,851	54.00
60.00	06000	LABORATORY	0.354676	306,727	108,789	60.00
65.00	06500	RESPIRATORY THERAPY	0.446867	273,392	122,170	65.00
66.00	06600	PHYSICAL THERAPY	0.763538	58,950	45,011	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.634634	28,346	17,989	67.00
68.00	06800	SPEECH PATHOLOGY	1.294798	10,948	14,175	68.00
69.00	06900	ELECTROCARDIOLOGY	0.023526	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.588021	6,466	3,802	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.239589	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.319050	692,519	220,948	73.00
76.00	03160	CARDIOPULMONARY	0.257442	68,239	17,568	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	2.242972	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	2.267170	0	0	90.02
90.03	09003	WOUND CLINIC	0.000000	0	0	90.03
90.04	09004	OP ORTHO CLINIC	3.120755	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	3.393594	0	0	90.05
90.06	09006	INFUSION CLINIC	0.171392	0	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	20.007341	0	0	90.07
91.00	09100	EMERGENCY	0.257471	24,180	6,226	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.444647	1,190	529	92.00
93.00	04950	OUTPATIENT PSYCH	0.665887	0	0	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,614,320	583,058	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,614,320		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1320 | Component CCN: 15-Z320 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3 | Date/Time Prepared: 5/26/2023 12:02 pm

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				30.00
40.00	04000	SUBPROVIDER - IPF				40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.450079	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.180317	29,206	5,266	54.00
60.00	06000	LABORATORY	0.354676	31,622	11,216	60.00
65.00	06500	RESPIRATORY THERAPY	0.446867	32,475	14,512	65.00
66.00	06600	PHYSICAL THERAPY	0.763538	75,900	57,953	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.634634	56,053	35,573	67.00
68.00	06800	SPEECH PATHOLOGY	1.294798	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.023526	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.588021	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.239589	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.319050	119,220	38,037	73.00
76.00	03160	CARDIOPULMONARY	0.257442	0	0	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	2.242972	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	2.267170	0	0	90.02
90.03	09003	WOUND CLINIC	0.000000	0	0	90.03
90.04	09004	OP ORTHO CLINIC	3.120755	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	3.393594	0	0	90.05
90.06	09006	INFUSION CLINIC	0.171392	0	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	20.007341	0	0	90.07
91.00	09100	EMERGENCY	0.257471	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.444647	0	0	92.00
93.00	04950	OUTPATIENT PSYCH	0.665887	0	0	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		344,476	162,557	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)		344,476		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1320 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3 | Date/Time Prepared: 5/26/2023 12:02 pm

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		29,579		30.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.450079	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.180317	5,373	969	54.00
60.00	06000	LABORATORY	0.354676	4,990	1,770	60.00
65.00	06500	RESPIRATORY THERAPY	0.446867	11,736	5,244	65.00
66.00	06600	PHYSICAL THERAPY	0.763538	1,334	1,019	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.634634	1,037	658	67.00
68.00	06800	SPEECH PATHOLOGY	1.294798	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.023526	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.588021	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.239589	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.319050	15,965	5,094	73.00
76.00	03160	CARDIOPULMONARY	0.257442	0	0	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	2.242972	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	2.267170	0	0	90.02
90.03	09003	WOUND CLINIC	0.000000	0	0	90.03
90.04	09004	OP ORTHO CLINIC	3.120755	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	3.393594	0	0	90.05
90.06	09006	INFUSION CLINIC	0.171392	0	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	20.007341	0	0	90.07
91.00	09100	EMERGENCY	0.257471	9,064	2,334	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.444647	0	0	92.00
93.00	04950	OUTPATIENT PSYCH	0.665887	0	0	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		49,499	17,088	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)		49,499		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1320 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E Part B Date/Time Prepared: 5/26/2023 12:02 pm

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,514,078	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)	6,514,078	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)	6,579,219	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)	125,264	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	2,257,786	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)	4,196,169	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)	4,196,169	30.00
31.00	Primary payer payments	1,672	31.00
32.00	Subtotal (line 30 minus line 31)	4,194,497	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)	470,748	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	305,986	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	174,844	36.00
37.00	Subtotal (see instructions)	4,500,483	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
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
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)	4,500,483	40.00
40.01	Sequestration adjustment (see instructions)	56,706	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM or CHART pass-throughs		40.03
41.00	Interim payments	4,056,996	41.00
41.01	Interim payments-PARHM or CHART		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM or CHART (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	386,781	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	361,566	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	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/26/2023 12:02 pm
	Title XVIII	Hospital	Cost

		1.00	
	MEDICARE PART B ANCILLARY COSTS		
200.00	Part B Combined Billed Days	0	200.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1320 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-1 Part I | Date/Time Prepared: 5/26/2023 12:02 pm

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		1,904,666		4,056,996	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)		1,904,666		4,056,996	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		66,537		386,781	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,971,203		4,443,777	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 01/01/2022 To 12/31/2022 | Worksheet E-1 Part I | Date/Time Prepared: 5/26/2023 12:02 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		755,088		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)		755,088		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		123,817		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		878,905		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 01/01/2022 To 12/31/2022 | Worksheet E-1 Part II Date/Time Prepared: 5/26/2023 12:02 pm

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 (see instructions)		2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		3.00
4.00	Total inpatient days (see instructions)		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 01/01/2022 To 12/31/2022 | Worksheet E-2 | Date/Time Prepared: 5/26/2023 12:02 pm

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)	733,409	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 and swing-bed pass-through, see instructions)	164,183	0	3.00
3.01	Nursing and allied health payment-PARHM or CHART (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	266	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)	897,592	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	897,592	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)	897,592	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	7,586	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	890,006	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)	176	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	114	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	890,120	0	19.00
19.01	Sequestration adjustment (see instructions)	11,215	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM or CHART pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	755,088	0	20.00
20.01	Interim payments-PARHM or CHART			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM or CHART (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)	123,817	0	22.00
22.01	Balance due provider/program-PARHM or CHART (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	49,526	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 01/01/2022 To 12/31/2022	Worksheet E-3 Part V Date/Time Prepared: 5/26/2023 12:02 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	2,155,469	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
3.01	Cellular therapy acquisition cost (see instructions)	0	3.01
4.00	Subtotal (sum of lines 1 through 3.01)	2,155,469	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,177,024	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)	2,177,024	19.00
20.00	Deductibles (exclude professional component)	197,540	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,979,484	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,979,484	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	25,958	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	16,873	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	13,374	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,996,357	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.98	Recovery of accelerated depreciation.	0	29.98
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	1,996,357	30.00
30.01	Sequestration adjustment (see instructions)	25,154	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM or CHART		30.03
31.00	Interim payments	1,904,666	31.00
31.01	Interim payments-PARHM or CHART		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM or CHART (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	66,537	33.00
33.01	Balance due provider/program-PARHM or CHART (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	119,937	34.00

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 01/01/2022 To 12/31/2022 | Worksheet G | Date/Time Prepared: 5/26/2023 12:02 pm

		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	-5,650,246	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	3,536,629	0	0	0	4.00
5.00	Other receivable	1,693,573	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	418,736	0	0	0	7.00
8.00	Prepaid expenses	114,519	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)	113,211	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	989,148	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	18,977,852	0	0	0	15.00
16.00	Accumulated depreciation	-6,157,586	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	42,146	0	0	0	21.00
22.00	Accumulated depreciation	-28,976	0	0	0	22.00
23.00	Major movable equipment	11,300,181	0	0	0	23.00
24.00	Accumulated depreciation	-7,230,344	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)	17,892,421	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)	18,005,632	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,191,029	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,065,929	0	0	0	38.00
39.00	Payroll taxes payable	62,177	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	268,533				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	6,376,908	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	8,964,576	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)	8,964,576	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	9,041,056				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)	9,041,056	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	18,005,632	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1320 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G-1 | Date/Time Prepared: 5/26/2023 12:02 pm

		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		10,739,691		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-1,698,633				2.00
3.00	Total (sum of line 1 and line 2)		9,041,058		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)		9,041,058		0		11.00
12.00	ROUNDING	2		0		0	12.00
13.00		0		0		0	13.00
14.00		0		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)		2		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		9,041,056		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	ROUNDING		0		12.00
13.00			0		13.00
14.00			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 01/01/2022 To 12/31/2022 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/26/2023 12:02 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,416,503		3,416,503	1.00
2.00	SUBPROVIDER - IPF	0		0	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	499,200		499,200	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)	3,915,703		3,915,703	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)	3,915,703		3,915,703	17.00
18.00	Ancillary services	4,722,317	45,827,081	50,549,398	18.00
19.00	Outpatient services	644,040	30,623,134	31,267,174	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)	9,282,060	76,450,215	85,732,275	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		40,995,296		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)		40,995,296		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-1320	Period: From 01/01/2022 To 12/31/2022	Worksheet G-3 Date/Time Prepared: 5/26/2023 12:02 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	85,732,275	1.00
2.00	Less contractual allowances and discounts on patients' accounts	46,899,345	2.00
3.00	Net patient revenues (line 1 minus line 2)	38,832,930	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	40,995,296	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,162,366	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	MISCELLANEOUS INCOME	463,733	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	463,733	25.00
26.00	Total (line 5 plus line 25)	-1,698,633	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)	-1,698,633	29.00