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 01/01/2023 To 12/31/2023	Worksheet S Parts I-III Date/Time Prepared: 5/24/2024 9:43 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/24/2024 Time: 9:43 am
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 01/01/2023 and ending 12/31/2023 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 Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	-39,308	-485,545	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	23,612	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC (RHC) I	0		68,810		0	10.00
200.00	TOTAL	0	-15,696	-416,735	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 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/24/2024 9:43 am

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

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	IU HEALTH JAY HOSPITAL	151320	99915	1	01/01/2004	N	O	P	3.00
4.00	Subprovider - IPF									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	IU HEALTH BLACKFORD PHYSICIANS	158558	99915		07/01/2023	N	O	O	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)	01/01/2023	12/31/2023	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 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/24/2024 9:43 am

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
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
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

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		V	XVIII	XIX	
		1.00	2.00	3.00	
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/24/2024 9:43 am

		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 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/24/2024 9:43 am

					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)?					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.		N	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

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		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
107.01	If this facility is a REH (line 3, column 4, is "12"), is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no. (see instructions)			107.01
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
	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

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		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	44,567	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.	Y	N	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

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						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	42	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II | Date/Time Prepared: 5/24/2024 9:43 am

			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	04/01/2024	Y	04/01/2024 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 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II Date/Time Prepared: 5/24/2024 9:43 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				Y	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.					33.00
	Provider-Based Physicians					
34.00	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

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		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 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I Date/Time Prepared: 5/24/2024 9:43 am

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH 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	21,120.00	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	21,120.00	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	21,120.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits				0.00	0	15.10
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	RHC (CONSOLIDATED)	88.00				0	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/24/2024 9:43 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	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)	382	9	880			1.00
2.00	HMO and other (see instructions)	312	78				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	211	0	211			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	250			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	593	9	1,341			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)	593	9	1,341	0.00	190.34	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits	0	0	0			15.10
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)			17			24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLIDATED)	2,018	0	8,884	0.00	1.85	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	192.19	27.00
28.00	Observation Bed Days		9	735			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 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/24/2024 9:43 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	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	133	4	284	1.00
2.00	HMO and other (see instructions)			88	24		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	133	4	284	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
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	RHC (CONSOLIDATED)	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						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-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1320 | Component CCN: 15-8558 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/24/2024 9:43 am

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			400 PILGRIM STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	HARTFORD CITY		IN	47348	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00
		Sunday		Monday		Tuesday
		from	to	from	to	from
		1.00	2.00	3.00	4.00	5.00
	Facility hours of operations (1)					
11.00	CLINIC			08:00	17:00	08:00
					1.00	2.00
12.00	Have you received an approval for an exception to the productivity standard?				N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				Y	1	13.00
13.01	If line 13, column 1, is "Y", are you reporting multiple consolidated RHCs (as defined in CMS Pub. 100-02, chapter 13, section 80.2)? Enter "Y" for yes or "N" for no. If yes, enter in column 2 the number of consolidated RHC groupings and complete a separate Worksheet S-8 for each consolidated RHC grouping. Consolidated RHC groupings are comprised exclusively of grandfathered consolidated RHCs in the grouping or comprised exclusively of new consolidated RHCs in the grouping.				N	0	13.01
				Provider name		CCN
				1.00		2.00
14.00	RHC/FQHC name, CCN			IU HEALTH BLACKFORD		158558	14.00
		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-1320 Component CCN: 15-8558	Period: From 01/01/2023 To 12/31/2023	Worksheet S-8 Date/Time Prepared: 5/24/2024 9:43 am
		RHC I	Cost

			County				
			4.00				
2.00	City, State, ZIP Code, County						2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	08:00	17:00	08:00	17:00	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	17:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-1320	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/24/2024 9:43 am

		1.00	
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)	0.401127	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	4,873,357	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?	N	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	20,113,145	6.00
7.00	Medicaid cost (line 1 times line 6)	8,067,926	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)	3,194,569	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 (see instructions)	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)	16	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	112	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	45	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)	29	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)	3,194,598	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)	1,587,517	111,452	1,698,969	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	636,796	86,949	723,745	21.00
22.00	Payments received from patients for amounts previously written off as charity care	5,192	0	5,192	22.00
23.00	Cost of charity care (see instructions)	631,604	86,949	718,553	23.00

		1.00	
24.00	Does the amount on line 20 col. 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
25.01	Charges for insured patients' liability (see instructions)	40,916	25.01
26.00	Bad debt amount (see instructions)	2,110,590	26.00
27.00	Medicare reimbursable bad debts (see instructions)	291,727	27.00
27.01	Medicare allowable bad debts (see instructions)	448,811	27.01
28.00	Non-Medicare bad debt amount (see instructions)	1,661,779	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	823,668	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	1,542,221	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,736,819	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-1320	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/24/2024 9:43 am

		1.00	
	PART II - HOSPITAL DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)		1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		5.00
6.00	Medicaid charges		6.00
7.00	Medicaid cost (line 1 times line 6)		7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)		8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP		9.00
10.00	Stand-alone CHIP charges		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)		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)		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		14.00
15.00	State or local indigent care program cost (line 1 times line 14)		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)		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		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)				20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)				21.00
22.00	Payments received from patients for amounts previously written off as charity care				22.00
23.00	Cost of charity care (see instructions)				23.00

		1.00	
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		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		25.00
25.01	Charges for insured patients' liability (see instructions)		25.01
26.00	Bad debt amount (see instructions)		26.00
27.00	Medicare reimbursable bad debts (see instructions)		27.00
27.01	Medicare allowable bad debts (see instructions)		27.01
28.00	Non-Medicare bad debt amount (see instructions)		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)		29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/24/2024 9:43 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	1,225,847	1,225,847	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-RHC		0	0	96,848	96,848	1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	1,021,127	1,021,127	2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB		0	0	22,245	22,245	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
2.04	00204	CAP REL COSTS-MVBLE EQUIP - RHC		0	0	0	0	2.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	9,578	77,726	87,304	2,977,752	3,065,056	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	251,416	9,567,039	9,818,455	-157,366	9,661,089	5.00
7.00	00700	OPERATION OF PLANT	630,842	3,600,948	4,231,790	-1,388,527	2,843,263	7.00
7.01	00701	OPERATION OF PLANT - MOB	0	194,134	194,134	-75,336	118,798	7.01
7.02	00702	OPERATION OF PLANT - POB	0	115,702	115,702	-35,073	80,629	7.02
7.03	00703	OPERATION OF PLANT - WJ	0	0	0	0	0	7.03
7.04	00704	OPERATION OF PLANT - RHC	0	0	0	0	0	7.04
8.00	00800	LAUNDRY & LINEN SERVICE	18,362	6,383	24,745	60,958	85,703	8.00
9.00	00900	HOUSEKEEPING	459,969	444,978	904,947	-129,673	775,274	9.00
10.00	01000	DIETARY	323,476	414,397	737,873	-444,815	293,058	10.00
11.00	01100	CAFETERIA	0	0	0	353,196	353,196	11.00
13.00	01300	NURSING ADMINISTRATION	1,084,009	574,313	1,658,322	-182,531	1,475,791	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	11,790	11,790	149,193	160,983	14.00
15.00	01500	PHARMACY	597,917	2,424,733	3,022,650	-1,947,232	1,075,418	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	1,559,160	1,395,330	2,954,490	-458,300	2,496,190	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	874,120	1,272,523	2,146,643	-731,536	1,415,107	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	1,079,240	828,314	1,907,554	-654,943	1,252,611	54.00
60.00	06000	LABORATORY	0	2,607,351	2,607,351	-794	2,606,557	60.00
65.00	06500	RESPIRATORY THERAPY	480,862	218,948	699,810	-153,574	546,236	65.00
66.00	06600	PHYSICAL THERAPY	564,421	94,768	659,189	-9,049	650,140	66.00
67.00	06700	OCCUPATIONAL THERAPY	99,104	0	99,104	0	99,104	67.00
68.00	06800	SPEECH PATHOLOGY	19,821	0	19,821	0	19,821	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,849	3,849	-254	3,595	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	58,044	58,044	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	21,788	21,788	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,375,125	2,375,125	73.00
76.00	03160	CARDIOPULMONARY	181,995	124,991	306,986	-62,397	244,589	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	291,520	1,246,251	1,537,771	-177,731	1,360,040	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	692,309	560,290	1,252,599	-442,532	810,067	90.01
90.02	09002	JAY FAMILY MEDICINE	897,344	719,093	1,616,437	-510,733	1,105,704	90.02
90.03	09003	WOUND CLINIC	0	445	445	-445	0	90.03
90.04	09004	OP ORTHO CLINIC	0	132	132	0	132	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	324,898	260,295	585,193	-198,242	386,951	90.05
90.06	09006	INFUSION CLINIC	89,932	36,213	126,145	-27,316	98,829	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	377,009	151,535	528,544	-120,928	407,616	90.07
91.00	09100	EMERGENCY	1,452,159	2,294,079	3,746,238	-475,251	3,270,987	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	86,929	60,011	146,940	-46,053	100,887	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)	12,446,392	29,306,561	41,752,953	51,182	41,804,135	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	18	18	0	18	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	146,628	74,608	221,236	-51,182	170,054	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

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/24/2024 9:43 am

	Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
200.00	TOTAL (SUM OF LINES 118 through 199)	12,593,020	29,381,187	41,974,207	0	41,974,207	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/24/2024 9:43 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-589,525	636,322		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	-61,278	-26,248		1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT-WJ	-9,433	0		1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT-RHC	-2,916	93,932		1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP	400,701	1,421,828		2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB	0	22,245		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
2.04	00204	CAP REL COSTS-MVBLE EQUIP - RHC	0	0		2.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-849,511	2,215,545		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,950,063	7,711,026		5.00
7.00	00700	OPERATION OF PLANT	-99,422	2,743,841		7.00
7.01	00701	OPERATION OF PLANT - MOB	0	118,798		7.01
7.02	00702	OPERATION OF PLANT - POB	0	80,629		7.02
7.03	00703	OPERATION OF PLANT - WJ	0	0		7.03
7.04	00704	OPERATION OF PLANT - RHC	0	0		7.04
8.00	00800	LAUNDRY & LINEN SERVICE	0	85,703		8.00
9.00	00900	HOUSEKEEPING	0	775,274		9.00
10.00	01000	DIETARY	1,946	295,004		10.00
11.00	01100	CAFETERIA	0	353,196		11.00
13.00	01300	NURSING ADMINISTRATION	138,321	1,614,112		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	160,983		14.00
15.00	01500	PHARMACY	-52,097	1,023,321		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	-748,312	1,747,878		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	-291,744	1,123,363		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	73,539	1,326,150		54.00
60.00	06000	LABORATORY	0	2,606,557		60.00
65.00	06500	RESPIRATORY THERAPY	39,175	585,411		65.00
66.00	06600	PHYSICAL THERAPY	-45,602	604,538		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	99,104		67.00
68.00	06800	SPEECH PATHOLOGY	0	19,821		68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,595		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	58,044		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	21,788		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,375,125		73.00
76.00	03160	CARDIOPULMONARY	44,966	289,555		76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC (RHC)	62,286	1,422,326		88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	-30,378	779,689		90.01
90.02	09002	JAY FAMILY MEDICINE	-81,147	1,024,557		90.02
90.03	09003	WOUND CLINIC	0	0		90.03
90.04	09004	OP ORTHO CLINIC	0	132		90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	-15,189	371,762		90.05
90.06	09006	INFUSION CLINIC	0	98,829		90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	407,616		90.07
91.00	09100	EMERGENCY	-265,785	3,005,202		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
93.00	04950	OUTPATIENT PSYCH	0	100,887		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)	-4,406,695	37,397,440		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	18		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	170,054		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
194.00	07950	VACANT	0	0		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)	-4,406,695	37,567,512		200.00

RECLASSIFICATIONS | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/24/2024 9:43 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA				
1.00	CAFETERIA	11.00	176,789	176,407	1.00
	0		176,789	176,407	
	B - DRUGS RECLASS				
1.00	PHARMACY	15.00	0	79,570	1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,375,125	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	2,454,695	
	C - SUPPLIES/IMPLANTS				
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	149,704	1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	58,044	2.00
3.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	21,788	3.00
4.00	ADMINISTRATIVE & GENERAL	5.00	0	2,336	4.00
5.00	HOUSEKEEPING	9.00	0	1,396	5.00
6.00	DIETARY	10.00	0	866	6.00
7.00	NURSING ADMINISTRATION	13.00	0	144	7.00
8.00	PHYSICAL THERAPY	66.00	0	288	8.00
9.00	CARDIOPULMONARY	76.00	0	652	9.00
10.00	HEALTH BEGINNINGS PROGRAM	90.07	0	70	10.00
11.00	OUTPATIENT PSYCH	93.00	0	250	11.00
12.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	190	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	235,728	
	D - LAUNDRY				
1.00	LAUNDRY & LINEN SERVICE	8.00	0	65,953	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
	0		0	65,953	
	E - DEPRECIATION				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,154,744	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-BLDG & FIXT-RHC	1.04	0	2,000	5.00
6.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,015,795	6.00
7.00	CAP REL COSTS-MVBLE EQUIP - MOB	2.01	0	22,245	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

RECLASSIFICATIONS | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/24/2024 9:43 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
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	2,314,474		
	F - PROPERTY TAXES					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	5,767		1.00
	TOTALS		0	5,767		
	G - PROPERTY INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	36,328		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	5,332		2.00
	0		0	41,660		
	H - HOUSEKEEPING SUPPLIES					
1.00	HOUSEKEEPING	9.00	0	4,496		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
	0		0	4,496		
	J - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,990,464		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
	0		0	2,990,464		
	Q - LEASE EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	29,008		1.00
2.00	CAP REL COSTS-BLDG & FIXT-RHC	1.04	0	94,848		2.00
	TOTALS		0	123,856		
500.00	Grand Total: Increases		176,789	8,413,500		500.00

RECLASSIFICATIONS | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/24/2024 9:43 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA						
1.00	DIETARY	10.00	176,789	176,407	0		1.00
	0		176,789	176,407			
	B - DRUGS RECLASS						
1.00	PHARMACY	15.00	0	1,843,944	0		1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	9,632	0		2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	142	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	13,357	0		4.00
5.00	OPERATING ROOM	50.00	0	15,206	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	73,833	0		6.00
7.00	LABORATORY	60.00	0	2	0		7.00
8.00	RESPIRATORY THERAPY	65.00	0	134	0		8.00
9.00	PHYSICAL THERAPY	66.00	0	39	0		9.00
10.00	CARDIOPULMONARY	76.00	0	1,899	0		10.00
11.00	RURAL HEALTH CLINIC (RHC)	88.00	0	61,235	0		11.00
12.00	FAMILY PRACTICE OF JAY COUNTY	90.01	0	144,178	0		12.00
13.00	JAY FAMILY MEDICINE	90.02	0	149,212	0		13.00
14.00	JAY FAMILY FIRST HEALTH CARE	90.05	0	75,967	0		14.00
15.00	INFUSION CLINIC	90.06	0	10,423	0		15.00
16.00	EMERGENCY	91.00	0	55,438	0		16.00
17.00	OUTPATIENT PSYCH	93.00	0	54	0		17.00
	0		0	2,454,695			
	C - SUPPLIES/IMPLANTS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	366	0		1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3	0		2.00
3.00	OPERATION OF PLANT	7.00	0	16,838	0		3.00
4.00	OPERATION OF PLANT - MOB	7.01	0	105	0		4.00
5.00	PHARMACY	15.00	0	596	0		5.00
6.00	ADULTS & PEDIATRICS	30.00	0	32,682	0		6.00
7.00	OPERATING ROOM	50.00	0	78,807	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,137	0		8.00
9.00	LABORATORY	60.00	0	785	0		9.00
10.00	RESPIRATORY THERAPY	65.00	0	13,491	0		10.00
11.00	ELECTROCARDIOLOGY	69.00	0	250	0		11.00
12.00	RURAL HEALTH CLINIC (RHC)	88.00	0	1,050	0		12.00
13.00	FAMILY PRACTICE OF JAY COUNTY	90.01	0	11,256	0		13.00
14.00	JAY FAMILY MEDICINE	90.02	0	10,175	0		14.00
15.00	JAY FAMILY FIRST HEALTH CARE	90.05	0	7,517	0		15.00
16.00	INFUSION CLINIC	90.06	0	3,870	0		16.00
17.00	EMERGENCY	91.00	0	55,800	0		17.00
	0		0	235,728			
	D - LAUNDRY						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	21	0		1.00
2.00	OPERATION OF PLANT - POB	7.02	0	43	0		2.00
3.00	DIETARY	10.00	0	127	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	18,457	0		4.00
5.00	OPERATING ROOM	50.00	0	15,174	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	11,654	0		6.00
7.00	PHYSICAL THERAPY	66.00	0	2,989	0		7.00
8.00	FAMILY PRACTICE OF JAY COUNTY	90.01	0	746	0		8.00
9.00	JAY FAMILY MEDICINE	90.02	0	341	0		9.00
10.00	JAY FAMILY FIRST HEALTH CARE	90.05	0	462	0		10.00
11.00	EMERGENCY	91.00	0	15,721	0		11.00
12.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	218	0		12.00
	0		0	65,953			
	E - DEPRECIATION						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3,077	9		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	53,604	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	23,050	9		6.00
7.00	PHARMACY	15.00	0	40,366	9		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	53,985	0		8.00
9.00	OPERATING ROOM	50.00	0	365,750	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	322,519	0		10.00
11.00	RESPIRATORY THERAPY	65.00	0	22,849	0		11.00
12.00	CARDIOPULMONARY	76.00	0	15,970	0		12.00
13.00	RURAL HEALTH CLINIC (RHC)	88.00	0	2,000	0		13.00
14.00	FAMILY PRACTICE OF JAY COUNTY	90.01	0	6,275	0		14.00

RECLASSIFICATIONS | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/24/2024 9:43 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
15.00	WOUND CLINIC	90.03	0	445	0		15.00
16.00	JAY FAMILY FIRST HEALTH CARE	90.05	0	1,579	0		16.00
17.00	INFUSION CLINIC	90.06	0	445	0		17.00
18.00	HEALTH BEGINNINGS PROGRAM	90.07	0	26,082	0		18.00
19.00	EMERGENCY	91.00	0	70,228	0		19.00
20.00	OUTPATIENT PSYCH	93.00	0	13,158	0		20.00
21.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	9,432	0		21.00
	0		0	2,314,474			
	F - PROPERTY TAXES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	5,767	13		1.00
	TOTALS		0	5,767			
	G - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	41,660	12		1.00
2.00		0.00	0	0	12		2.00
	0		0	41,660			
	H - HOUSEKEEPING SUPPLIES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	43	0		1.00
2.00	OPERATION OF PLANT - MOB	7.01	0	4	0		2.00
3.00	DIETARY	10.00	0	1,395	0		3.00
4.00	NURSING ADMINISTRATION	13.00	0	13	0		4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	3	0		5.00
6.00	PHARMACY	15.00	0	197	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	706	0		7.00
8.00	OPERATING ROOM	50.00	0	750	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	36	0		9.00
10.00	LABORATORY	60.00	0	7	0		10.00
11.00	RESPIRATORY THERAPY	65.00	0	1	0		11.00
12.00	PHYSICAL THERAPY	66.00	0	15	0		12.00
13.00	ELECTROCARDIOLOGY	69.00	0	4	0		13.00
14.00	CARDIOPULMONARY	76.00	0	6	0		14.00
15.00	FAMILY PRACTICE OF JAY COUNTY	90.01	0	109	0		15.00
16.00	JAY FAMILY MEDICINE	90.02	0	466	0		16.00
17.00	JAY FAMILY FIRST HEALTH CARE	90.05	0	85	0		17.00
18.00	INFUSION CLINIC	90.06	0	9	0		18.00
19.00	HEALTH BEGINNINGS PROGRAM	90.07	0	7	0		19.00
20.00	EMERGENCY	91.00	0	640	0		20.00
	0		0	4,496			
	J - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	58,607	0		1.00
2.00	OPERATION OF PLANT	7.00	0	169,278	0		2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	4,995	0		3.00
4.00	HOUSEKEEPING	9.00	0	135,565	0		4.00
5.00	DIETARY	10.00	0	67,913	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	182,662	0		6.00
7.00	PHARMACY	15.00	0	141,699	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	339,113	0		8.00
9.00	OPERATING ROOM	50.00	0	255,849	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	244,764	0		10.00
11.00	RESPIRATORY THERAPY	65.00	0	117,099	0		11.00
12.00	PHYSICAL THERAPY	66.00	0	6,294	0		12.00
13.00	CARDIOPULMONARY	76.00	0	45,174	0		13.00
14.00	RURAL HEALTH CLINIC (RHC)	88.00	0	18,598	0		14.00
15.00	FAMILY PRACTICE OF JAY COUNTY	90.01	0	279,968	0		15.00
16.00	JAY FAMILY MEDICINE	90.02	0	350,539	0		16.00
17.00	JAY FAMILY FIRST HEALTH CARE	90.05	0	112,632	0		17.00
18.00	INFUSION CLINIC	90.06	0	12,569	0		18.00
19.00	HEALTH BEGINNINGS PROGRAM	90.07	0	94,909	0		19.00
20.00	EMERGENCY	91.00	0	277,424	0		20.00
21.00	OUTPATIENT PSYCH	93.00	0	33,091	0		21.00
22.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	41,722	0		22.00
	0		0	2,990,464			
	Q - LEASE EXPENSE						
1.00	OPERATION OF PLANT	7.00	0	29,008	9		1.00
2.00	RURAL HEALTH CLINIC (RHC)	88.00	0	94,848	9		2.00
	TOTALS		0	123,856			
500.00	Grand Total: Decreases		176,789	8,413,500			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part I | Date/Time Prepared: 5/24/2024 9:43 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: 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	359,981	0	359,981	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	9,823,231	1,840,577	0	1,840,577	107,155	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	29,790,231	2,200,558	0	2,200,558	107,155	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	29,790,231	2,200,558	0	2,200,558	107,155	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	359,981	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	11,556,653	5,153,615	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	31,883,634	5,153,615	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	31,883,634	5,153,615	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part II | Date/Time Prepared: 5/24/2024 9:43 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT-MOB	0	0	0	0	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT-POB	0	0	0	0	0	1.02
1.03	CAP REL COSTS-BLDG & FIXT-WJ	0	0	0	0	0	1.03
1.04	CAP REL COSTS-BLDG & FIXT-RHC	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
2.04	CAP REL COSTS-MVBLE EQUIP - RHC	0	0	0	0	0	2.04
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-RHC	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
2.04	CAP REL COSTS-MVBLE EQUIP - RHC	0	0	2.04
3.00	Total (sum of lines 1-2)	0	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part III | Date/Time Prepared: 5/24/2024 9:43 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	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-RHC	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
2.04	CAP REL COSTS-MVBLE EQUIP - RHC	0	0	0	0.000000	0	2.04
3.00	Total (sum of lines 1-2)	0	0	0	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	594,227	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	-26,248	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-RHC	0	0	0	93,932	0	1.04
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,416,496	0	2.00
2.01	CAP REL COSTS-MVBLE EQUIP - MOB	0	0	0	22,245	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
2.04	CAP REL COSTS-MVBLE EQUIP - RHC	0	0	0	0	0	2.04
3.00	Total (sum of lines 1-2)	0	0	0	2,100,652	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	36,328	5,767	0	636,322	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	-26,248	1.02
1.03	CAP REL COSTS-BLDG & FIXT-WJ	0	0	0	0	0	1.03
1.04	CAP REL COSTS-BLDG & FIXT-RHC	0	0	0	0	93,932	1.04
2.00	CAP REL COSTS-MVBLE EQUIP	0	5,332	0	0	1,421,828	2.00
2.01	CAP REL COSTS-MVBLE EQUIP - MOB	0	0	0	0	22,245	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
2.04	CAP REL COSTS-MVBLE EQUIP - RHC	0	0	0	0	0	2.04
3.00	Total (sum of lines 1-2)	0	41,660	5,767	0	2,148,079	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/24/2024 9:43 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	358,298	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-RHC (chapter 2)		0	CAP REL COSTS-BLDG & FIXT-RHC	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
2.04	Investment income - CAP REL COSTS-MVBLE EQUIP - RHC (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP - RHC	2.04	0	2.04
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	-35,371	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	-392,359			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	2,047,492			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	0	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 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/24/2024 9:43 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
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-RHC		0	CAP REL COSTS-BLDG & FIXT-RHC	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
27.04	Depreciation - CAP REL COSTS-MVBLE EQUIP - RHC		0	CAP REL COSTS-MVBLE EQUIP - RHC	2.04	0	27.04
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	-2,990,464	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
33.01	HOSPITAL ASSESSMENT FEES	A	-1,963,903	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	MISCELLANEOUS INCOME	B	-21,829	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	MISCELLANEOUS INCOME	B	-26,248	CAP REL COSTS-BLDG & FIXT-POB	1.02	9	33.03
33.04	CONTRACTED HOSPITALIST	A	-748,312	ADULTS & PEDIATRICS	30.00	0	33.04
33.05	CONTRACTED CRNA	A	-279,188	OPERATING ROOM	50.00	0	33.05
33.06	MEDICARE DEPRECIATION EXPENSE	A	-483,883	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	264,224	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	-140	JAY FAMILY MEDICINE	90.02	0	33.12
33.13	MARKETING EXPENSES	A	-10,606	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	MARKETING EXPENSES	A	-1,800	OPERATING ROOM	50.00	0	33.14
33.15	MISCELLANEOUS NON-ALLOWABLE	A	0		0.00	0	33.15
33.16	MISCELLANEOUS NON-ALLOWABLE	A	0		0.00	0	33.16
33.17	MISC NON-ALLOWABLE	A	0		0.00	0	33.17
33.18	MISC NON-ALLOWABLE	A	0		0.00	0	33.18
33.19	MISCELLANEOUS INCOME	B	-2,916	CAP REL COSTS-BLDG & FIXT-RHC	1.04	9	33.19
33.20	MISCELLANEOUS INCOME	B	0		0.00	0	33.20
33.21	MISCELLANEOUS INCOME	B	0		0.00	0	33.21
33.22	MISC NON-ALLOWABLE	A	0		0.00	0	33.22
33.23	MISC NON-ALLOWABLE	A	0		0.00	0	33.23

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/24/2024 9:43 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,406,695				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 01/01/2023 To 12/31/2023 | Worksheet A-8-1 | Date/Time Prepared: 5/24/2024 9:43 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	-399,561	29,008	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	136,477	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	2,197,992	0	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	6,374,951	6,673,311	3.01
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	RELATED PARTY	0	57,039	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	RELATED PARTY	816,049	471,414	4.01
4.02	7.00	OPERATION OF PLANT	RELATED PARTY	63,395	162,817	4.02
4.03	10.00	DIETARY	RELATED PARTY	9,321	7,375	4.03
4.04	13.00	NURSING ADMINISTRATION	RELATED PARTY	345,422	207,101	4.04
4.05	15.00	PHARMACY	RELATED PARTY	166,125	218,222	4.05
4.06	50.00	OPERATING ROOM	RELATED PARTY	0	10,756	4.06
4.07	54.00	RADIOLOGY-DIAGNOSTIC	RELATED PARTY	139,017	65,478	4.07
4.08	65.00	RESPIRATORY THERAPY	RELATED PARTY	57,542	18,367	4.08
4.09	66.00	PHYSICAL THERAPY	RELATED PARTY	28,340	73,942	4.09
4.10	76.00	CARDIOPULMONARY	RELATED PARTY	55,600	10,634	4.10
4.11	88.00	RURAL HEALTH CLINIC (RHC)	RHC EXPENSE	1,095,077	1,032,791	4.11
4.12	1.04	CAP REL COSTS-BLDG & FIXT-RH	SHARED EMPLOYEES	94,848	94,848	4.12
4.13	4.00	EMPLOYEE BENEFITS DEPARTMENT	SHARED EMPLOYEES	14,872	14,872	4.13
4.14	5.00	ADMINISTRATIVE & GENERAL	SHARED EMPLOYEES	5,026	5,026	4.14
4.15	10.00	DIETARY	SHARED EMPLOYEES	38,353	38,353	4.15
4.16	13.00	NURSING ADMINISTRATION	SHARED EMPLOYEES	113,098	113,098	4.16
4.17	15.00	PHARMACY	SHARED EMPLOYEES	109,498	109,498	4.17
4.18	30.00	ADULTS & PEDIATRICS	SHARED EMPLOYEES	761,225	761,225	4.18
4.19	50.00	OPERATING ROOM	SHARED EMPLOYEES	12,870	12,870	4.19
4.20	60.00	LABORATORY	SHARED EMPLOYEES	2,305,680	2,305,680	4.20
4.21	66.00	PHYSICAL THERAPY	SHARED EMPLOYEES	541,766	541,766	4.21
4.22	67.00	OCCUPATIONAL THERAPY	SHARED EMPLOYEES	99,104	99,104	4.22
4.23	68.00	SPEECH PATHOLOGY	SHARED EMPLOYEES	19,821	19,821	4.23
4.24	76.00	CARDIOPULMONARY	SHARED EMPLOYEES	25,996	25,996	4.24
4.25	88.00	RURAL HEALTH CLINIC (RHC)	SHARED EMPLOYEES	60	60	4.25
4.26	90.01	FAMILY PRACTICE OF JAY COUNT	SHARED EMPLOYEES	31,398	31,398	4.26
4.27	90.02	JAY FAMILY MEDICINE	SHARED EMPLOYEES	111,322	111,322	4.27
4.28	90.05	JAY FAMILY FIRST HEALTH CARE	SHARED EMPLOYEES	15,639	15,639	4.28
4.29	91.00	EMERGENCY	SHARED EMPLOYEES	1,614,732	1,614,732	4.29
4.30	0.00		SHARED EMPLOYEES	0	0	4.30
4.31	0.00		SHARED EMPLOYEES	0	0	4.31
4.32	0.00			0	0	4.32
4.33	0.00			0	0	4.33
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			17,001,055	14,953,563	5.00

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

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

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

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

6.00	B		0.00	IU HEALTH BALL	100.00	6.00
7.00	B		0.00	IU HEALTH	100.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-1320	Period: From 01/01/2023 To 12/31/2023	Worksheet A-8-1 Date/Time Prepared: 5/24/2024 9:43 am

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-1 | Date/Time Prepared: 5/24/2024 9:43 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	-428,569	9		1.00
2.00	136,477	9		2.00
3.00	2,197,992	0		3.00
3.01	-298,360	0		3.01
4.00	-57,039	0		4.00
4.01	344,635	0		4.01
4.02	-99,422	0		4.02
4.03	1,946	0		4.03
4.04	138,321	0		4.04
4.05	-52,097	0		4.05
4.06	-10,756	0		4.06
4.07	73,539	0		4.07
4.08	39,175	0		4.08
4.09	-45,602	0		4.09
4.10	44,966	0		4.10
4.11	62,286	0		4.11
4.12	0	9		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
4.29	0	0		4.29
4.30	0	0		4.30
4.31	0	0		4.31
4.32	0	0		4.32
4.33	0	0		4.33
5.00	2,047,492			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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-1320	Period: From 01/01/2023 To 12/31/2023	Worksheet A-8-1 Date/Time Prepared: 5/24/2024 9:43 am

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		

(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 01/01/2023 To 12/31/2023 | Worksheet A-8-2 | Date/Time Prepared: 5/24/2024 9:43 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	90.01	FAMILY PRACTICE OF JAY COUNTY	30,378	30,378	0	0	0	1.00
2.00	90.02	JAY FAMILY MEDICINE	81,007	81,007	0	0	0	2.00
3.00	90.05	JAY FAMILY FIRST HEALTH CARE	15,189	15,189	0	0	0	3.00
4.00	91.00	EMERGENCY	1,531,170	265,785	1,265,385	0	0	4.00
5.00	0.00		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			1,657,744	392,359	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	90.01	FAMILY PRACTICE OF JAY COUNTY	0	0	0	0	0	1.00
2.00	90.02	JAY FAMILY MEDICINE	0	0	0	0	0	2.00
3.00	90.05	JAY FAMILY FIRST HEALTH CARE	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	0.00		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	90.01	FAMILY PRACTICE OF JAY COUNTY	0	0	0	30,378		1.00
2.00	90.02	JAY FAMILY MEDICINE	0	0	0	81,007		2.00
3.00	90.05	JAY FAMILY FIRST HEALTH CARE	0	0	0	15,189		3.00
4.00	91.00	EMERGENCY	0	0	0	265,785		4.00
5.00	0.00		0	0	0	0		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	392,359		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/24/2024 9:43 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	BLDG & FIXT-MOB	BLDG & FIXT-POB	BLDG & FIXT-WJ	
			0	1.00	1.01	1.02	1.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	636,322	636,322				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	-26,248	0	0	-26,248		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-RHC	93,932	0	0	0	0	1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,421,828					2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB	22,245					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
2.04	00204	CAP REL COSTS-MVBLE EQUIP - RHC	0					2.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,215,545	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,711,026	72,617	0	0	0	5.00
7.00	00700	OPERATION OF PLANT	2,743,841	144,265	0	0	0	7.00
7.01	00701	OPERATION OF PLANT - MOB	118,798	0	0	0	0	7.01
7.02	00702	OPERATION OF PLANT - POB	80,629	0	0	0	0	7.02
7.03	00703	OPERATION OF PLANT - WJ	0	0	0	0	0	7.03
7.04	00704	OPERATION OF PLANT - RHC	0	0	0	0	0	7.04
8.00	00800	LAUNDRY & LINEN SERVICE	85,703	4,609	0	0	0	8.00
9.00	00900	HOUSEKEEPING	775,274	4,671	0	0	0	9.00
10.00	01000	DIETARY	295,004	15,029	0	0	0	10.00
11.00	01100	CAFETERIA	353,196	18,117	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,614,112	7,216	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	160,983	0	0	0	0	14.00
15.00	01500	PHARMACY	1,023,321	7,759	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	1,747,878	76,466	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	1,123,363	30,974	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	1,326,150	37,725	0	0	0	54.00
60.00	06000	LABORATORY	2,606,557	20,290	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	585,411	5,672	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	604,538	26,133	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	99,104	3,631	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	19,821	47	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,595	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	58,044	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	21,788	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,375,125	0	0	0	0	73.00
76.00	03160	CARDIOPULMONARY	289,555	0	0	0	0	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	1,422,326	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	779,689	0	0	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	1,024,557	0	0	0	0	90.02
90.03	09003	WOUND CLINIC	0	0	0	0	0	90.03
90.04	09004	OP ORTHO CLINIC	132	0	0	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	371,762	39,610	0	0	0	90.05
90.06	09006	INFUSION CLINIC	98,829	4,795	0	0	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	407,616	28,848	0	0	0	90.07
91.00	09100	EMERGENCY	3,005,202	37,011	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	100,887	12,190	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)	37,397,440	597,675	0	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	18	5,982	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	170,054	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/24/2024 9:43 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	BLDG & FIXT-MOB	BLDG & FIXT-POB	BLDG & FIXT-WJ	
			0	1.00	1.01	1.02	1.03	
194.00	07950	VACANT	0	20,212	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	12,453	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	-26,248	0	201.00
202.00		TOTAL (sum lines 118 through 201)	37,567,512	636,322	0	-26,248	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/24/2024 9:43 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT-RHC	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-RHC	93,932					1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,421,828				2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB		0	22,245			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
2.04	00204	CAP REL COSTS-MVBLE EQUIP - RHC		0	0	0	0	2.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	162,259	1,451	0	0	5.00
7.00	00700	OPERATION OF PLANT	0	322,351	0	0	0	7.00
7.01	00701	OPERATION OF PLANT - MOB	0	0	507	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
7.04	00704	OPERATION OF PLANT - RHC	0	0	0	0	0	7.04
8.00	00800	LAUNDRY & LINEN SERVICE	0	10,298	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	10,437	0	0	0	9.00
10.00	01000	DIETARY	0	33,582	0	0	0	10.00
11.00	01100	CAFETERIA	0	40,482	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	16,124	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	17,337	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	170,859	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	69,210	936	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	84,294	0	0	0	54.00
60.00	06000	LABORATORY	0	45,337	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	12,674	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	58,392	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	8,114	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	104	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	1,550	0	0	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	93,932	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	0	8,930	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	8,728	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	88,507	143	0	0	90.05
90.06	09006	INFUSION CLINIC	0	10,714	0	0	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	64,460	0	0	0	90.07
91.00	09100	EMERGENCY	0	82,699	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	0	27,237	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)	93,932	1,335,471	22,245	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,367	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	45,164	0	0	0	194.00
194.02	07952	WEST JAY CLINIC	0	0	0	0	0	194.02
194.03	07953	JAY MERIDIAN URGENT CARE	0	27,826	0	0	0	194.03

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/24/2024 9:43 am

	Cost Center Description	CAPITAL RELATED COSTS					
		BLDG & FIXT-RHC	MVBLE EQUIP	MVBLE EQUIP - MOB	MVBLE EQUIP - POB	MVBLE EQUIP - WJ	
		1.04	2.00	2.01	2.02	2.03	
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)	93,932	1,421,828	22,245	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/24/2024 9:43 am

		Cost Center Description	CAPITAL RELATED COSTS MVBLE EQUIP - RHC	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	
			2.04	4.00	4A	5.00	7.00	
		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-RHC						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
2.04	00204	CAP REL COSTS-MVBLE EQUIP - RHC	0					2.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,215,545				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	44,266	7,991,619	7,991,619		5.00
7.00	00700	OPERATION OF PLANT	0	111,071	3,321,528	896,706	4,218,234	7.00
7.01	00701	OPERATION OF PLANT - MOB	0	0	119,305	32,209	23,040	7.01
7.02	00702	OPERATION OF PLANT - POB	0	0	80,629	21,767	28,568	7.02
7.03	00703	OPERATION OF PLANT - WJ	0	0	0	0	0	7.03
7.04	00704	OPERATION OF PLANT - RHC	0	0	0	0	0	7.04
8.00	00800	LAUNDRY & LINEN SERVICE	0	3,233	103,843	28,034	27,592	8.00
9.00	00900	HOUSEKEEPING	0	80,986	871,368	235,241	27,964	9.00
10.00	01000	DIETARY	0	25,827	369,442	99,738	89,977	10.00
11.00	01100	CAFETERIA	0	31,127	442,922	119,575	108,465	11.00
13.00	01300	NURSING ADMINISTRATION	0	190,859	1,828,311	493,585	43,200	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	160,983	43,460	0	14.00
15.00	01500	PHARMACY	0	105,274	1,153,691	311,460	46,452	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	274,524	2,269,727	612,754	457,782	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	153,905	1,378,388	372,121	525,323	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	190,020	1,638,189	442,259	225,848	54.00
60.00	06000	LABORATORY	0	0	2,672,184	721,404	121,471	60.00
65.00	06500	RESPIRATORY THERAPY	0	84,664	688,421	185,852	33,956	65.00
66.00	06600	PHYSICAL THERAPY	0	99,376	788,439	212,853	156,449	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	17,449	128,298	34,636	21,739	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,490	23,462	6,334	279	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	3,595	971	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	58,044	15,670	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	21,788	5,882	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,375,125	641,208	0	73.00
76.00	03160	CARDIOPULMONARY	0	32,043	323,148	87,240	70,421	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	51,327	1,567,585	423,198	146,276	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	121,893	910,512	245,809	405,663	90.01
90.02	09002	JAY FAMILY MEDICINE	0	157,994	1,191,279	321,607	396,512	90.02
90.03	09003	WOUND CLINIC	0	0	0	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0	0	132	36	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0	57,204	557,226	150,433	243,639	90.05
90.06	09006	INFUSION CLINIC	0	15,834	130,172	35,142	28,707	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	66,379	567,303	153,154	172,707	90.07
91.00	09100	EMERGENCY	0	255,679	3,380,591	912,639	221,575	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
93.00	04950	OUTPATIENT PSYCH	0	15,305	155,619	42,012	72,976	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	2,189,729	37,272,868	7,904,989	3,696,581	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	19,367	5,228	35,814	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	25,816	195,870	52,879	290,277	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT	0	0	65,376	17,649	121,007	194.00
194.02	07952	WEST JAY CLINIC	0	0	0	0	0	194.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/24/2024 9:43 am

		Cost Center Description	CAPITAL RELATED COSTS MVBLE EQUIP - RHC	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	
			2.04	4.00	4A	5.00	7.00	
194.03	07953	JAY MERIDIAN URGENT CARE	0	0	40,279	10,874	74,555	194.03
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers	0	0	-26,248	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,215,545	37,567,512	7,991,619	4,218,234	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/24/2024 9:43 am

		Cost Center Description	OPERATION OF PLANT - MOB	OPERATION OF PLANT - POB	OPERATION OF PLANT - WJ	OPERATION OF PLANT - RHC	LAUNDRY & LINEN SERVICE	
			7.01	7.02	7.03	7.04	8.00	
		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-RHC						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
2.04	00204	CAP REL COSTS-MVBLE EQUIP - RHC						2.04
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	174,554					7.01
7.02	00702	OPERATION OF PLANT - POB	0	130,964				7.02
7.03	00703	OPERATION OF PLANT - WJ	0	0	0			7.03
7.04	00704	OPERATION OF PLANT - RHC	0	0	0	0		7.04
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	159,469	8.00
9.00	00900	HOUSEKEEPING	0	0	0	0	0	9.00
10.00	01000	DIETARY	0	0	0	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	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	0	0	0	159,469	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	8,050	93,963	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	13,338	0	0	0	0	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	76,834	0	0	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	75,100	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	1,232	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						92.00
93.00	04950	OUTPATIENT PSYCH	0	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)	174,554	93,963	0	0	159,469	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	37,001	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

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/24/2024 9:43 am

	Cost Center Description	OPERATION OF PLANT - MOB	OPERATION OF PLANT - POB	OPERATION OF PLANT - WJ	OPERATION OF PLANT - RHC	LAUNDRY & LINEN SERVICE	
		7.01	7.02	7.03	7.04	8.00	
202.00	TOTAL (sum lines 118 through 201)	174,554	130,964	0	0	159,469	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/24/2024 9:43 am

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		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-RHC						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
2.04	00204	CAP REL COSTS-MVBLE EQUIP - RHC						2.04
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
7.04	00704	OPERATION OF PLANT - RHC						7.04
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	1,134,573					9.00
10.00	01000	DIETARY	24,832	583,989				10.00
11.00	01100	CAFETERIA	29,934	0	700,896			11.00
13.00	01300	NURSING ADMINISTRATION	11,922	0	45,351	2,422,369		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	204,443	14.00
15.00	01500	PHARMACY	12,820	0	28,092	0	1,058	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	126,340	583,989	98,927	693,440	25,888	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	144,982	0	50,025	382,015	19,953	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	62,330	0	56,588	0	6,354	54.00
60.00	06000	LABORATORY	33,524	0	54,206	0	593	60.00
65.00	06500	RESPIRATORY THERAPY	9,371	0	23,462	0	11,370	65.00
66.00	06600	PHYSICAL THERAPY	42,459	0	20,316	519	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,628	0	6,472	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	154	0	449	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	215	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	49,844	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	18,710	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03160	CARDIOPULMONARY	19,435	0	10,248	7,786	351	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	40,370	0	4,135	4,152	902	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	111,956	0	67,779	145,332	9,462	90.01
90.02	09002	JAY FAMILY MEDICINE	109,431	0	80,634	268,345	8,686	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	67,240	0	30,654	64,361	6,297	90.05
90.06	09006	INFUSION CLINIC	7,923	0	4,090	47,233	3,168	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	47,664	0	19,237	161,941	0	90.07
91.00	09100	EMERGENCY	61,151	0	76,454	642,574	41,529	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	20,140	0	10,787	0	63	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)	990,606	583,989	687,906	2,417,698	204,443	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9,884	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	80,111	0	12,990	4,671	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT	33,396	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	20,576	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/24/2024 9:43 am

	Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		9.00	10.00	11.00	13.00	14.00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	1,134,573	583,989	700,896	2,422,369	204,443	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/24/2024 9:43 am

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	17.00	24.00	25.00	
		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-RHC						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
2.04	00204	CAP REL COSTS-MVBLE EQUIP - RHC						2.04
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
7.04	00704	OPERATION OF PLANT - RHC						7.04
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	1,553,573					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,002	0	0	5,034,318	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	4,838	0	0	2,979,658	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	3,556	0	0	2,435,124	0	54.00
60.00	06000	LABORATORY	0	0	0	3,603,382	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	952,432	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,221,035	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	197,773	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	30,678	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	4,781	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	123,558	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	46,380	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,503,297	0	0	4,519,630	0	73.00
76.00	03160	CARDIOPULMONARY	320	0	0	532,287	0	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	0	0	2,186,618	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	0	0	1,973,347	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	0	2,451,594	0	90.02
90.03	09003	WOUND CLINIC	0	0	0	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0	0	0	168	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0	0	0	1,121,082	0	90.05
90.06	09006	INFUSION CLINIC	5,686	0	0	262,121	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	0	0	1,122,006	0	90.07
91.00	09100	EMERGENCY	29,874	0	0	5,366,387	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
93.00	04950	OUTPATIENT PSYCH	0	0	0	301,597	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)	1,553,573	0	0	36,465,956	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	70,293	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	673,799	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT	0	0	0	237,428	0	194.00
194.02	07952	WEST JAY CLINIC	0	0	0	0	0	194.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/24/2024 9:43 am

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	17.00	24.00	25.00	
194.03	07953	JAY MERIDIAN URGENT CARE	0	0	0	146,284	0	194.03
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	-26,248	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,553,573	0	0	37,567,512	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/24/2024 9:43 am

		Cost Center Description	Total		
			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-RHC			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
2.04	00204	CAP REL COSTS-MVBLE EQUIP - RHC			2.04
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
7.04	00704	OPERATION OF PLANT - RHC			7.04
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			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	5,034,318		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	2,979,658		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		52.00
53.00	05300	ANESTHESIOLOGY	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,435,124		54.00
60.00	06000	LABORATORY	3,603,382		60.00
65.00	06500	RESPIRATORY THERAPY	952,432		65.00
66.00	06600	PHYSICAL THERAPY	1,221,035		66.00
67.00	06700	OCCUPATIONAL THERAPY	197,773		67.00
68.00	06800	SPEECH PATHOLOGY	30,678		68.00
69.00	06900	ELECTROCARDIOLOGY	4,781		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	123,558		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	46,380		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,519,630		73.00
76.00	03160	CARDIOPULMONARY	532,287		76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0		78.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC (RHC)	2,186,618		88.00
90.00	09000	CLINIC	0		90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1,973,347		90.01
90.02	09002	JAY FAMILY MEDICINE	2,451,594		90.02
90.03	09003	WOUND CLINIC	0		90.03
90.04	09004	OP ORTHO CLINIC	168		90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	1,121,082		90.05
90.06	09006	INFUSION CLINIC	262,121		90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	1,122,006		90.07
91.00	09100	EMERGENCY	5,366,387		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
93.00	04950	OUTPATIENT PSYCH	301,597		93.00
		OTHER REIMBURSABLE COST CENTERS			
102.00	10200	OPIOID TREATMENT PROGRAM	0		102.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	36,465,956		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	70,293		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	673,799		192.00
193.00	19300	NONPAID WORKERS	0		193.00
194.00	07950	VACANT	237,428		194.00
194.02	07952	WEST JAY CLINIC	0		194.02
194.03	07953	JAY MERIDIAN URGENT CARE	146,284		194.03
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	-26,248		201.00
202.00		TOTAL (sum lines 118 through 201)	37,567,512		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/24/2024 9:43 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	BLDG & FIXT-MOB	BLDG & FIXT-POB	BLDG & FIXT-WJ	
			0	1.00	1.01	1.02	1.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MOB						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT-POB						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT-WJ						1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT-RHC						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
2.04	00204	CAP REL COSTS-MVBLE EQUIP - RHC						2.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	72,617	0	0	0	5.00
7.00	00700	OPERATION OF PLANT	0	144,265	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
7.04	00704	OPERATION OF PLANT - RHC	0	0	0	0	0	7.04
8.00	00800	LAUNDRY & LINEN SERVICE	0	4,609	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	4,671	0	0	0	9.00
10.00	01000	DIETARY	0	15,029	0	0	0	10.00
11.00	01100	CAFETERIA	0	18,117	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	7,216	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	7,759	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	76,466	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	30,974	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	37,725	0	0	0	54.00
60.00	06000	LABORATORY	0	20,290	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	5,672	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	26,133	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,631	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	47	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
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	0	0	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	0	0	0	90.02
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	39,610	0	0	0	90.05
90.06	09006	INFUSION CLINIC	0	4,795	0	0	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	28,848	0	0	0	90.07
91.00	09100	EMERGENCY	0	37,011	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	0	12,190	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	597,675	0	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,982	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	20,212	0	0	0	194.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/24/2024 9:43 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	BLDG & FIXT-MOB	BLDG & FIXT-POB	BLDG & FIXT-WJ	
			0	1.00	1.01	1.02	1.03	
194.02	07952	WEST JAY CLINIC	0	0	0	0	0	194.02
194.03	07953	JAY MERIDIAN URGENT CARE	0	12,453	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	-26,248	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	636,322	0	-26,248	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/24/2024 9:43 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT-RHC	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-RHC						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
2.04	00204	CAP REL COSTS-MVBLE EQUIP - RHC						2.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	162,259	1,451	0	0	5.00
7.00	00700	OPERATION OF PLANT	0	322,351	0	0	0	7.00
7.01	00701	OPERATION OF PLANT - MOB	0	0	507	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
7.04	00704	OPERATION OF PLANT - RHC	0	0	0	0	0	7.04
8.00	00800	LAUNDRY & LINEN SERVICE	0	10,298	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	10,437	0	0	0	9.00
10.00	01000	DIETARY	0	33,582	0	0	0	10.00
11.00	01100	CAFETERIA	0	40,482	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	16,124	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	17,337	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	170,859	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	69,210	936	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	84,294	0	0	0	54.00
60.00	06000	LABORATORY	0	45,337	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	12,674	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	58,392	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	8,114	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	104	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	1,550	0	0	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	93,932	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	0	8,930	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	8,728	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	88,507	143	0	0	90.05
90.06	09006	INFUSION CLINIC	0	10,714	0	0	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	64,460	0	0	0	90.07
91.00	09100	EMERGENCY	0	82,699	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	0	27,237	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)	93,932	1,335,471	22,245	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,367	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	45,164	0	0	0	194.00
194.02	07952	WEST JAY CLINIC	0	0	0	0	0	194.02
194.03	07953	JAY MERIDIAN URGENT CARE	0	27,826	0	0	0	194.03

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/24/2024 9:43 am

	Cost Center Description	CAPITAL RELATED COSTS					
		BLDG & FIXT-RHC	MVBLE EQUIP	MVBLE EQUIP - MOB	MVBLE EQUIP - POB	MVBLE EQUIP - WJ	
		1.04	2.00	2.01	2.02	2.03	
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)	93,932	1,421,828	22,245	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/24/2024 9:43 am

		Cost Center Description	CAPITAL RELATED COSTS MVBLE EQUIP - RHC	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	
			2.04	2A	4.00	5.00	7.00	
		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-RHC						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
2.04	00204	CAP REL COSTS-MVBLE EQUIP - RHC						2.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	236,327	0	236,327		5.00
7.00	00700	OPERATION OF PLANT	0	466,616	0	26,516	493,132	7.00
7.01	00701	OPERATION OF PLANT - MOB	0	507	0	952	2,693	7.01
7.02	00702	OPERATION OF PLANT - POB	0	0	0	644	3,340	7.02
7.03	00703	OPERATION OF PLANT - WJ	0	0	0	0	0	7.03
7.04	00704	OPERATION OF PLANT - RHC	0	0	0	0	0	7.04
8.00	00800	LAUNDRY & LINEN SERVICE	0	14,907	0	829	3,226	8.00
9.00	00900	HOUSEKEEPING	0	15,108	0	6,956	3,269	9.00
10.00	01000	DIETARY	0	48,611	0	2,949	10,519	10.00
11.00	01100	CAFETERIA	0	58,599	0	3,536	12,680	11.00
13.00	01300	NURSING ADMINISTRATION	0	23,340	0	14,595	5,050	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	1,285	0	14.00
15.00	01500	PHARMACY	0	25,096	0	9,210	5,430	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	247,325	0	18,119	53,517	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	101,120	0	11,004	61,412	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	122,019	0	13,078	26,403	54.00
60.00	06000	LABORATORY	0	65,627	0	21,332	14,201	60.00
65.00	06500	RESPIRATORY THERAPY	0	18,346	0	5,496	3,970	65.00
66.00	06600	PHYSICAL THERAPY	0	84,525	0	6,294	18,290	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	11,745	0	1,024	2,541	67.00
68.00	06800	SPEECH PATHOLOGY	0	151	0	187	33	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	29	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	463	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	174	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	18,961	0	73.00
76.00	03160	CARDIOPULMONARY	0	1,550	0	2,580	8,233	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	93,932	0	12,514	17,100	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	8,930	0	7,269	47,424	90.01
90.02	09002	JAY FAMILY MEDICINE	0	8,728	0	9,510	46,354	90.02
90.03	09003	WOUND CLINIC	0	0	0	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0	0	0	1	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0	128,260	0	4,448	28,483	90.05
90.06	09006	INFUSION CLINIC	0	15,509	0	1,039	3,356	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	93,308	0	4,529	20,190	90.07
91.00	09100	EMERGENCY	0	119,710	0	26,999	25,903	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0				92.00
93.00	04950	OUTPATIENT PSYCH	0	39,427	0	1,242	8,531	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	2,049,323	0	233,764	432,148	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	19,349	0	155	4,187	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	1,564	33,935	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT	0	65,376	0	522	14,146	194.00
194.02	07952	WEST JAY CLINIC	0	0	0	0	0	194.02

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/24/2024 9:43 am

		Cost Center Description	CAPITAL RELATED COSTS MVBLE EQUIP - RHC	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	
			2.04	2A	4.00	5.00	7.00	
194.03	07953	JAY MERIDIAN URGENT CARE	0	40,279	0	322	8,716	194.03
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	-26,248	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,148,079	0	236,327	493,132	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/24/2024 9:43 am

		Cost Center Description	OPERATION OF PLANT - MOB	OPERATION OF PLANT - POB	OPERATION OF PLANT - WJ	OPERATION OF PLANT - RHC	LAUNDRY & LINEN SERVICE	
			7.01	7.02	7.03	7.04	8.00	
		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-RHC						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
2.04	00204	CAP REL COSTS-MVBLE EQUIP - RHC						2.04
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	4,152					7.01
7.02	00702	OPERATION OF PLANT - POB	0	3,984				7.02
7.03	00703	OPERATION OF PLANT - WJ	0	0	0			7.03
7.04	00704	OPERATION OF PLANT - RHC	0	0	0	0		7.04
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	18,962	8.00
9.00	00900	HOUSEKEEPING	0	0	0	0	0	9.00
10.00	01000	DIETARY	0	0	0	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	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	0	0	0	18,962	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	191	2,858	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	317	0	0	0	0	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1,829	0	0	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	1,786	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	29	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						92.00
93.00	04950	OUTPATIENT PSYCH	0	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)	4,152	2,858	0	0	18,962	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,126	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

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/24/2024 9:43 am

	Cost Center Description	OPERATION OF PLANT - MOB	OPERATION OF PLANT - POB	OPERATION OF PLANT - WJ	OPERATION OF PLANT - RHC	LAUNDRY & LINEN SERVICE	
		7.01	7.02	7.03	7.04	8.00	
202.00	TOTAL (sum lines 118 through 201)	4,152	3,984	0	0	18,962	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/24/2024 9:43 am

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		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-RHC						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
2.04	00204	CAP REL COSTS-MVBLE EQUIP - RHC						2.04
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
7.04	00704	OPERATION OF PLANT - RHC						7.04
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	25,333					9.00
10.00	01000	DIETARY	554	62,633				10.00
11.00	01100	CAFETERIA	668	0	75,483			11.00
13.00	01300	NURSING ADMINISTRATION	266	0	4,884	48,135		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	1,285	14.00
15.00	01500	PHARMACY	286	0	3,025	0	7	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	2,821	62,633	10,655	13,778	163	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	3,239	0	5,387	7,591	125	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	1,392	0	6,094	0	40	54.00
60.00	06000	LABORATORY	749	0	5,838	0	4	60.00
65.00	06500	RESPIRATORY THERAPY	209	0	2,527	0	71	65.00
66.00	06600	PHYSICAL THERAPY	948	0	2,188	10	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	148	0	697	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	3	0	48	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	1	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	313	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	118	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03160	CARDIOPULMONARY	434	0	1,104	155	2	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	901	0	445	83	6	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	2,500	0	7,299	2,888	59	90.01
90.02	09002	JAY FAMILY MEDICINE	2,443	0	8,684	5,332	55	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	1,501	0	3,301	1,279	40	90.05
90.06	09006	INFUSION CLINIC	177	0	440	939	20	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	1,064	0	2,072	3,218	0	90.07
91.00	09100	EMERGENCY	1,365	0	8,234	12,769	261	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	450	0	1,162	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)	22,118	62,633	74,084	48,042	1,285	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	221	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,789	0	1,399	93	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT	746	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	459	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/24/2024 9:43 am

	Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		9.00	10.00	11.00	13.00	14.00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	25,333	62,633	75,483	48,135	1,285	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/24/2024 9:43 am

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	17.00	24.00	25.00	
		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-RHC						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
2.04	00204	CAP REL COSTS-MVBLE EQUIP - RHC						2.04
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
7.04	00704	OPERATION OF PLANT - RHC						7.04
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	43,054					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	166	0	0	428,139	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	134	0	0	193,061	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	99	0	0	169,125	0	54.00
60.00	06000	LABORATORY	0	0	0	107,751	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	30,619	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	112,255	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	16,155	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	422	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	30	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	776	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	292	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	41,660	0	0	60,621	0	73.00
76.00	03160	CARDIOPULMONARY	9	0	0	14,384	0	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	0	0	124,981	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	0	0	78,198	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	0	82,892	0	90.02
90.03	09003	WOUND CLINIC	0	0	0	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0	0	0	1	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0	0	0	167,341	0	90.05
90.06	09006	INFUSION CLINIC	158	0	0	21,638	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	0	0	124,381	0	90.07
91.00	09100	EMERGENCY	828	0	0	196,069	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
93.00	04950	OUTPATIENT PSYCH	0	0	0	50,812	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)	43,054	0	0	1,979,943	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	23,912	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	39,906	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT	0	0	0	80,790	0	194.00
194.02	07952	WEST JAY CLINIC	0	0	0	0	0	194.02

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/24/2024 9:43 am

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	17.00	24.00	25.00	
194.03	07953	JAY MERIDIAN URGENT CARE	0	0	0	49,776	0	194.03
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	-26,248	0	201.00
202.00		TOTAL (sum lines 118 through 201)	43,054	0	0	2,148,079	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/24/2024 9:43 am

		Cost Center Description	Total		
			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-RHC			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
2.04	00204	CAP REL COSTS-MVBLE EQUIP - RHC			2.04
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
7.04	00704	OPERATION OF PLANT - RHC			7.04
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			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	428,139		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	193,061		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		52.00
53.00	05300	ANESTHESIOLOGY	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	169,125		54.00
60.00	06000	LABORATORY	107,751		60.00
65.00	06500	RESPIRATORY THERAPY	30,619		65.00
66.00	06600	PHYSICAL THERAPY	112,255		66.00
67.00	06700	OCCUPATIONAL THERAPY	16,155		67.00
68.00	06800	SPEECH PATHOLOGY	422		68.00
69.00	06900	ELECTROCARDIOLOGY	30		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	776		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	292		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	60,621		73.00
76.00	03160	CARDIOPULMONARY	14,384		76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0		78.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC (RHC)	124,981		88.00
90.00	09000	CLINIC	0		90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	78,198		90.01
90.02	09002	JAY FAMILY MEDICINE	82,892		90.02
90.03	09003	WOUND CLINIC	0		90.03
90.04	09004	OP ORTHO CLINIC	1		90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	167,341		90.05
90.06	09006	INFUSION CLINIC	21,638		90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	124,381		90.07
91.00	09100	EMERGENCY	196,069		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
93.00	04950	OUTPATIENT PSYCH	50,812		93.00
		OTHER REIMBURSABLE COST CENTERS			
102.00	10200	OPIOID TREATMENT PROGRAM	0		102.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,979,943		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	23,912		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	39,906		192.00
193.00	19300	NONPAID WORKERS	0		193.00
194.00	07950	VACANT	80,790		194.00
194.02	07952	WEST JAY CLINIC	0		194.02
194.03	07953	JAY MERIDIAN URGENT CARE	49,776		194.03
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	-26,248		201.00
202.00		TOTAL (sum lines 118 through 201)	2,148,079		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/24/2024 9:43 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	BLDG & FIXT-MOB (SQUARE FEET-MOB)	BLDG & FIXT-POB (SQUARE FEET-POB)	BLDG & FIXT-WJ (SQUARE FEET-WJ)	BLDG & FIXT-RHC (SQUARE FEET-RHC)	
			1.00	1.01	1.02	1.03	1.04	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	82,010					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MOB	0	21,755				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-RHC	0	0	0	0	3,149	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
2.04	00204	CAP REL COSTS-MVBLE EQUIP - RHC						2.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,359	1,419	0	0	0	5.00
7.00	00700	OPERATION OF PLANT	18,593	0	0	0	0	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
7.04	00704	OPERATION OF PLANT - RHC	0	0	0	0	0	7.04
8.00	00800	LAUNDRY & LINEN SERVICE	594	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	602	0	0	0	0	9.00
10.00	01000	DIETARY	1,937	0	0	0	0	10.00
11.00	01100	CAFETERIA	2,335	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	930	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	1,000	0	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	9,855	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
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,992	915	6,402	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	4,862	0	0	0	0	54.00
60.00	06000	LABORATORY	2,615	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	731	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	3,368	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	468	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	6	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	1,516	0	0	0	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	0	0	0	3,149	88.00
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	140	0	0	0	90.05
90.06	09006	INFUSION CLINIC	618	0	0	0	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	3,718	0	0	0	0	90.07
91.00	09100	EMERGENCY	4,770	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	1,571	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)	77,029	21,755	7,017	0	3,149	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	0	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

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/24/2024 9:43 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	BLDG & FIXT-MOB (SQUARE FEET-MOB)	BLDG & FIXT-POB (SQUARE FEET-POB)	BLDG & FIXT-WJ (SQUARE FEET-WJ)	BLDG & FIXT-RHC (SQUARE FEET-RHC)	
			1.00	1.01	1.02	1.03	1.04	
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
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	636,322	0	-26,248	0	93,932	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.759078	0.000000	0.000000	0.000000	29.829152	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 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/24/2024 9:43 am

		Cost Center Description	CAPITAL RELATED COSTS					
			MVBLE EQUIP (SQUARE FEET)	MVBLE EQUIP - MOB (SQUARE FEET-MOB)	MVBLE EQUIP - POB (SQUARE FEET-POB)	MVBLE EQUIP - WJ (SQUARE FEET-WJ)	MVBLE EQUIP - RHC (SQUARE FEET-RHC)	
			2.00	2.01	2.02	2.03	2.04	
		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-RHC						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP	82,010					2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB	0	21,755				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
2.04	00204	CAP REL COSTS-MVBLE EQUIP - RHC	0	0	0	0	3,149	2.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,359	1,419	0	0	0	5.00
7.00	00700	OPERATION OF PLANT	18,593	0	0	0	0	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
7.04	00704	OPERATION OF PLANT - RHC	0	0	0	0	0	7.04
8.00	00800	LAUNDRY & LINEN SERVICE	594	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	602	0	0	0	0	9.00
10.00	01000	DIETARY	1,937	0	0	0	0	10.00
11.00	01100	CAFETERIA	2,335	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	930	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	1,000	0	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	9,855	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
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,992	915	6,402	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	4,862	0	0	0	0	54.00
60.00	06000	LABORATORY	2,615	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	731	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	3,368	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	468	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	6	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	1,516	0	0	0	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	0	0	0	3,149	88.00
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	140	0	0	0	90.05
90.06	09006	INFUSION CLINIC	618	0	0	0	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	3,718	0	0	0	0	90.07
91.00	09100	EMERGENCY	4,770	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	1,571	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)	77,029	21,755	7,017	0	3,149	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	0	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

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/24/2024 9:43 am

		Cost Center Description	CAPITAL RELATED COSTS					
			MVBLE EQUIP (SQUARE FEET)	MVBLE EQUIP - MOB (SQUARE FEET-MOB)	MVBLE EQUIP - POB (SQUARE FEET-POB)	MVBLE EQUIP - WJ (SQUARE FEET-WJ)	MVBLE EQUIP - RHC (SQUARE FEET-RHC)	
			2.00	2.01	2.02	2.03	2.04	
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
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,421,828	22,245	0	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	17.337252	1.022524	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 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/24/2024 9:43 am

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT - MOB (SQUARE FEET-MOB)	
			4.00	5A	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-RHC						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
2.04	00204	CAP REL COSTS-MVBLE EQUIP - RHC						2.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	12,583,442					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	251,416	-7,991,619	29,602,141			5.00
7.00	00700	OPERATION OF PLANT	630,842	0	3,321,528	90,809		7.00
7.01	00701	OPERATION OF PLANT - MOB	0	0	119,305	496	19,840	7.01
7.02	00702	OPERATION OF PLANT - POB	0	0	80,629	615	0	7.02
7.03	00703	OPERATION OF PLANT - WJ	0	0	0	0	0	7.03
7.04	00704	OPERATION OF PLANT - RHC	0	0	0	0	0	7.04
8.00	00800	LAUNDRY & LINEN SERVICE	18,362	0	103,843	594	0	8.00
9.00	00900	HOUSEKEEPING	459,969	0	871,368	602	0	9.00
10.00	01000	DIETARY	146,687	0	369,442	1,937	0	10.00
11.00	01100	CAFETERIA	176,789	0	442,922	2,335	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,084,009	0	1,828,311	930	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	160,983	0	0	14.00
15.00	01500	PHARMACY	597,917	0	1,153,691	1,000	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	1,559,160	0	2,269,727	9,855	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	874,120	0	1,378,388	11,309	915	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	1,079,240	0	1,638,189	4,862	0	54.00
60.00	06000	LABORATORY	0	0	2,672,184	2,615	0	60.00
65.00	06500	RESPIRATORY THERAPY	480,862	0	688,421	731	0	65.00
66.00	06600	PHYSICAL THERAPY	564,421	0	788,439	3,368	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	99,104	0	128,298	468	0	67.00
68.00	06800	SPEECH PATHOLOGY	19,821	0	23,462	6	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	3,595	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	58,044	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	21,788	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,375,125	0	0	73.00
76.00	03160	CARDIOPULMONARY	181,995	0	323,148	1,516	1,516	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	291,520	0	1,567,585	3,149	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	692,309	0	910,512	8,733	8,733	90.01
90.02	09002	JAY FAMILY MEDICINE	897,344	0	1,191,279	8,536	8,536	90.02
90.03	09003	WOUND CLINIC	0	0	0	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0	0	132	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	324,898	0	557,226	5,245	140	90.05
90.06	09006	INFUSION CLINIC	89,932	0	130,172	618	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	377,009	0	567,303	3,718	0	90.07
91.00	09100	EMERGENCY	1,452,159	0	3,380,591	4,770	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	86,929	0	155,619	1,571	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)	12,436,814	-7,991,619	29,281,249	79,579	19,840	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	19,367	771	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	146,628	0	195,870	6,249	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT	0	0	65,376	2,605	0	194.00
194.02	07952	WEST JAY CLINIC	0	0	0	0	0	194.02

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		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT - MOB (SQUARE FEET-MOB)	
			4.00	5A	5.00	7.00	7.01	
194.03	07953	JAY MERIDIAN URGENT CARE	0	0	40,279	1,605	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)	2,215,545		7,991,619	4,218,234	174,554	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.176068		0.269968	46.451717	8.798085	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0		236,327	493,132	4,152	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000		0.007983	5.430431	0.209274	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 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/24/2024 9:43 am

		Cost Center Description	OPERATION OF PLANT - POB (SQUARE FEET-POB)	OPERATION OF PLANT - WJ (SQUARE FEET-WJ)	OPERATION OF PLANT - RHC (SQUARE FEET-RHC)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	
			7.02	7.03	7.04	8.00	9.00	
		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-RHC						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
2.04	00204	CAP REL COSTS-MVBLE EQUIP - RHC						2.04
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	8,923					7.02
7.03	00703	OPERATION OF PLANT - WJ	0	3,728				7.03
7.04	00704	OPERATION OF PLANT - RHC	0	0	3,149			7.04
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	880		8.00
9.00	00900	HOUSEKEEPING	0	0	0	0	88,501	9.00
10.00	01000	DIETARY	0	0	0	0	1,937	10.00
11.00	01100	CAFETERIA	0	0	0	0	2,335	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	930	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	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	0	0	0	880	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	6,402	0	0	0	11,309	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	4,862	54.00
60.00	06000	LABORATORY	0	0	0	0	2,615	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	731	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	3,312	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	517	67.00
68.00	06800	SPEECH PATHOLOGY	0	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	0	0	0	1,516	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	0	3,149	0	3,149	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	0	0	0	8,733	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	0	0	8,536	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	5,245	90.05
90.06	09006	INFUSION CLINIC	0	0	0	0	618	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	0	0	0	3,718	90.07
91.00	09100	EMERGENCY	0	0	0	0	4,770	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	0	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)	6,402	0	3,149	880	77,271	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	771	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,521	3,728	0	0	6,249	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT	0	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	0	0	0	0	1,605	194.03

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/24/2024 9:43 am

	Cost Center Description	OPERATION OF PLANT - POB (SQUARE FEET-POB)	OPERATION OF PLANT - WJ (SQUARE FEET-WJ)	OPERATION OF PLANT - RHC (SQUARE FEET-RHC)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	
		7.02	7.03	7.04	8.00	9.00	
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)	130,964	0	0	159,469	1,134,573	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	14.677127	0.000000	0.000000	181.214773	12.819889	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	3,984	0	0	18,962	25,333	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.446487	0.000000	0.000000	21.547727	0.286245	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 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/24/2024 9:43 am

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			10.00	11.00	13.00	14.00	15.00	
		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-RHC						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
2.04	00204	CAP REL COSTS-MVBLE EQUIP - RHC						2.04
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
7.04	00704	OPERATION OF PLANT - RHC						7.04
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	6,904					10.00
11.00	01100	CAFETERIA	0	15,594				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,009	4,667			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	238,076		14.00
15.00	01500	PHARMACY	0	625	0	1,232	2,454,558	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	6,904	2,201	1,336	30,147	9,483	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	1,113	736	23,236	7,643	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	1,259	0	7,399	5,619	54.00
60.00	06000	LABORATORY	0	1,206	0	690	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	522	0	13,241	0	65.00
66.00	06600	PHYSICAL THERAPY	0	452	1	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	144	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	10	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	250	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	58,044	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	21,788	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	2,375,125	73.00
76.00	03160	CARDIOPULMONARY	0	228	15	409	505	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	92	8	1,050	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	1,508	280	11,019	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0	1,794	517	10,115	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	682	124	7,333	0	90.05
90.06	09006	INFUSION CLINIC	0	91	91	3,689	8,984	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	428	312	0	0	90.07
91.00	09100	EMERGENCY	0	1,701	1,238	48,361	47,199	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	0	240	0	73	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)	6,904	15,305	4,658	238,076	2,454,558	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	289	9	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

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/24/2024 9:43 am

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			10.00	11.00	13.00	14.00	15.00	
194.03	07953	JAY MERIDIAN URGENT CARE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	583,989	700,896	2,422,369	204,443	1,553,573	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	84.587051	44.946518	519.041997	0.858730	0.632934	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	62,633	75,483	48,135	1,285	43,054	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	9.071987	4.840516	10.313906	0.005397	0.017540	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 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/24/2024 9:43 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)		
			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-RHC				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
2.04	00204	CAP REL COSTS-MVBLE EQUIP - RHC				2.04
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
7.04	00704	OPERATION OF PLANT - RHC				7.04
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	90,908,813			16.00
17.00	01700	SOCIAL SERVICE	0	0		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	6,864,951	0		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	7,420,758	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	14,494,285	0		54.00
60.00	06000	LABORATORY	10,049,969	0		60.00
65.00	06500	RESPIRATORY THERAPY	2,374,274	0		65.00
66.00	06600	PHYSICAL THERAPY	1,898,322	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	346,805	0		67.00
68.00	06800	SPEECH PATHOLOGY	14,602	0		68.00
69.00	06900	ELECTROCARDIOLOGY	130,304	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	226,319	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	328,698	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,294,652	0		73.00
76.00	03160	CARDIOPULMONARY	2,709,630	0		76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC (RHC)	1,697,771	0		88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	919,837	0		90.01
90.02	09002	JAY FAMILY MEDICINE	915,358	0		90.02
90.03	09003	WOUND CLINIC	0	0		90.03
90.04	09004	OP ORTHO CLINIC	0	0		90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	370,307	0		90.05
90.06	09006	INFUSION CLINIC	2,100,886	0		90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	0		90.07
91.00	09100	EMERGENCY	23,002,909	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
93.00	04950	OUTPATIENT PSYCH	748,176	0		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)	90,908,813	0		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
194.00	07950	VACANT	0	0		194.00
194.02	07952	WEST JAY CLINIC	0	0		194.02

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/24/2024 9:43 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)		
			16.00	17.00		
194.03	07953	JAY MERIDIAN URGENT CARE	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	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	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 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/24/2024 9:43 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,034,318		5,034,318	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	2,979,658		2,979,658	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	2,435,124		2,435,124	0	0	54.00
60.00	06000	LABORATORY	3,603,382		3,603,382	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	952,432	0	952,432	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,221,035	0	1,221,035	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	197,773	0	197,773	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	30,678	0	30,678	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,781		4,781	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	123,558		123,558	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	46,380		46,380	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,519,630		4,519,630	0	0	73.00
76.00	03160	CARDIOPULMONARY	532,287		532,287	0	0	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0		0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	2,186,618		2,186,618	0	0	88.00
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1,973,347		1,973,347	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	2,451,594		2,451,594	0	0	90.02
90.03	09003	WOUND CLINIC	0		0	0	0	90.03
90.04	09004	OP ORTHO CLINIC	168		168	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	1,121,082		1,121,082	0	0	90.05
90.06	09006	INFUSION CLINIC	262,121		262,121	0	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	1,122,006		1,122,006	0	0	90.07
91.00	09100	EMERGENCY	5,366,387		5,366,387	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,999,612		1,999,612		0	92.00
93.00	04950	OUTPATIENT PSYCH	301,597		301,597	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
200.00		Subtotal (see instructions)	38,465,568	0	38,465,568	0	0	200.00
201.00		Less Observation Beds	1,999,612		1,999,612		0	201.00
202.00		Total (see instructions)	36,465,956	0	36,465,956	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/24/2024 9:43 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,822,430		2,822,430			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	80,902	7,339,856	7,420,758	0.401530	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	383,458	14,110,827	14,494,285	0.168006	0.000000	54.00
60.00	06000	LABORATORY	534,169	9,515,800	10,049,969	0.358547	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	573,632	1,800,642	2,374,274	0.401147	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	218,138	1,680,184	1,898,322	0.643218	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	163,951	182,854	346,805	0.570271	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	13,648	954	14,602	2.100945	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	299	130,005	130,304	0.036691	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	45,035	181,284	226,319	0.545946	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	51,170	277,528	328,698	0.141102	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,234,735	13,059,917	14,294,652	0.316176	0.000000	73.00
76.00	03160	CARDIOPULMONARY	181,454	2,528,176	2,709,630	0.196443	0.000000	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0.000000	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	1,697,771	1,697,771			88.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	919,837	919,837	2.145322	0.000000	90.01
90.02	09002	JAY FAMILY MEDICINE	0	915,358	915,358	2.678290	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	0	0	0.000000	0.000000	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0	370,307	370,307	3.027439	0.000000	90.05
90.06	09006	INFUSION CLINIC	0	2,100,886	2,100,886	0.124767	0.000000	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	0	0	0.000000	0.000000	90.07
91.00	09100	EMERGENCY	356,063	22,646,846	23,002,909	0.233292	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	11,049	4,031,472	4,042,521	0.494645	0.000000	92.00
93.00	04950	OUTPATIENT PSYCH	0	748,176	748,176	0.403110	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
200.00		Subtotal (see instructions)	6,670,133	84,238,680	90,908,813			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	6,670,133	84,238,680	90,908,813			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/24/2024 9:43 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		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
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000		78.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC (RHC)			88.00
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0.000000		90.01
90.02	09002	JAY FAMILY MEDICINE	0.000000		90.02
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 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/24/2024 9:43 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,034,318		5,034,318	0	5,034,318	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	2,979,658		2,979,658	0	2,979,658	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	2,435,124		2,435,124	0	2,435,124	54.00
60.00	06000	LABORATORY	3,603,382		3,603,382	0	3,603,382	60.00
65.00	06500	RESPIRATORY THERAPY	952,432	0	952,432	0	952,432	65.00
66.00	06600	PHYSICAL THERAPY	1,221,035	0	1,221,035	0	1,221,035	66.00
67.00	06700	OCCUPATIONAL THERAPY	197,773	0	197,773	0	197,773	67.00
68.00	06800	SPEECH PATHOLOGY	30,678	0	30,678	0	30,678	68.00
69.00	06900	ELECTROCARDIOLOGY	4,781		4,781	0	4,781	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	123,558		123,558	0	123,558	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	46,380		46,380	0	46,380	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,519,630		4,519,630	0	4,519,630	73.00
76.00	03160	CARDIOPULMONARY	532,287		532,287	0	532,287	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0		0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	2,186,618		2,186,618	0	2,186,618	88.00
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1,973,347		1,973,347	0	1,973,347	90.01
90.02	09002	JAY FAMILY MEDICINE	2,451,594		2,451,594	0	2,451,594	90.02
90.03	09003	WOUND CLINIC	0		0	0	0	90.03
90.04	09004	OP ORTHO CLINIC	168		168	0	168	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	1,121,082		1,121,082	0	1,121,082	90.05
90.06	09006	INFUSION CLINIC	262,121		262,121	0	262,121	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	1,122,006		1,122,006	0	1,122,006	90.07
91.00	09100	EMERGENCY	5,366,387		5,366,387	0	5,366,387	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,999,612		1,999,612		1,999,612	92.00
93.00	04950	OUTPATIENT PSYCH	301,597		301,597	0	301,597	93.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
200.00		Subtotal (see instructions)	38,465,568	0	38,465,568	0	38,465,568	200.00
201.00		Less Observation Beds	1,999,612		1,999,612		1,999,612	201.00
202.00		Total (see instructions)	36,465,956	0	36,465,956	0	36,465,956	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/24/2024 9:43 am

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,822,430		2,822,430			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	80,902	7,339,856	7,420,758	0.401530	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	383,458	14,110,827	14,494,285	0.168006	0.000000	54.00
60.00	06000	LABORATORY	534,169	9,515,800	10,049,969	0.358547	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	573,632	1,800,642	2,374,274	0.401147	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	218,138	1,680,184	1,898,322	0.643218	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	163,951	182,854	346,805	0.570271	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	13,648	954	14,602	2.100945	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	299	130,005	130,304	0.036691	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	45,035	181,284	226,319	0.545946	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	51,170	277,528	328,698	0.141102	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,234,735	13,059,917	14,294,652	0.316176	0.000000	73.00
76.00	03160	CARDIOPULMONARY	181,454	2,528,176	2,709,630	0.196443	0.000000	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0.000000	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	1,697,771	1,697,771	1.287935	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	919,837	919,837	2.145322	0.000000	90.01
90.02	09002	JAY FAMILY MEDICINE	0	915,358	915,358	2.678290	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	0	0	0.000000	0.000000	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0	370,307	370,307	3.027439	0.000000	90.05
90.06	09006	INFUSION CLINIC	0	2,100,886	2,100,886	0.124767	0.000000	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	0	0	0.000000	0.000000	90.07
91.00	09100	EMERGENCY	356,063	22,646,846	23,002,909	0.233292	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	11,049	4,031,472	4,042,521	0.494645	0.000000	92.00
93.00	04950	OUTPATIENT PSYCH	0	748,176	748,176	0.403110	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
200.00		Subtotal (see instructions)	6,670,133	84,238,680	90,908,813			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	6,670,133	84,238,680	90,908,813			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/24/2024 9:43 am

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.401530		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	0.168006		54.00
60.00	06000	LABORATORY	0.358547		60.00
65.00	06500	RESPIRATORY THERAPY	0.401147		65.00
66.00	06600	PHYSICAL THERAPY	0.643218		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.570271		67.00
68.00	06800	SPEECH PATHOLOGY	2.100945		68.00
69.00	06900	ELECTROCARDIOLOGY	0.036691		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.545946		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.141102		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.316176		73.00
76.00	03160	CARDIOPULMONARY	0.196443		76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000		78.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC (RHC)	1.287935		88.00
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	2.145322		90.01
90.02	09002	JAY FAMILY MEDICINE	2.678290		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	3.027439		90.05
90.06	09006	INFUSION CLINIC	0.124767		90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0.000000		90.07
91.00	09100	EMERGENCY	0.233292		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.494645		92.00
93.00	04950	OUTPATIENT PSYCH	0.403110		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 01/01/2023 To 12/31/2023 | Worksheet C Part II | Date/Time Prepared: 5/24/2024 9:43 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,979,658	193,061	2,786,597	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	2,435,124	169,125	2,265,999	0	0	54.00
60.00	06000	LABORATORY	3,603,382	107,751	3,495,631	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	952,432	30,619	921,813	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,221,035	112,255	1,108,780	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	197,773	16,155	181,618	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	30,678	422	30,256	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,781	30	4,751	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	123,558	776	122,782	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	46,380	292	46,088	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,519,630	60,621	4,459,009	0	0	73.00
76.00	03160	CARDIOPULMONARY	532,287	14,384	517,903	0	0	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	2,186,618	124,981	2,061,637	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1,973,347	78,198	1,895,149	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	2,451,594	82,892	2,368,702	0	0	90.02
90.03	09003	WOUND CLINIC	0	0	0	0	0	90.03
90.04	09004	OP ORTHO CLINIC	168	1	167	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	1,121,082	167,341	953,741	0	0	90.05
90.06	09006	INFUSION CLINIC	262,121	21,638	240,483	0	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	1,122,006	124,381	997,625	0	0	90.07
91.00	09100	EMERGENCY	5,366,387	196,069	5,170,318	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,999,612	170,055	1,829,557	0	0	92.00
93.00	04950	OUTPATIENT PSYCH	301,597	50,812	250,785	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)	33,431,250	1,721,859	31,709,391	0	0	200.00
201.00		Less Observation Beds	1,999,612	170,055	1,829,557	0	0	201.00
202.00		Total (line 200 minus line 201)	31,431,638	1,551,804	29,879,834	0	0	202.00

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

Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part II | Date/Time Prepared: 5/24/2024 9:43 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,979,658	7,420,758	0.401530		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	2,435,124	14,494,285	0.168006		54.00
60.00	06000	LABORATORY	3,603,382	10,049,969	0.358547		60.00
65.00	06500	RESPIRATORY THERAPY	952,432	2,374,274	0.401147		65.00
66.00	06600	PHYSICAL THERAPY	1,221,035	1,898,322	0.643218		66.00
67.00	06700	OCCUPATIONAL THERAPY	197,773	346,805	0.570271		67.00
68.00	06800	SPEECH PATHOLOGY	30,678	14,602	2.100945		68.00
69.00	06900	ELECTROCARDIOLOGY	4,781	130,304	0.036691		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	123,558	226,319	0.545946		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	46,380	328,698	0.141102		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,519,630	14,294,652	0.316176		73.00
76.00	03160	CARDIOPULMONARY	532,287	2,709,630	0.196443		76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0.000000		78.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC (RHC)	2,186,618	1,697,771	1.287935		88.00
90.00	09000	CLINIC	0	0	0.000000		90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1,973,347	919,837	2.145322		90.01
90.02	09002	JAY FAMILY MEDICINE	2,451,594	915,358	2.678290		90.02
90.03	09003	WOUND CLINIC	0	0	0.000000		90.03
90.04	09004	OP ORTHO CLINIC	168	0	0.000000		90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	1,121,082	370,307	3.027439		90.05
90.06	09006	INFUSION CLINIC	262,121	2,100,886	0.124767		90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	1,122,006	0	0.000000		90.07
91.00	09100	EMERGENCY	5,366,387	23,002,909	0.233292		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,999,612	4,042,521	0.494645		92.00
93.00	04950	OUTPATIENT PSYCH	301,597	748,176	0.403110		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)	33,431,250	88,086,383			200.00
201.00		Less Observation Beds	1,999,612	0			201.00
202.00		Total (line 200 minus line 201)	31,431,638	88,086,383			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II Date/Time Prepared: 5/24/2024 9:43 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	193,061	7,420,758	0.026016	6,720	175	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	169,125	14,494,285	0.011668	121,849	1,422	54.00
60.00	06000	LABORATORY	107,751	10,049,969	0.010722	169,459	1,817	60.00
65.00	06500	RESPIRATORY THERAPY	30,619	2,374,274	0.012896	170,269	2,196	65.00
66.00	06600	PHYSICAL THERAPY	112,255	1,898,322	0.059134	30,001	1,774	66.00
67.00	06700	OCCUPATIONAL THERAPY	16,155	346,805	0.046582	23,786	1,108	67.00
68.00	06800	SPEECH PATHOLOGY	422	14,602	0.028900	6,858	198	68.00
69.00	06900	ELECTROCARDIOLOGY	30	130,304	0.000230	299	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	776	226,319	0.003429	13,626	47	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	292	328,698	0.000888	31,142	28	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	60,621	14,294,652	0.004241	352,476	1,495	73.00
76.00	03160	CARDIOPULMONARY	14,384	2,709,630	0.005308	69,521	369	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	124,981	1,697,771	0.073615	0	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	78,198	919,837	0.085013	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	82,892	915,358	0.090557	0	0	90.02
90.03	09003	WOUND CLINIC	0	0	0.000000	0	0	90.03
90.04	09004	OP ORTHO CLINIC	1	0	0.000000	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	167,341	370,307	0.451898	0	0	90.05
90.06	09006	INFUSION CLINIC	21,638	2,100,886	0.010299	0	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	124,381	0	0.000000	0	0	90.07
91.00	09100	EMERGENCY	196,069	23,002,909	0.008524	7,755	66	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	170,055	4,042,521	0.042067	0	0	92.00
93.00	04950	OUTPATIENT PSYCH	50,812	748,176	0.067915	0	0	93.00
200.00		Total (lines 50 through 199)	1,721,859	88,086,383		1,003,761	10,695	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/24/2024 9:43 am

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
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	0	0	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	0	0	0	90.02
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 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/24/2024 9:43 am

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	7,420,758	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	14,494,285	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	10,049,969	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,374,274	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,898,322	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	346,805	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	14,602	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	130,304	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	226,319	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	328,698	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	14,294,652	0.000000	73.00
76.00	03160	CARDIOPULMONARY	0	0	0	2,709,630	0.000000	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	0	0	1,697,771	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	0	0	919,837	0.000000	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	0	915,358	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	0	0.000000	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0	0	0	370,307	0.000000	90.05
90.06	09006	INFUSION CLINIC	0	0	0	2,100,886	0.000000	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	0	0	0	0.000000	90.07
91.00	09100	EMERGENCY	0	0	0	23,002,909	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	4,042,521	0.000000	92.00
93.00	04950	OUTPATIENT PSYCH	0	0	0	748,176	0.000000	93.00
200.00		Total (lines 50 through 199)	0	0	0	88,086,383		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/24/2024 9:43 am

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	6,720	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	121,849	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	169,459	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	170,269	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	30,001	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	23,786	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	6,858	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	299	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	13,626	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	31,142	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	352,476	0	0	0	73.00
76.00	03160	CARDIOPULMONARY	0.000000	69,521	0	0	0	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	0.000000	0	0	0	0	88.00
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	7,755	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)		1,003,761	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/24/2024 9:43 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.401530	0	1,276,900	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	0.168006	0	2,440,929	100	0	54.00
60.00	06000	LABORATORY	0.358547	0	1,511,164	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.401147	0	283,125	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.643218	0	491,967	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.570271	0	30,624	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	2.100945	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.036691	0	18,424	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.545946	0	24,073	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.141102	0	55,031	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.316176	0	1,723,065	122,032	0	73.00
76.00	03160	CARDIOPULMONARY	0.196443	0	687,112	0	0	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)						88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	2.145322	0	232,593	23,922	0	90.01
90.02	09002	JAY FAMILY MEDICINE	2.678290	0	398,441	28,388	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	3.027439	0	63,932	5,948	0	90.05
90.06	09006	INFUSION CLINIC	0.124767	0	522,109	702	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0.000000	0	0	0	0	90.07
91.00	09100	EMERGENCY	0.233292	0	2,981,746	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.494645	0	908,088	301	0	92.00
93.00	04950	OUTPATIENT PSYCH	0.403110	0	26,177	0	0	93.00
200.00		Subtotal (see instructions)		0	13,675,500	181,393	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	13,675,500	181,393	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/24/2024 9:43 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	512,714	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	410,091	17		54.00
60.00	06000	LABORATORY	541,823	0		60.00
65.00	06500	RESPIRATORY THERAPY	113,575	0		65.00
66.00	06600	PHYSICAL THERAPY	316,442	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	17,464	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	676	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,143	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,765	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	544,792	38,584		73.00
76.00	03160	CARDIOPULMONARY	134,978	0		76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC (RHC)				88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	498,987	51,320		90.01
90.02	09002	JAY FAMILY MEDICINE	1,067,141	76,031		90.02
90.03	09003	WOUND CLINIC	0	0		90.03
90.04	09004	OP ORTHO CLINIC	0	0		90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	193,550	18,007		90.05
90.06	09006	INFUSION CLINIC	65,142	88		90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	0		90.07
91.00	09100	EMERGENCY	695,617	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	449,181	149		92.00
93.00	04950	OUTPATIENT PSYCH	10,552	0		93.00
200.00		Subtotal (see instructions)	5,593,633	184,196		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	5,593,633	184,196		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part I Date/Time Prepared: 5/24/2024 9:43 am

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	428,139	54,481	373,658	1,615	231.37	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)	428,139		373,658	1,615		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	9	2,082				30.00
40.00	SUBPROVIDER - IPF	0	0				40.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	9	2,082				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II Date/Time Prepared: 5/24/2024 9:43 am

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	193,061	7,420,758	0.026016	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	169,125	14,494,285	0.011668	3,489	41	54.00
60.00	06000	LABORATORY	107,751	10,049,969	0.010722	6,488	70	60.00
65.00	06500	RESPIRATORY THERAPY	30,619	2,374,274	0.012896	5,155	66	65.00
66.00	06600	PHYSICAL THERAPY	112,255	1,898,322	0.059134	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	16,155	346,805	0.046582	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	422	14,602	0.028900	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	30	130,304	0.000230	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	776	226,319	0.003429	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	292	328,698	0.000888	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	60,621	14,294,652	0.004241	15,099	64	73.00
76.00	03160	CARDIOPULMONARY	14,384	2,709,630	0.005308	0	0	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	124,981	1,697,771	0.073615	0	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	78,198	919,837	0.085013	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	82,892	915,358	0.090557	0	0	90.02
90.03	09003	WOUND CLINIC	0	0	0.000000	0	0	90.03
90.04	09004	OP ORTHO CLINIC	1	0	0.000000	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	167,341	370,307	0.451898	0	0	90.05
90.06	09006	INFUSION CLINIC	21,638	2,100,886	0.010299	0	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	124,381	0	0.000000	0	0	90.07
91.00	09100	EMERGENCY	196,069	23,002,909	0.008524	15,355	131	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	170,055	4,042,521	0.042067	0	0	92.00
93.00	04950	OUTPATIENT PSYCH	50,812	748,176	0.067915	0	0	93.00
200.00		Total (lines 50 through 199)	1,721,859	88,086,383		45,586	372	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part III Date/Time Prepared: 5/24/2024 9:43 am

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	1,615	0.00	9	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	1,615		9	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 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/24/2024 9:43 am

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
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	0	0	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	0	0	0	90.02
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 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/24/2024 9:43 am

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	7,420,758	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	14,494,285	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	10,049,969	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,374,274	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,898,322	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	346,805	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	14,602	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	130,304	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	226,319	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	328,698	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	14,294,652	0.000000	73.00
76.00	03160	CARDIOPULMONARY	0	0	0	2,709,630	0.000000	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	0	0	1,697,771	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	0	0	919,837	0.000000	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	0	915,358	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	0	0.000000	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0	0	0	370,307	0.000000	90.05
90.06	09006	INFUSION CLINIC	0	0	0	2,100,886	0.000000	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	0	0	0	0.000000	90.07
91.00	09100	EMERGENCY	0	0	0	23,002,909	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	4,042,521	0.000000	92.00
93.00	04950	OUTPATIENT PSYCH	0	0	0	748,176	0.000000	93.00
200.00		Total (lines 50 through 199)	0	0	0	88,086,383		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/24/2024 9:43 am

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	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	3,489	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	6,488	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	5,155	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	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	15,099	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
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	0.000000	0	0	0	0	88.00
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	15,355	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)		45,586	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/24/2024 9:43 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.401530	0	79,260	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	0.168006	0	113,757	0	0	54.00
60.00	06000	LABORATORY	0.358547	0	113,813	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.401147	0	16,217	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.643218	0	6,218	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.570271	0	745	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	2.100945	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.036691	0	1,316	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.545946	0	8,187	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.141102	0	6,953	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.316176	0	616,905	0	0	73.00
76.00	03160	CARDIOPULMONARY	0.196443	0	21,391	0	0	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)						88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	2.145322	0	22,759	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	2.678290	0	14,828	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	3.027439	0	9,205	0	0	90.05
90.06	09006	INFUSION CLINIC	0.124767	0	19,199	0	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0.000000	0	0	0	0	90.07
91.00	09100	EMERGENCY	0.233292	0	368,715	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.494645	0	61,184	0	0	92.00
93.00	04950	OUTPATIENT PSYCH	0.403110	0	31,410	0	0	93.00
200.00		Subtotal (see instructions)		0	1,512,062	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	1,512,062	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/24/2024 9:43 am

Title XIX | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	31,825	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	19,112	0		54.00
60.00	06000	LABORATORY	40,807	0		60.00
65.00	06500	RESPIRATORY THERAPY	6,505	0		65.00
66.00	06600	PHYSICAL THERAPY	4,000	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	425	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	48	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,470	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	981	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	195,051	0		73.00
76.00	03160	CARDIOPULMONARY	4,202	0		76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC (RHC)				88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	48,825	0		90.01
90.02	09002	JAY FAMILY MEDICINE	39,714	0		90.02
90.03	09003	WOUND CLINIC	0	0		90.03
90.04	09004	OP ORTHO CLINIC	0	0		90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	27,868	0		90.05
90.06	09006	INFUSION CLINIC	2,395	0		90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	0		90.07
91.00	09100	EMERGENCY	86,018	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	30,264	0		92.00
93.00	04950	OUTPATIENT PSYCH	12,662	0		93.00
200.00		Subtotal (see instructions)	555,172	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	555,172	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/24/2024 9:43 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,076	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,615	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)	880	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	211	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	250	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)	382	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)	211	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	266.32	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)	5,034,318	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)	66,580	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)	640,618	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,393,700	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,393,700	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)	2,720.56	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,039,254	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)	1,039,254	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/24/2024 9:43 am

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	338,254	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)	1,377,508	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)	574,038	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	574,038	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)	735	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,720.56	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,999,612	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/24/2024 9:43 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	428,139	5,034,318	0.085044	1,999,612	170,055	90.00
91.00	Nursing Program cost	0	5,034,318	0.000000	1,999,612	0	91.00
92.00	Allied health cost	0	5,034,318	0.000000	1,999,612	0	92.00
93.00	All other Medical Education	0	5,034,318	0.000000	1,999,612	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/24/2024 9:43 am

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,076	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,615	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)	880	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	211	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	250	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)	9	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	266.32	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)	5,034,318	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)	66,580	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)	640,618	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,393,700	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,393,700	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)	2,720.56	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	24,485	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)	24,485	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/24/2024 9:43 am

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	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)	13,336	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)	37,821	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)	2,082	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	372	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	2,454	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	35,367	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)	735	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,720.56	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,999,612	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/24/2024 9:43 am

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	428,139	5,034,318	0.085044	1,999,612	170,055	90.00
91.00	Nursing Program cost	0	5,034,318	0.000000	1,999,612	0	91.00
92.00	Allied health cost	0	5,034,318	0.000000	1,999,612	0	92.00
93.00	All other Medical Education	0	5,034,318	0.000000	1,999,612	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/24/2024 9:43 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		880,690		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	0.401530	6,720	2,698	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	0.168006	121,849	20,471	54.00
60.00	06000	LABORATORY	0.358547	169,459	60,759	60.00
65.00	06500	RESPIRATORY THERAPY	0.401147	170,269	68,303	65.00
66.00	06600	PHYSICAL THERAPY	0.643218	30,001	19,297	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.570271	23,786	13,564	67.00
68.00	06800	SPEECH PATHOLOGY	2.100945	6,858	14,408	68.00
69.00	06900	ELECTROCARDIOLOGY	0.036691	299	11	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.545946	13,626	7,439	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.141102	31,142	4,394	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.316176	352,476	111,444	73.00
76.00	03160	CARDIOPULMONARY	0.196443	69,521	13,657	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC (RHC)	0.000000		0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	2.145322	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	2.678290	0	0	90.02
90.03	09003	WOUND CLINIC	0.000000	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0.000000	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	3.027439	0	0	90.05
90.06	09006	INFUSION CLINIC	0.124767	0	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0.000000	0	0	90.07
91.00	09100	EMERGENCY	0.233292	7,755	1,809	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.494645	0	0	92.00
93.00	04950	OUTPATIENT PSYCH	0.403110	0	0	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,003,761	338,254	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)		1,003,761		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1320 | Component CCN: 15-Z320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/24/2024 9:43 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
40.00	04000	SUBPROVIDER - IPF				40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.401530	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	0.168006	20,320	3,414	54.00
60.00	06000	LABORATORY	0.358547	38,014	13,630	60.00
65.00	06500	RESPIRATORY THERAPY	0.401147	52,046	20,878	65.00
66.00	06600	PHYSICAL THERAPY	0.643218	69,613	44,776	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.570271	47,975	27,359	67.00
68.00	06800	SPEECH PATHOLOGY	2.100945	1,083	2,275	68.00
69.00	06900	ELECTROCARDIOLOGY	0.036691	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.545946	4,694	2,563	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.141102	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.316176	106,397	33,640	73.00
76.00	03160	CARDIOPULMONARY	0.196443	5,339	1,049	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC (RHC)	0.000000		0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	2.145322	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	2.678290	0	0	90.02
90.03	09003	WOUND CLINIC	0.000000	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0.000000	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	3.027439	0	0	90.05
90.06	09006	INFUSION CLINIC	0.124767	0	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0.000000	0	0	90.07
91.00	09100	EMERGENCY	0.233292	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.494645	0	0	92.00
93.00	04950	OUTPATIENT PSYCH	0.403110	0	0	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		345,481	149,584	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)		345,481		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/24/2024 9:43 am

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		18,639		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	0.401530	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	0.168006	3,489	586	54.00
60.00	06000	LABORATORY	0.358547	6,488	2,326	60.00
65.00	06500	RESPIRATORY THERAPY	0.401147	5,155	2,068	65.00
66.00	06600	PHYSICAL THERAPY	0.643218	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.570271	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	2.100945	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.036691	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.545946	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.141102	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.316176	15,099	4,774	73.00
76.00	03160	CARDIOPULMONARY	0.196443	0	0	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC (RHC)	1.287935	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	2.145322	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	2.678290	0	0	90.02
90.03	09003	WOUND CLINIC	0.000000	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0.000000	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	3.027439	0	0	90.05
90.06	09006	INFUSION CLINIC	0.124767	0	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0.000000	0	0	90.07
91.00	09100	EMERGENCY	0.233292	15,355	3,582	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.494645	0	0	92.00
93.00	04950	OUTPATIENT PSYCH	0.403110	0	0	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		45,586	13,336	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)		45,586		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1320	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/24/2024 9:43 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,777,829	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS or REH 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 including REH direct graduate medical education 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)	5,777,829	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)	5,835,607	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)	102,310	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	2,286,878	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	3,446,419	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
28.50	REH facility payment amount (see instructions)		28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	3,446,419	30.00
31.00	Primary payer payments	2,272	31.00
32.00	Subtotal (line 30 minus line 31)	3,444,147	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)	432,753	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	281,289	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	380,105	36.00
37.00	Subtotal (see instructions)	3,725,436	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)	3,725,436	40.00
40.01	Sequestration adjustment (see instructions)	74,509	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	4,136,472	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	-485,545	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	340,914	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1320	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/24/2024 9:43 am

		Title XVIII	Hospital	Cost	
				1.00	
94.00	Total (sum of lines 91 and 93)			0	94.00
				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 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I | Date/Time Prepared: 5/24/2024 9:43 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,144,097		3,897,772	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	09/05/2023	111,400	09/05/2023	238,700	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)		111,400		238,700	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)		1,255,497		4,136,472	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		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		39,308		485,545	6.02
7.00	Total Medicare program liability (see instructions)		1,216,189		3,650,927	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 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I | Date/Time Prepared: 5/24/2024 9:43 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		607,581		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	09/05/2023	82,500		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		82,500		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		690,081		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		23,612		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		713,693		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 01/01/2023 To 12/31/2023	Worksheet E-1 Part II Date/Time Prepared: 5/24/2024 9:43 am
	Title XVIII	Hospital	Cost

			1.00
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		1.00
2.00	Medicare days (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 01/01/2023 To 12/31/2023 | Worksheet E-2 | Date/Time Prepared: 5/24/2024 9:43 am

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	579,778	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)	151,080	0	3.00
3.01	Nursing and allied health payment-PARHM (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	211	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)	730,858	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	730,858	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)	730,858	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	2,600	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	728,258	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	728,258	0	19.00
19.01	Sequestration adjustment (see instructions)	14,565	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	690,081	0	20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM (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)	23,612	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	39,723	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 01/01/2023 To 12/31/2023	Worksheet E-3 Part V Date/Time Prepared: 5/24/2024 9:43 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,377,508	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)	1,377,508	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,391,283	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)	1,391,283	19.00
20.00	Deductibles (exclude professional component)	159,912	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,231,371	22.00
23.00	Coinsurance	800	23.00
24.00	Subtotal (line 22 minus line 23)	1,230,571	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	16,058	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	10,438	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	15,316	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,241,009	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)	1,241,009	30.00
30.01	Sequestration adjustment (see instructions)	24,820	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	1,255,497	31.00
31.01	Interim payments-PARHM		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	-39,308	33.00
33.01	Balance due provider/program-PARHM (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	77,176	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 01/01/2023 To 12/31/2023 | Worksheet G | Date/Time Prepared: 5/24/2024 9:43 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	-10,843,539	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	3,073,221	0	0	0	4.00
5.00	Other receivable	891,842	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	409,205	0	0	0	7.00
8.00	Prepaid expenses	78,689	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)	-6,390,582	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	19,337,833	0	0	0	15.00
16.00	Accumulated depreciation	-7,606,012	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	-39,512	0	0	0	22.00
23.00	Major movable equipment	12,940,233	0	0	0	23.00
24.00	Accumulated depreciation	-8,156,803	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)	17,507,033	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)	11,116,451	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,633,060	0	0	0	37.00
38.00	Salaries, wages, and fees payable	741,018	0	0	0	38.00
39.00	Payroll taxes payable	67,831	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	458,332				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	3,978,863	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	7,879,104	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)	7,879,104	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	3,237,347				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)	3,237,347	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	11,116,451	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-1 | Date/Time Prepared: 5/24/2024 9:43 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		9,041,056		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-5,803,710				2.00
3.00	Total (sum of line 1 and line 2)		3,237,346		0		3.00
4.00	ROUNDING	1		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)		1		0		10.00
11.00	Subtotal (line 3 plus line 10)		3,237,347		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		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)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		3,237,347		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	ROUNDING		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			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 01/01/2023 To 12/31/2023 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/24/2024 9:43 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,360,814		2,360,814	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	461,616		461,616	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)	2,822,430		2,822,430	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)	2,822,430		2,822,430	17.00
18.00	Ancillary services	3,480,591	50,808,027	54,288,618	18.00
19.00	Outpatient services	367,112	31,732,882	32,099,994	19.00
20.00	RURAL HEALTH CLINIC (RHC)	0	1,697,771	1,697,771	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)	6,670,133	84,238,680	90,908,813	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		41,974,207		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)		41,974,207		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-1320	Period: From 01/01/2023 To 12/31/2023	Worksheet G-3 Date/Time Prepared: 5/24/2024 9:43 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	90,908,813	1.00
2.00	Less contractual allowances and discounts on patients' accounts	54,681,848	2.00
3.00	Net patient revenues (line 1 minus line 2)	36,226,965	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	41,974,207	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-5,747,242	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	-56,468	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	-56,468	25.00
26.00	Total (line 5 plus line 25)	-5,803,710	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)	-5,803,710	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1320 | Component CCN: 15-8558 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/24/2024 9:43 am

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	133,839	3,350	137,189	-129	137,060	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	74,743	12,464	87,207	-6,129	81,078	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
7.10	Marriage and Family Therapist						7.10
7.11	Mental Health Counselor						7.11
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	82,938	18,590	101,528	-12,341	89,187	9.00
10.00	Subtotal (sum of lines 1 through 9)	291,520	34,404	325,924	-18,599	307,325	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	0	0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	2,000	2,000	-2,000	0	17.00
18.00	Professional Liability Insurance	0	2,888	2,888	0	2,888	18.00
19.00	Other Health Care Costs	0	1,206,959	1,206,959	-157,132	1,049,827	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	1,211,847	1,211,847	-159,132	1,052,715	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	291,520	1,246,251	1,537,771	-177,731	1,360,040	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	0	0	0	0	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	0	0	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	291,520	1,246,251	1,537,771	-177,731	1,360,040	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1320 | Component CCN: 15-8558 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/24/2024 9:43 am

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	371,527	508,587		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	102,904	183,982		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
7.10	Marriage and Family Therapist				7.10
7.11	Mental Health Counselor				7.11
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	443,466	532,653		9.00
10.00	Subtotal (sum of lines 1 through 9)	917,897	1,225,222		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	0		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	9,999	9,999		17.00
18.00	Professional Liability Insurance	0	2,888		18.00
19.00	Other Health Care Costs	-945,216	104,611		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	-935,217	117,498		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-17,320	1,342,720		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	79,606	79,606		29.00
30.00	Administrative Costs	0	0		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	79,606	79,606		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	62,286	1,422,326		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1320 | Component CCN: 15-8558 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-2 | Date/Time Prepared: 5/24/2024 9:43 am

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.01	5,826	4,200	4,242		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.84	3,058	2,100	1,764		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.85	8,884		6,006	8,884	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
7.03	Marriage and Family Therapist						7.03
7.04	Mental Health Counselor						7.04
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.85	8,884			8,884	8.00
9.00	Physician Services Under Agreements		0			0	9.00

		1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES		
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	1,342,720	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	1,342,720	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	79,606	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	764,292	15.00
16.00	Total overhead (sum of lines 14 and 15)	843,898	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	843,898	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	843,898	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	2,186,618	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1320 Component CCN: 15-8558	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 5/24/2024 9:43 am
	Title XVIII	RHC I	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			2,186,618	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			108,551	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			2,078,067	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			8,884	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			8,884	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			233.91	7.00
		Calculation of Limit (1)			
		Rate Period N/A	Rate Period 1 (01/01/2023 through 12/31/2023)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	290.32		8.00
9.00	Rate for Program covered visits (see instructions)	0.00	233.91		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	2,018		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	472,030		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	472,030		16.00
16.01	Total program charges (see instructions)(from contractor's records)		367,105		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		23,376		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		30,057		16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		344,466		16.04
16.05	Total program cost (see instructions)	0	374,523		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		11,391		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		66,468		19.00
20.00	Net program cost excluding injections/infusions (see instructions)		374,523		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		1,308		21.00
21.50	Total program IOP OPPS payments (see instructions)				21.50
21.55	Total program IOP Costs (see instructions)				21.55
21.60	Program IOP deductible and coinsurance (see instructions)				21.60
22.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, minus line 21.60)		375,831		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		375,831		26.00
26.01	Sequestration adjustment (see instructions)		7,517		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		299,504		27.00
28.00	Tentative settlement (for contractor use only)		0		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		68,810		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		20,673		30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1320 | Component CCN: 15-8558 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-4 | Date/Time Prepared: 5/24/2024 9:43 am

Title XVIII | RHC I | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,225,222	1,225,222	1,225,222	1,225,222	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.008440	0.027854	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	10,341	34,127	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	8,900	13,289	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	19,241	47,416	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,342,720	1,342,720	1,342,720	1,342,720	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	843,898	843,898	843,898	843,898	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.014330	0.035313	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	12,093	29,801	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	31,334	77,217	0	0	10.00
11.00	Total number of injections/infusions (from your records)	251	828	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	124.84	93.26	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	3	10	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	375	933	0	0	14.00

			COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
		1.00	2.00	
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		108,551	15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		1,308	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1320 Component CCN: 15-8558	Period: From 01/01/2023 To 12/31/2023	Worksheet M-5 Date/Time Prepared: 5/24/2024 9:43 am
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		299,504	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	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			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		299,504	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			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		68,810	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		368,314	7.00

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