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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 151320	Period: From 10/01/2014 To 09/30/2015	Worksheet S Parts I-III Date/Time Prepared: 2/17/2016 10:11 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/17/2016 Time: 10:11 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by JAY COUNTY HOSPITAL (151320) for the cost reporting period beginning 10/01/2014 and ending 09/30/2015 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.

(Signed)_____
Officer or Administrator of Provider(s)

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-13,201	-71,131	0	29,117	1.00
2.00	Subprovider - IPF	0	0	0		23,556	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVIDER I	0	0	0		0	4.00
5.00	Swing bed - SNF	0	-931	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00	Total	0	-14,132	-71,131	0	52,673	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 2/17/2016 10:07 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	JAY COUNTY HOSPITAL	151320	99915	1	01/01/2004	N	O	O	3.00
4.00	Subprovider - IPF	JAY COUNTY HOSPITAL-PSYCH UNIT	15M320	99915	4	10/01/2005	N	P	O	4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	JAY COUNTY HOSPITAL	15Z320	99915		01/01/2004	N	O	O	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
17.10	Hospital-Based (CORF) I									17.10
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2014	09/30/2015	20.00
21.00	Type of Control (see instructions)	9		21.00
	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 §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 2/17/2016 10:07 am

		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
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)(ii)? 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)(ii)? 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 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	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)		0.00	0.00			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)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			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)		0.00	0.00			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)		0.00	0.00			61.06

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 2/17/2016 10:07 am

		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 and enter in column 4, 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 and enter in column 4, 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 64-67. (see instructions)	N	63.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 2/17/2016 10:07 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 Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	Y			70.00
71.00	If line 70 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 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 a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.	N	87.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	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

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		V	XIX	
		1.00	2.00	
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
	Rural Providers			
105.00	Does this hospital qualify as a critical access hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	Y	Y	Y	109.00

		1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo)for the current cost reporting period? Enter "Y" for yes or "N" for no.	N	110.00

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	254,584	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.	N		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 2/17/2016 10:07 am

		1.00	2.00	
	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		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:	Contractor's Name:	Contractor's Number:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	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.	N		145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

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

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00
161.10	CORF		N	N	N	161.10

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

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2014	09/30/2015	170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 151320	Period: From 10/01/2014 To 09/30/2015	Worksheet S-2 Part I Date/Time Prepared: 2/17/2016 10:07 am

		1.00	
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. (see instructions)	N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 2/17/2016 10:07 am

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		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)		N		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.		N	C	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.		N		5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.		N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
			Part A		Part B
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
	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)		Y	01/21/2016	Y 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)		N		N 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
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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part II Date/Time Prepared: 2/17/2016 10:07 am

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
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.				N	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				Y	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.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				Y	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	N		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.	N		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.	N		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.	TINA	SEVERS	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7946	TSEVERS@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 2/17/2016 10:07 am

		Part B Date 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)	01/21/2016			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)				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.				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.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			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.		MANAGER		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: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part I Date/Time Prepared: 2/17/2016 10:07 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	49,008.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	49,008.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	0	0	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	9,125	49,008.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	10	3,650		0	16.00
17.00	SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00	SUBPROVIDER	42.00	0	0		0	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
25.10	CMHC - CORF	99.10				0	25.10
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		35				27.00
28.00	Observation Bed Days					0	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part I | Date/Time Prepared: 2/17/2016 10:07 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	839	38	2,042			1.00
2.00	HMO and other (see instructions)	96	0				2.00
3.00	HMO IPF Subprovider	22	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	276	0	484			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	30			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,115	38	2,556			7.00
8.00	INTENSIVE CARE UNIT	0	0	0			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	153			13.00
14.00	Total (see instructions)	1,115	38	2,709	0.00	275.27	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	1,415	40	1,943	0.00	15.03	16.00
17.00	SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00	SUBPROVIDER	0	0	0	0.00	0.00	18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
26.00	RURAL HEALTH CLINIC	0	0	0	0.00	0.00	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	290.30	27.00
28.00	Observation Bed Days		0	85			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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part I | Date/Time Prepared: 2/17/2016 10:07 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	279	11	667	1.00
2.00	HMO and other (see instructions)			28	0		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	279	11	667	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	95	0	155	16.00
17.00	SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00	SUBPROVIDER	0.00	0	0	0	0	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
25.10	CMHC - CORF	0.00					25.10
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						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						33.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-10 | Date/Time Prepared: 2/17/2016 10:07 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.341147	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	0	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 or supplemental payments from Medicaid?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	0	6.00
7.00	Medicaid cost (line 1 times line 6)	0	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (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 , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	693,436	0	693,436	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	236,564	0	236,564	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	236,564	0	236,564	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	0	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	289,804	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	-289,804	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	-98,866	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	137,698	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	137,698	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A | Date/Time Prepared: 2/17/2016 10:07 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						
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		1,809,945	1,809,945	0	1,809,945	2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP MOB		10,285	10,285	0	10,285	2.01
2.02	00202	NEW CAP REL COSTS-MVBLE EQUIP-POB		119,979	119,979	0	119,979	2.02
2.03	00203	NEW CAP REL COSTS-MVBLE EQUIP- WJ		31,142	31,142	0	31,142	2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,880,570	5,880,570	0	5,880,570	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,346,972	3,549,963	5,896,935	0	5,896,935	5.00
7.00	00700	OPERATION OF PLANT	332,052	889,973	1,222,025	-15,008	1,207,017	7.00
7.01	00701	OPERATION OF PLANT-MOB	0	33,974	33,974	4,987	38,961	7.01
7.02	00702	OPERATION OF PLANT-POB	0	74,708	74,708	7,232	81,940	7.02
7.03	00703	OPERATION OF PLANT-WJ	0	32	32	2,789	2,821	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	35,288	29,430	64,718	0	64,718	8.00
9.00	00900	HOUSEKEEPING	343,074	60,960	404,034	0	404,034	9.00
10.00	01000	DIETARY	330,170	286,722	616,892	-286,287	330,605	10.00
11.00	01100	CAFETERIA	0	0	0	286,287	286,287	11.00
13.00	01300	NURSING ADMINISTRATION	960,092	8,515	968,607	0	968,607	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	67,669	16,606	84,275	0	84,275	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	348,435	57,999	406,434	0	406,434	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,354,308	115,896	1,470,204	-240,284	1,229,920	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	651,976	246,500	898,476	0	898,476	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	221,796	221,796	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	845,575	683,137	1,528,712	0	1,528,712	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	18,488	18,488	52.00
53.00	05300	ANESTHESIOLOGY	0	854,907	854,907	0	854,907	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	813,052	570,490	1,383,542	0	1,383,542	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	629,639	1,170,217	1,799,856	0	1,799,856	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	354,136	354,136	0	354,136	65.00
66.00	06600	PHYSICAL THERAPY	0	793,060	793,060	-135,372	657,688	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	108,738	108,738	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	26,634	26,634	68.00
69.00	06900	ELECTROCARDIOLOGY	191,374	163,454	354,828	0	354,828	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	394,065	1,114,270	1,508,335	0	1,508,335	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	451,939	240,009	691,948	0	691,948	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1,473,060	264,152	1,737,212	0	1,737,212	90.01
90.02	09002	JAY FAMILY MEDICINE	1,024,837	342,592	1,367,429	0	1,367,429	90.02
91.00	09100	EMERGENCY	2,131,895	471,267	2,603,162	0	2,603,162	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	14,725,472	20,244,890	34,970,362	0	34,970,362	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MOB	0	13	13	0	13	194.00
194.01	07951	POB	0	0	0	0	0	194.01
194.02	07952	WEST JAY CLINIC	452,947	107,355	560,302	0	560,302	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
194.05	07955	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.05
194.06	07956	TRI COUNTY	180,777	1,305,891	1,486,668	0	1,486,668	194.06

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A | Date/Time Prepared: 2/17/2016 10:07 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	
194.07	07957	HOSPITALIST	66,300	535	66,835	0	66,835	194.07
200.00		TOTAL (SUM OF LINES 118-199)	15,425,496	21,658,684	37,084,180	0	37,084,180	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A | Date/Time Prepared: 2/17/2016 10:07 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-477,863	1,332,082		2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP MOB	0	10,285		2.01
2.02	00202	NEW CAP REL COSTS-MVBLE EQUIP-POB	0	119,979		2.02
2.03	00203	NEW CAP REL COSTS-MVBLE EQUIP- WJ	0	31,142		2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-292,875	5,587,695		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,071,420	4,825,515		5.00
7.00	00700	OPERATION OF PLANT	0	1,207,017		7.00
7.01	00701	OPERATION OF PLANT-MOB	0	38,961		7.01
7.02	00702	OPERATION OF PLANT-POB	0	81,940		7.02
7.03	00703	OPERATION OF PLANT-WJ	0	2,821		7.03
8.00	00800	LAUNDRY & LINEN SERVICE	0	64,718		8.00
9.00	00900	HOUSEKEEPING	-58,657	345,377		9.00
10.00	01000	DIETARY	0	330,605		10.00
11.00	01100	CAFETERIA	-166,730	119,557		11.00
13.00	01300	NURSING ADMINISTRATION	-8,726	959,881		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	84,275		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-13,534	392,900		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,229,920		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
40.00	04000	SUBPROVIDER - IPF	0	898,476		40.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
42.00	04200	SUBPROVIDER	0	0		42.00
43.00	04300	NURSERY	0	221,796		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,528,712		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	18,488		52.00
53.00	05300	ANESTHESIOLOGY	-854,907	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-856	1,382,686		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	-55,000	1,744,856		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	354,136		65.00
66.00	06600	PHYSICAL THERAPY	-21,659	636,029		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	108,738		67.00
68.00	06800	SPEECH PATHOLOGY	0	26,634		68.00
69.00	06900	ELECTROCARDIOLOGY	-20,857	333,971		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-86,323	1,422,012		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	-427,441	264,507		90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	-1,289,083	448,129		90.01
90.02	09002	JAY FAMILY MEDICINE	-882,210	485,219		90.02
91.00	09100	EMERGENCY	-1,678,951	924,211		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF	0	0		99.10
		SPECIAL PURPOSE COST CENTERS				
106.00	10600	HEART ACQUISITION	0	0		106.00
109.00	10900	PANCREAS ACQUISITION	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0		111.00
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-7,407,092	27,563,270		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	MOB	0	13		194.00
194.01	07951	POB	0	0		194.01
194.02	07952	WEST JAY CLINIC	0	560,302		194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.04
194.05	07955	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.05
194.06	07956	TRI COUNTY	0	1,486,668		194.06
194.07	07957	HOSPITALIST	0	66,835		194.07
200.00		TOTAL (SUM OF LINES 118-199)	-7,407,092	29,677,088		200.00

RECLASSIFICATIONS | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-6 | Date/Time Prepared: 2/17/2016 10:07 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - NURSERY RECLASS				
1.00	NURSERY	43.00	137,138	84,658	1.00
	TOTALS		137,138	84,658	
	B - LABOR & DELIVERY RECLASS				
1.00	DELIVERY ROOM & LABOR ROOM	52.00	17,453	1,035	1.00
	TOTALS		17,453	1,035	
	C - CAFETERIA RECLASS				
1.00	CAFETERIA	11.00	153,225	133,062	1.00
	TOTALS		153,225	133,062	
	D - MOB, POB, WEST JAY MAINT RECLASS				
1.00	OPERATION OF PLANT-MOB	7.01	4,987	0	1.00
2.00	OPERATION OF PLANT-POB	7.02	7,232	0	2.00
3.00	OPERATION OF PLANT-WJ	7.03	2,789	0	3.00
	TOTALS		15,008	0	
	F - OCCUPATIONAL AND SPEECH THERAPY RECL				
1.00	OCCUPATIONAL THERAPY	67.00	0	108,738	1.00
2.00	SPEECH PATHOLOGY	68.00	0	26,634	2.00
	TOTALS		0	135,372	
500.00	Grand Total: Increases		322,824	354,127	500.00

RECLASSIFICATIONS | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-6 | Date/Time Prepared: 2/17/2016 10:07 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - NURSERY RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	137,138	84,658	0		1.00
	TOTALS		137,138	84,658			
	B - LABOR & DELIVERY RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	17,453	1,035	0		1.00
	TOTALS		17,453	1,035			
	C - CAFETERIA RECLASS						
1.00	DIETARY	10.00	153,225	133,062	0		1.00
	TOTALS		153,225	133,062			
	D - MOB, POB, WEST JAY MAINT RECLASS						
1.00	OPERATION OF PLANT	7.00	15,008	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		15,008	0			
	F - OCCUPATIONAL AND SPEECH THERAPY RECL						
1.00	PHYSICAL THERAPY	66.00	0	135,372	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	135,372			
500.00	Grand Total: Decreases		322,824	354,127			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-7 Part I | Date/Time Prepared: 2/17/2016 10:07 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	220,245	127,488	0	127,488	0	1.00
2.00	Land Improvements	936,209	16,123	0	16,123	0	2.00
3.00	Buildings and Fixtures	23,337,569	0	0	0	11,312	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	3,105,733	554,134	0	554,134	0	5.00
6.00	Movable Equipment	11,458,040	1,030,395	0	1,030,395	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	39,057,796	1,728,140	0	1,728,140	11,312	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	39,057,796	1,728,140	0	1,728,140	11,312	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	347,733	0	1.00
2.00	Land Improvements	952,332	0	2.00
3.00	Buildings and Fixtures	23,326,257	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	3,659,867	0	5.00
6.00	Movable Equipment	12,488,435	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	40,774,624	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	40,774,624	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-7 Part II Date/Time Prepared: 2/17/2016 10:07 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						
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,809,945	0	0	0	0	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP MOB	10,285	0	0	0	0	2.01
2.02	NEW CAP REL COSTS-MVBLE EQUIP-POB	119,979	0	0	0	0	2.02
2.03	NEW CAP REL COSTS-MVBLE EQUIP- WJ	31,142	0	0	0	0	2.03
3.00	Total (sum of lines 1-2)	1,971,351	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				
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	1,809,945		2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP MOB	0	10,285		2.01
2.02	NEW CAP REL COSTS-MVBLE EQUIP-POB	0	119,979		2.02
2.03	NEW CAP REL COSTS-MVBLE EQUIP- WJ	0	31,142		2.03
3.00	Total (sum of lines 1-2)	0	1,971,351		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-7 Part III Date/Time Prepared: 2/17/2016 10:07 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
2.00	NEW CAP REL COSTS-MVBLE EQUIP	11,458,040	0	11,458,040	1.000000	0	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP MOB	0	0	0	0.000000	0	2.01
2.02	NEW CAP REL COSTS-MVBLE EQUIP-POB	0	0	0	0.000000	0	2.02
2.03	NEW CAP REL COSTS-MVBLE EQUIP- WJ	0	0	0	0.000000	0	2.03
3.00	Total (sum of lines 1-2)	11,458,040	0	11,458,040	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	1,332,082	0	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP MOB	0	0	0	10,285	0	2.01
2.02	NEW CAP REL COSTS-MVBLE EQUIP-POB	0	0	0	119,979	0	2.02
2.03	NEW CAP REL COSTS-MVBLE EQUIP- WJ	0	0	0	31,142	0	2.03
3.00	Total (sum of lines 1-2)	0	0	0	1,493,488	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						
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	1,332,082	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP MOB	0	0	0	0	10,285	2.01
2.02	NEW CAP REL COSTS-MVBLE EQUIP-POB	0	0	0	0	119,979	2.02
2.03	NEW CAP REL COSTS-MVBLE EQUIP- WJ	0	0	0	0	31,142	2.03
3.00	Total (sum of lines 1-2)	0	0	0	0	1,493,488	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8 | Date/Time Prepared: 2/17/2016 10:07 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)		0	*** Cost Center Deleted ***	1.00	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
2.01	Investment income - NEW CAP REL COSTS-MVBLE EQUIP MOB (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP MOB	2.01	0	2.01
2.02	Investment income - NEW CAP REL COSTS-MVBLE EQUIP-POB (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP-POB	2.02	0	2.02
2.03	Investment income - NEW CAP REL COSTS-MVBLE EQUIP- WJ (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP- WJ	2.03	0	2.03
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-4,332,685			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	-21,659			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-167,708	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	B	-13,534	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
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	*** Cost Center Deleted ***	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
27.01	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP MOB		0	NEW CAP REL COSTS-MVBLE EQUIP MOB	2.01	0	27.01
27.02	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP-POB		0	NEW CAP REL COSTS-MVBLE EQUIP-POB	2.02	0	27.02

ADJUSTMENTS TO EXPENSES | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8 | Date/Time Prepared: 2/17/2016 10:07 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	
27.03	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP- WJ		0	NEW CAP REL COSTS-MVBLE EQUIP- WJ	2.03	0	27.03
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	JEMS RENTAL	B	-6,001	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	SUPPLY REBATES AND DISCOUNTS	B	-35,556	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	OTHER REVENUE	B	-1,636	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	OTHER REVENUE-DIABETIC COUNSELING	B	-8,726	NURSING ADMINISTRATION	13.00	0	33.03
33.04	CRNA OFFSET	A	-854,907	ANESTHESIOLOGY	53.00	0	33.04
33.05	PHYSICIAN RECRUITMENT	A	-76,451	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	ADVERTISING EXPENSE	A	-122,788	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	SENIOR PROGRAM	A	-14,970	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	SWITCHBOARD SALARY	A	-8,105	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	SWITCHBOARD EH&W	A	-2,642	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.09
33.10	PATIENT TELEPHONE EXPENSE	A	-15,598	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	PATIENT TELEPHONE DEPRECIATION	A	-3,996	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	33.11
33.12	HEALTH EDUCATION	B	-151,929	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	VENDING MACHINE REVENUE	B	978	CAFETERIA	11.00	0	33.13
33.14	PHARMACY EMPLOYEE SALES	B	-86,323	DRUGS CHARGED TO PATIENTS	73.00	0	33.14
33.15	PENSION EXPENSE	A	-290,233	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.15
33.16	HOUSEKEEPING WAGES	A	-58,657	HOUSEKEEPING	9.00	0	33.16
33.17	IHA DUES	A	-584	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	LAND RENT	B	-750	ADMINISTRATIVE & GENERAL	5.00	0	33.18
33.19	CLINIC RENTAL	B	-20,857	ELECTROCARDIOLOGY	69.00	0	33.19
33.20	CONFERENCE ROOM RENTAL	B	-400	ADMINISTRATIVE & GENERAL	5.00	0	33.20
33.21	VENDOR/CONTRACT REV	B	-11,121	ADMINISTRATIVE & GENERAL	5.00	0	33.21
33.22	EHR DEPRECIATION	B	-473,867	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	33.22
33.23	HOSPITAL ASSESSMENT FEE	A	-625,531	ADMINISTRATIVE & GENERAL	5.00	0	33.23
33.24	OTHER REVENUE	B	-856	RADIOLOGY-DIAGNOSTIC	54.00	0	33.24
33.25	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.25
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-7,407,092				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: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8-1 | Date/Time Prepared: 2/17/2016 10:07 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	66.00	PHYSICAL THERAPY	RENT/LEASE EXPENSE	28,341	50,000	1.00
2.00	0.00			0	0	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			28,341	50,000	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	C	JAY CO MED FAC	65.00		0.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 151320	Period: From 10/01/2014 To 09/30/2015	Worksheet A-8-1 Date/Time Prepared: 2/17/2016 10:07 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	-21,659	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	-21,659			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			6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8-2 | Date/Time Prepared: 2/17/2016 10:07 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	60.00	LABORATORY	55,000	55,000	0	0	0	1.00
2.00	90.00	CLINIC	427,441	427,441	0	0	0	2.00
3.00	90.01	FAMILY PRACTICE OF JAY COUNTY	1,289,083	1,289,083	0	0	0	3.00
4.00	90.02	JAY FAMILY MEDICINE	882,210	882,210	0	0	0	4.00
5.00	91.00	EMERGENCY	2,022,833	1,678,951	343,882	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			4,676,567	4,332,685	343,882		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	60.00	LABORATORY	0	0	0	0	0	1.00
2.00	90.00	CLINIC	0	0	0	0	0	2.00
3.00	90.01	FAMILY PRACTICE OF JAY COUNTY	0	0	0	0	0	3.00
4.00	90.02	JAY FAMILY MEDICINE	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	60.00	LABORATORY	0	0	0	55,000		1.00
2.00	90.00	CLINIC	0	0	0	427,441		2.00
3.00	90.01	FAMILY PRACTICE OF JAY COUNTY	0	0	0	1,289,083		3.00
4.00	90.02	JAY FAMILY MEDICINE	0	0	0	882,210		4.00
5.00	91.00	EMERGENCY	0	0	0	1,678,951		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	4,332,685		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 2/17/2016 10:07 am

Physical Therapy — Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					0.00	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	2,155.00	3,907.00	2,053.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	89.53	77.86	50.61	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	38.93	38.93	25.31			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					192,937	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					304,199	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					103,902	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					601,038	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					601,038	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					601,038	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 151320	Period: From 10/01/2014 To 09/30/2015	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/17/2016 10:07 am

Physical Therapy — Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	77.86	50.61	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	601,038		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	601,038		63.00
64.00	Total cost of outside supplier services (from your records)	585,856		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	0		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	0		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	0		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 151320	Period: From 10/01/2014 To 09/30/2015	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/17/2016 10:07 am

		Respiratory Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		52	1.00
2.00	Line 1 multiplied by 15 hours per week		780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		0.00	7.00
8.00	Optional travel expense rate per mile		0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	1,863.00	5,949.00	0.00	1,800.00	0.00	9.00
10.00	AHSEA (see instructions)	70.38	61.20	0.00	45.90	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	30.60	30.60	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)						12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)						13.01

			1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION			
14.00	Supervisors (column 1, line 9 times column 1, line 10)		131,118	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)		364,079	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)		0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)		495,197	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)		82,620	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)		0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)		577,817	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.			
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)		0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)		0	22.00
23.00	Total salary equivalency (see instructions)		577,817	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE			
	Standard Travel Allowance			
24.00	Therapists (line 3 times column 2, line 11)		0	24.00
25.00	Assistants (line 4 times column 3, line 11)		0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)		0	28.00
	Optional Travel Allowance and Optional Travel Expense			
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)		0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)		0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)		0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)		0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)		0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE			
	Standard Travel Expense			
36.00	Therapists (line 5 times column 2, line 11)		0	36.00
37.00	Assistants (line 6 times column 3, line 11)		0	37.00
38.00	Subtotal (sum of lines 36 and 37)		0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)		0	39.00
	Optional Travel Allowance and Optional Travel Expense			
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)		0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)		0	41.00
42.00	Subtotal (sum of lines 40 and 41)		0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)		0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.			
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)		0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 151320	Period: From 10/01/2014 To 09/30/2015	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/17/2016 10:07 am

		Respiratory Therapy	Cost	
			1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)		0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	113.00	0.00	45.00	0.00	158.00	47.00
48.00	Overtime rate (see instructions)	91.80	0.00	68.85	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	10,373.40	0.00	3,098.25	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	71.52	0.00	28.48	0.00	100.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	1,487.62	0.00	592.38	0.00	2,080.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	61.20	0.00	45.90	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	91,042	0	27,190	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	10,373	0	3,098	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	6,916	0	2,066	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	3,457	0	1,032	0	4,489	56.00

			1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)		577,817	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))		0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)		0	59.00
60.00	Overtime allowance (from column 5, line 56)		4,489	60.00
61.00	Equipment cost (see instructions)		0	61.00
62.00	Supplies (see instructions)		800	62.00
63.00	Total allowance (sum of lines 57-62)		583,106	63.00
64.00	Total cost of outside supplier services (from your records)		346,046	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)		0	65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others		0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27		0	100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	101.01
101.02	Line 34 = sum of lines 27 and 31		0	101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others		0	102.01
102.02	Line 35 = sum of lines 31 and 32		0	102.02

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		Occupational Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		52	1.00
2.00	Line 1 multiplied by 15 hours per week		780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		0.00	7.00
8.00	Optional travel expense rate per mile		0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	15.00	1,833.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	81.19	73.81	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	36.91	36.91	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	1,218	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	135,294	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	136,512	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	136,512	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	136,512	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	0	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	0	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 151320	Period: From 10/01/2014 To 09/30/2015	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/17/2016 10:07 am

		Occupational Therapy	Cost	
			1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)		0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	73.81	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	136,512	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	136,512	63.00
64.00	Total cost of outside supplier services (from your records)	108,738	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	0	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	0	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

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Speech Pathology — Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					0.00	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	184.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	70.94	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	35.47	35.47	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					13,053	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					13,053	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					13,053	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					70.94	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					55,333	22.00
23.00	Total salary equivalency (see instructions)					55,333	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 2/17/2016 10:07 am

Speech Pathology — Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	70.94	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	55,333		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	55,333		63.00
64.00	Total cost of outside supplier services (from your records)	26,634		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	0		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	0		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	0		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I | Date/Time Prepared: 2/17/2016 10:07 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW MVBLE EQUIP	NEW MVBLE EQUIP MOB	NEW MVBLE EQUIP-POB	NEW MVBLE EQUIP- WJ	
			0	2.00	2.01	2.02	2.03	
		GENERAL SERVICE COST CENTERS						
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	1,332,082	1,332,082				2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP MOB	10,285	0	10,285			2.01
2.02	00202	NEW CAP REL COSTS-MVBLE EQUIP-POB	119,979	0	0	119,979		2.02
2.03	00203	NEW CAP REL COSTS-MVBLE EQUIP- WJ	31,142	0	0	0	31,142	2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,587,695	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,825,515	159,003	2,189	3,354	0	5.00
7.00	00700	OPERATION OF PLANT	1,207,017	82,852	0	0	0	7.00
7.01	00701	OPERATION OF PLANT-MOB	38,961	0	0	0	0	7.01
7.02	00702	OPERATION OF PLANT-POB	81,940	0	0	0	0	7.02
7.03	00703	OPERATION OF PLANT-WJ	2,821	0	0	0	0	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	64,718	8,961	0	0	0	8.00
9.00	00900	HOUSEKEEPING	345,377	7,130	0	0	0	9.00
10.00	01000	DIETARY	330,605	41,689	373	0	0	10.00
11.00	01100	CAFETERIA	119,557	40,033	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	959,881	28,384	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	84,275	39,351	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	392,900	27,565	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,229,920	260,751	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	898,476	90,313	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	221,796	20,124	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,528,712	124,678	0	57,125	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	18,488	2,474	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,382,686	121,853	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,744,856	46,754	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	354,136	5,455	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	636,029	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	108,738	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	26,634	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	333,971	19,481	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	1,422,012	21,624	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	264,507	81,820	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	448,129	0	0	59,500	0	90.01
90.02	09002	JAY FAMILY MEDICINE	485,219	0	0	0	0	90.02
91.00	09100	EMERGENCY	924,211	90,586	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	27,563,270	1,320,881	2,562	119,979	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,201	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	MOB	13	0	7,723	0	0	194.00
194.01	07951	POB	0	0	0	0	0	194.01
194.02	07952	WEST JAY CLINIC	560,302	0	0	0	31,142	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.03

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I Date/Time Prepared: 2/17/2016 10:07 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				NEW MVBLE EQUIP	NEW MVBLE EQUIP MOB	NEW MVBLE EQUIP-POB	NEW MVBLE EQUIP- WJ	
			0	2.00	2.01	2.02	2.03	
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
194.05	07955	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.05
194.06	07956	TRI COUNTY	1,486,668	0	0	0	0	194.06
194.07	07957	HOSPITALIST	66,835	0	0	0	0	194.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	29,677,088	1,332,082	10,285	119,979	31,142	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I | Date/Time Prepared: 2/17/2016 10:07 am

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT-MOB	
			4.00	4A	5.00	7.00	7.01	
		GENERAL SERVICE COST CENTERS						
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP MOB						2.01
2.02	00202	NEW CAP REL COSTS-MVBLE EQUIP-POB						2.02
2.03	00203	NEW CAP REL COSTS-MVBLE EQUIP- WJ						2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,587,695					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	850,158	5,840,219	5,840,219			5.00
7.00	00700	OPERATION OF PLANT	114,844	1,404,713	344,166	1,748,879		7.00
7.01	00701	OPERATION OF PLANT-MOB	1,806	40,767	9,988	0	50,755	7.01
7.02	00702	OPERATION OF PLANT-POB	2,620	84,560	20,718	0	0	7.02
7.03	00703	OPERATION OF PLANT-WJ	1,010	3,831	939	0	0	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	12,783	86,462	21,184	14,375	0	8.00
9.00	00900	HOUSEKEEPING	124,273	476,780	116,815	11,438	0	9.00
10.00	01000	DIETARY	64,096	436,763	107,010	66,875	2,341	10.00
11.00	01100	CAFETERIA	55,503	215,093	52,700	64,219	0	11.00
13.00	01300	NURSING ADMINISTRATION	347,779	1,336,044	327,341	45,531	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	24,552	148,178	36,305	63,125	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	126,215	546,680	133,941	44,219	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	434,579	1,925,250	471,702	418,283	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	236,169	1,224,958	300,125	144,875	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	49,676	291,596	71,443	32,281	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	306,297	2,016,812	494,135	200,000	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,322	27,284	6,685	3,969	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	294,516	1,799,055	440,783	195,469	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	228,077	2,019,687	494,833	75,000	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	359,591	88,103	8,750	0	65.00
66.00	06600	PHYSICAL THERAPY	0	636,029	155,832	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	108,738	26,642	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	26,634	6,526	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	69,322	422,774	103,583	31,250	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	142,744	1,586,380	388,676	34,688	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	168,034	514,361	126,023	131,250	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	533,594	1,041,223	255,108	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	366,906	852,125	208,777	0	0	90.02
91.00	09100	EMERGENCY	772,247	1,787,044	437,840	145,313	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,334,122	27,259,631	5,247,923	1,730,910	2,341	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,201	2,744	17,969	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	MOB	0	7,736	1,895	0	48,414	194.00
194.01	07951	POB	0	0	0	0	0	194.01
194.02	07952	WEST JAY CLINIC	164,073	755,517	185,108	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
194.05	07955	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.05
194.06	07956	TRI COUNTY	65,484	1,552,152	380,290	0	0	194.06
194.07	07957	HOSPITALIST	24,016	90,851	22,259	0	0	194.07

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I Date/Time Prepared: 2/17/2016 10:07 am

	Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT-MOB	
		4.00	4A	5.00	7.00	7.01	
200.00	Cross Foot Adjustments		0				200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	5,587,695	29,677,088	5,840,219	1,748,879	50,755	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I | Date/Time Prepared: 2/17/2016 10:07 am

		Cost Center Description	OPERATION OF PLANT-POB	OPERATION OF PLANT-WJ	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			7.02	7.03	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP MOB						2.01
2.02	00202	NEW CAP REL COSTS-MVBLE EQUIP-POB						2.02
2.03	00203	NEW CAP REL COSTS-MVBLE EQUIP- WJ						2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-MOB						7.01
7.02	00702	OPERATION OF PLANT-POB	105,278					7.02
7.03	00703	OPERATION OF PLANT-WJ	0	4,770				7.03
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	122,021			8.00
9.00	00900	HOUSEKEEPING	0	0	14,264	619,297		9.00
10.00	01000	DIETARY	0	0	4,896	16,343	634,228	10.00
11.00	01100	CAFETERIA	0	0	0	15,694	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	11,127	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	15,426	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	10,806	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	27,664	102,218	324,984	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	8,145	35,404	309,244	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	215	7,889	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	51,568	0	27,320	91,145	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	970	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	10,517	47,768	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	18,328	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,138	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,995	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	1,813	7,637	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	8,477	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	32,074	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	53,710	0	0	44,026	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	25,192	35,511	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	105,278	0	122,021	502,981	634,228	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	4,391	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	MOB	0	0	0	67,899	0	194.00
194.01	07951	POB	0	0	0	44,026	0	194.01
194.02	07952	WEST JAY CLINIC	0	4,770	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
194.05	07955	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.05
194.06	07956	TRI COUNTY	0	0	0	0	0	194.06
194.07	07957	HOSPITALIST	0	0	0	0	0	194.07
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I Date/Time Prepared: 2/17/2016 10:07 am

	Cost Center Description	OPERATION OF PLANT-POB	OPERATION OF PLANT-WJ	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		7.02	7.03	8.00	9.00	10.00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	105,278	4,770	122,021	619,297	634,228	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I | Date/Time Prepared: 2/17/2016 10:07 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	Subtotal	
			11.00	13.00	14.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP MOB						2.01
2.02	00202	NEW CAP REL COSTS-MVBLE EQUIP-POB						2.02
2.03	00203	NEW CAP REL COSTS-MVBLE EQUIP- WJ						2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-MOB						7.01
7.02	00702	OPERATION OF PLANT-POB						7.02
7.03	00703	OPERATION OF PLANT-WJ						7.03
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	347,706					11.00
13.00	01300	NURSING ADMINISTRATION	24,225	1,744,268				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,038	0	267,072			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16,524	0	271	752,441		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	48,732	602,458	12,505	43,447	3,977,243	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	26,733	330,472	1,209	14,895	2,396,060	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	5,354	66,182	0	1,211	476,171	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	25,595	316,400	72,140	124,385	3,419,500	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	516	6,376	0	1,318	47,118	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,666	0	15,917	242,365	2,777,540	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	26,021	0	71,412	163,501	2,868,782	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	958	7,549	467,089	65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,057	20,827	815,740	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,687	139,067	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	554	33,714	68.00
69.00	06900	ELECTROCARDIOLOGY	8,111	0	3,735	15,184	594,087	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	9,534	0	2,299	36,635	2,066,689	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	18,640	0	8,150	2,816	833,314	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	44,715	0	26,390	8,379	1,473,551	90.01
90.02	09002	JAY FAMILY MEDICINE	28,956	0	25,973	4,132	1,119,963	90.02
91.00	09100	EMERGENCY	34,168	422,380	13,627	61,556	2,962,631	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	347,528	1,744,268	255,643	752,441	26,468,259	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	36,305	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	MOB	0	0	0	0	125,944	194.00
194.01	07951	POB	0	0	0	0	44,026	194.01
194.02	07952	WEST JAY CLINIC	0	0	7,303	0	952,698	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
194.05	07955	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.05
194.06	07956	TRI COUNTY	0	0	4,077	0	1,936,519	194.06
194.07	07957	HOSPITALIST	178	0	49	0	113,337	194.07

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I Date/Time Prepared: 2/17/2016 10:07 am

	Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	Subtotal	
		11.00	13.00	14.00	16.00	24.00	
200.00	Cross Foot Adjustments					0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	347,706	1,744,268	267,072	752,441	29,677,088	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I | Date/Time Prepared: 2/17/2016 10:07 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP MOB				2.01
2.02	00202	NEW CAP REL COSTS-MVBLE EQUIP-POB				2.02
2.03	00203	NEW CAP REL COSTS-MVBLE EQUIP- WJ				2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	OPERATION OF PLANT-MOB				7.01
7.02	00702	OPERATION OF PLANT-POB				7.02
7.03	00703	OPERATION OF PLANT-WJ				7.03
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	3,977,243		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
40.00	04000	SUBPROVIDER - IPF	0	2,396,060		40.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
42.00	04200	SUBPROVIDER	0	0		42.00
43.00	04300	NURSERY	0	476,171		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	3,419,500		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	47,118		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,777,540		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	2,868,782		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	467,089		65.00
66.00	06600	PHYSICAL THERAPY	0	815,740		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	139,067		67.00
68.00	06800	SPEECH PATHOLOGY	0	33,714		68.00
69.00	06900	ELECTROCARDIOLOGY	0	594,087		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,066,689		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	833,314		90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	1,473,551		90.01
90.02	09002	JAY FAMILY MEDICINE	0	1,119,963		90.02
91.00	09100	EMERGENCY	0	2,962,631		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF	0	0		99.10
		SPECIAL PURPOSE COST CENTERS				
106.00	10600	HEART ACQUISITION	0	0		106.00
109.00	10900	PANCREAS ACQUISITION	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0		111.00
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	26,468,259		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	36,305		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
194.00	07950	MOB	0	125,944		194.00
194.01	07951	POB	0	44,026		194.01
194.02	07952	WEST JAY CLINIC	0	952,698		194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.04
194.05	07955	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.05

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I Date/Time Prepared: 2/17/2016 10:07 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
194.06	07956	TRI COUNTY	0	1,936,519		194.06
194.07	07957	HOSPITALIST	0	113,337		194.07
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	29,677,088		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II Date/Time Prepared: 2/17/2016 10:07 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW MVBLE EQUIP	NEW MVBLE EQUIP MOB	NEW MVBLE EQUIP-POB	NEW MVBLE EQUIP- WJ	
			0	2.00	2.01	2.02	2.03	
		GENERAL SERVICE COST CENTERS						
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP MOB						2.01
2.02	00202	NEW CAP REL COSTS-MVBLE EQUIP-POB						2.02
2.03	00203	NEW CAP REL COSTS-MVBLE EQUIP- WJ						2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	159,003	2,189	3,354	0	5.00
7.00	00700	OPERATION OF PLANT	0	82,852	0	0	0	7.00
7.01	00701	OPERATION OF PLANT-MOB	0	0	0	0	0	7.01
7.02	00702	OPERATION OF PLANT-POB	0	0	0	0	0	7.02
7.03	00703	OPERATION OF PLANT-WJ	0	0	0	0	0	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	0	8,961	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	7,130	0	0	0	9.00
10.00	01000	DIETARY	0	41,689	373	0	0	10.00
11.00	01100	CAFETERIA	0	40,033	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	28,384	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	39,351	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	27,565	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	260,751	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	90,313	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	20,124	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	124,678	0	57,125	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,474	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	121,853	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	46,754	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	5,455	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	19,481	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	21,624	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	81,820	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	0	0	59,500	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	90,586	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,320,881	2,562	119,979	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,201	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	MOB	0	0	7,723	0	0	194.00
194.01	07951	POB	0	0	0	0	0	194.01
194.02	07952	WEST JAY CLINIC	0	0	0	0	31,142	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II Date/Time Prepared: 2/17/2016 10:07 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW MVBLE EQUIP	NEW MVBLE EQUIP MOB	NEW MVBLE EQUIP-POB	NEW MVBLE EQUIP- WJ	
			0	2.00	2.01	2.02	2.03	
194.05	07955	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.05
194.06	07956	TRI COUNTY	0	0	0	0	0	194.06
194.07	07957	HOSPITALIST	0	0	0	0	0	194.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	1,332,082	10,285	119,979	31,142	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II | Date/Time Prepared: 2/17/2016 10:07 am

		Cost Center Description	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT-MOB	
			2A	4.00	5.00	7.00	7.01	
		GENERAL SERVICE COST CENTERS						
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP MOB						2.01
2.02	00202	NEW CAP REL COSTS-MVBLE EQUIP-POB						2.02
2.03	00203	NEW CAP REL COSTS-MVBLE EQUIP- WJ						2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	164,546	0	164,546			5.00
7.00	00700	OPERATION OF PLANT	82,852	0	9,697	92,549		7.00
7.01	00701	OPERATION OF PLANT-MOB	0	0	281	0	281	7.01
7.02	00702	OPERATION OF PLANT-POB	0	0	584	0	0	7.02
7.03	00703	OPERATION OF PLANT-WJ	0	0	26	0	0	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	8,961	0	597	761	0	8.00
9.00	00900	HOUSEKEEPING	7,130	0	3,291	605	0	9.00
10.00	01000	DIETARY	42,062	0	3,015	3,539	13	10.00
11.00	01100	CAFETERIA	40,033	0	1,485	3,398	0	11.00
13.00	01300	NURSING ADMINISTRATION	28,384	0	9,223	2,409	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	39,351	0	1,023	3,341	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	27,565	0	3,774	2,340	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	260,751	0	13,290	22,134	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	90,313	0	8,456	7,667	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	20,124	0	2,013	1,708	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	181,803	0	13,922	10,584	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,474	0	188	210	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	121,853	0	12,419	10,344	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	46,754	0	13,941	3,969	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	5,455	0	2,482	463	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	4,391	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	751	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	184	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	19,481	0	2,918	1,654	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	21,624	0	10,951	1,836	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	81,820	0	3,551	6,946	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	59,500	0	7,188	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	5,882	0	0	90.02
91.00	09100	EMERGENCY	90,586	0	12,336	7,690	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,443,422	0	147,859	91,598	13	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	11,201	0	77	951	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	MOB	7,723	0	53	0	268	194.00
194.01	07951	POB	0	0	0	0	0	194.01
194.02	07952	WEST JAY CLINIC	31,142	0	5,215	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
194.05	07955	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.05
194.06	07956	TRI COUNTY	0	0	10,715	0	0	194.06
194.07	07957	HOSPITALIST	0	0	627	0	0	194.07

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II Date/Time Prepared: 2/17/2016 10:07 am

	Cost Center Description	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT-MOB	
		2A	4.00	5.00	7.00	7.01	
200.00	Cross Foot Adjustments	0					200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	1,493,488	0	164,546	92,549	281	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II | Date/Time Prepared: 2/17/2016 10:07 am

		Cost Center Description	OPERATION OF PLANT-POB	OPERATION OF PLANT-WJ	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			7.02	7.03	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP MOB						2.01
2.02	00202	NEW CAP REL COSTS-MVBLE EQUIP-POB						2.02
2.03	00203	NEW CAP REL COSTS-MVBLE EQUIP- WJ						2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-MOB						7.01
7.02	00702	OPERATION OF PLANT-POB	584					7.02
7.03	00703	OPERATION OF PLANT-WJ	0	26				7.03
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	10,319			8.00
9.00	00900	HOUSEKEEPING	0	0	1,206	12,232		9.00
10.00	01000	DIETARY	0	0	414	323	49,366	10.00
11.00	01100	CAFETERIA	0	0	0	310	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	220	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	305	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	213	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	2,341	2,019	25,296	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	689	699	24,070	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	18	156	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	286	0	2,310	1,800	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	19	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	889	943	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	362	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	42	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	169	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	153	151	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	167	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	634	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	298	0	0	870	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	2,130	701	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	584	0	10,319	9,934	49,366	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	87	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	MOB	0	0	0	1,341	0	194.00
194.01	07951	POB	0	0	0	870	0	194.01
194.02	07952	WEST JAY CLINIC	0	26	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
194.05	07955	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.05
194.06	07956	TRI COUNTY	0	0	0	0	0	194.06
194.07	07957	HOSPITALIST	0	0	0	0	0	194.07
200.00		Cross Foot Adjustments						200.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II Date/Time Prepared: 2/17/2016 10:07 am

	Cost Center Description	OPERATION OF PLANT-POB	OPERATION OF PLANT-WJ	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		7.02	7.03	8.00	9.00	10.00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	584	26	10,319	12,232	49,366	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II | Date/Time Prepared: 2/17/2016 10:07 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	Subtotal	
			11.00	13.00	14.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP MOB						2.01
2.02	00202	NEW CAP REL COSTS-MVBLE EQUIP-POB						2.02
2.03	00203	NEW CAP REL COSTS-MVBLE EQUIP- WJ						2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-MOB						7.01
7.02	00702	OPERATION OF PLANT-POB						7.02
7.03	00703	OPERATION OF PLANT-WJ						7.03
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	45,226					11.00
13.00	01300	NURSING ADMINISTRATION	3,151	43,387				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	525	0	44,545			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,149	0	45	36,086		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,340	14,986	2,086	2,083	351,326	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	3,477	8,220	202	714	144,507	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	696	1,646	0	58	26,419	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,329	7,870	12,033	5,964	239,901	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	67	159	0	63	3,180	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,338	0	2,655	11,628	164,069	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	3,385	0	11,911	7,840	88,162	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	160	362	8,964	65.00
66.00	06600	PHYSICAL THERAPY	0	0	176	999	5,735	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	177	928	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	27	211	68.00
69.00	06900	ELECTROCARDIOLOGY	1,055	0	623	728	26,763	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	1,240	0	383	1,757	37,958	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	2,425	0	1,359	135	96,870	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	5,816	0	4,401	402	78,475	90.01
90.02	09002	JAY FAMILY MEDICINE	3,766	0	4,332	198	14,178	90.02
91.00	09100	EMERGENCY	4,444	10,506	2,273	2,951	133,617	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	45,203	43,387	42,639	36,086	1,421,263	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	12,316	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	MOB	0	0	0	0	9,385	194.00
194.01	07951	POB	0	0	0	0	870	194.01
194.02	07952	WEST JAY CLINIC	0	0	1,218	0	37,601	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
194.05	07955	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.05
194.06	07956	TRI COUNTY	0	0	680	0	11,395	194.06
194.07	07957	HOSPITALIST	23	0	8	0	658	194.07

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II Date/Time Prepared: 2/17/2016 10:07 am

	Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	Subtotal	
		11.00	13.00	14.00	16.00	24.00	
200.00	Cross Foot Adjustments					0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	45,226	43,387	44,545	36,086	1,493,488	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II Date/Time Prepared: 2/17/2016 10:07 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP MOB				2.01
2.02	00202	NEW CAP REL COSTS-MVBLE EQUIP-POB				2.02
2.03	00203	NEW CAP REL COSTS-MVBLE EQUIP- WJ				2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	OPERATION OF PLANT-MOB				7.01
7.02	00702	OPERATION OF PLANT-POB				7.02
7.03	00703	OPERATION OF PLANT-WJ				7.03
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	351,326		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
40.00	04000	SUBPROVIDER - IPF	0	144,507		40.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
42.00	04200	SUBPROVIDER	0	0		42.00
43.00	04300	NURSERY	0	26,419		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	239,901		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,180		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	164,069		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	88,162		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	8,964		65.00
66.00	06600	PHYSICAL THERAPY	0	5,735		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	928		67.00
68.00	06800	SPEECH PATHOLOGY	0	211		68.00
69.00	06900	ELECTROCARDIOLOGY	0	26,763		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	37,958		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	96,870		90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	78,475		90.01
90.02	09002	JAY FAMILY MEDICINE	0	14,178		90.02
91.00	09100	EMERGENCY	0	133,617		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF	0	0		99.10
		SPECIAL PURPOSE COST CENTERS				
106.00	10600	HEART ACQUISITION	0	0		106.00
109.00	10900	PANCREAS ACQUISITION	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0		111.00
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,421,263		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12,316		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
194.00	07950	MOB	0	9,385		194.00
194.01	07951	POB	0	870		194.01
194.02	07952	WEST JAY CLINIC	0	37,601		194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.04
194.05	07955	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.05

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II Date/Time Prepared: 2/17/2016 10:07 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
194.06	07956	TRI COUNTY	0	11,395		194.06
194.07	07957	HOSPITALIST	0	658		194.07
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	1,493,488		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/17/2016 10:07 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW MVBLE EQUIP (SQUARE FEET)	NEW MVBLE EQUIP MOB (SQUARE FEET)	NEW MVBLE EQUIP-POB (SQUARE FEET)	NEW MVBLE EQUIP- WJ (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
			2.00	2.01	2.02	2.03	4.00	
		GENERAL SERVICE COST CENTERS						
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	68,379					2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP MOB	0	11,841				2.01
2.02	00202	NEW CAP REL COSTS-MVBLE EQUIP-POB	0	0	11,625			2.02
2.03	00203	NEW CAP REL COSTS-MVBLE EQUIP- WJ	0	0	0	3,300		2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	15,425,606	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,162	2,520	325	0	2,346,972	5.00
7.00	00700	OPERATION OF PLANT	4,253	0	0	0	317,044	7.00
7.01	00701	OPERATION OF PLANT-MOB	0	0	0	0	4,987	7.01
7.02	00702	OPERATION OF PLANT-POB	0	0	0	0	7,232	7.02
7.03	00703	OPERATION OF PLANT-WJ	0	0	0	0	2,789	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	460	0	0	0	35,288	8.00
9.00	00900	HOUSEKEEPING	366	0	0	0	343,074	9.00
10.00	01000	DIETARY	2,140	430	0	0	176,945	10.00
11.00	01100	CAFETERIA	2,055	0	0	0	153,225	11.00
13.00	01300	NURSING ADMINISTRATION	1,457	0	0	0	960,092	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,020	0	0	0	67,779	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,415	0	0	0	348,435	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,385	0	0	0	1,199,717	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	4,636	0	0	0	651,976	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	1,033	0	0	0	137,138	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,400	0	5,535	0	845,575	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	127	0	0	0	17,453	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,255	0	0	0	813,052	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2,400	0	0	0	629,639	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	280	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	1,000	0	0	0	191,374	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	1,110	0	0	0	394,065	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	4,200	0	0	0	463,880	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	0	5,765	0	1,473,060	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	0	0	1,012,896	90.02
91.00	09100	EMERGENCY	4,650	0	0	0	2,131,895	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	67,804	2,950	11,625	0	14,725,582	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	575	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MOB	0	8,891	0	0	0	194.00
194.01	07951	POB	0	0	0	0	0	194.01
194.02	07952	WEST JAY CLINIC	0	0	0	3,300	452,947	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.03

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/17/2016 10:07 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW MVBLE EQUIP (SQUARE FEET)	NEW MVBLE EQUIP MOB (SQUARE FEET)	NEW MVBLE EQUIP-POB (SQUARE FEET)	NEW MVBLE EQUIP- WJ (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
			2.00	2.01	2.02	2.03	4.00	
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
194.05	07955	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.05
194.06	07956	TRI COUNTY	0	0	0	0	180,777	194.06
194.07	07957	HOSPITALIST	0	0	0	0	66,300	194.07
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)	1,332,082	10,285	119,979	31,142	5,587,695	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	19.480864	0.868592	10.320774	9.436970	0.362235	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)					0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)					0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/17/2016 10:07 am

		Cost Center Description	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT-MOB (SQUARE FEET)	OPERATION OF PLANT-POB (SQUARE FEET)	
			5A	5.00	7.00	7.01	7.02	
		GENERAL SERVICE COST CENTERS						
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP MOB						2.01
2.02	00202	NEW CAP REL COSTS-MVBLE EQUIP-POB						2.02
2.03	00203	NEW CAP REL COSTS-MVBLE EQUIP- WJ						2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-5,840,219	23,836,869				5.00
7.00	00700	OPERATION OF PLANT	0	1,404,713	55,964			7.00
7.01	00701	OPERATION OF PLANT-MOB	0	40,767	0	9,321		7.01
7.02	00702	OPERATION OF PLANT-POB	0	84,560	0	0	11,300	7.02
7.03	00703	OPERATION OF PLANT-WJ	0	3,831	0	0	0	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	0	86,462	460	0	0	8.00
9.00	00900	HOUSEKEEPING	0	476,780	366	0	0	9.00
10.00	01000	DIETARY	0	436,763	2,140	430	0	10.00
11.00	01100	CAFETERIA	0	215,093	2,055	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,336,044	1,457	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	148,178	2,020	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	546,680	1,415	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,925,250	13,385	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	1,224,958	4,636	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	291,596	1,033	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,016,812	6,400	0	5,535	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	27,284	127	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,799,055	6,255	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	2,019,687	2,400	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	359,591	280	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	636,029	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	108,738	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	26,634	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	422,774	1,000	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	1,586,380	1,110	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	514,361	4,200	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	1,041,223	0	0	5,765	90.01
90.02	09002	JAY FAMILY MEDICINE	0	852,125	0	0	0	90.02
91.00	09100	EMERGENCY	0	1,787,044	4,650	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-5,840,219	21,419,412	55,389	430	11,300	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,201	575	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	MOB	0	7,736	0	8,891	0	194.00
194.01	07951	POB	0	0	0	0	0	194.01
194.02	07952	WEST JAY CLINIC	0	755,517	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
194.05	07955	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.05
194.06	07956	TRI COUNTY	0	1,552,152	0	0	0	194.06

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/17/2016 10:07 am

		Cost Center Description	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT-MOB (SQUARE FEET)	OPERATION OF PLANT-POB (SQUARE FEET)	
			5A	5.00	7.00	7.01	7.02	
194.07	07957	HOSPITALIST	0	90,851	0	0	0	194.07
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)		5,840,219	1,748,879	50,755	105,278	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.245008	31.250071	5.445231	9.316637	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		164,546	92,549	281	584	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.006903	1.653724	0.030147	0.051681	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/17/2016 10:07 am

		Cost Center Description	OPERATION OF PLANT-WJ (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
			7.03	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP MOB						2.01
2.02	00202	NEW CAP REL COSTS-MVBLE EQUIP-POB						2.02
2.03	00203	NEW CAP REL COSTS-MVBLE EQUIP- WJ						2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-MOB						7.01
7.02	00702	OPERATION OF PLANT-POB						7.02
7.03	00703	OPERATION OF PLANT-WJ	3,300					7.03
8.00	00800	LAUNDRY & LINEN SERVICE	0	40,376				8.00
9.00	00900	HOUSEKEEPING	0	4,720	81,094			9.00
10.00	01000	DIETARY	0	1,620	2,140	30,261		10.00
11.00	01100	CAFETERIA	0	0	2,055	0	19,549	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	1,457	0	1,362	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	2,020	0	227	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	1,415	0	929	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	9,154	13,385	15,506	2,740	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	2,695	4,636	14,755	1,503	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	71	1,033	0	301	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	9,040	11,935	0	1,439	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	127	0	29	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,480	6,255	0	1,443	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	2,400	0	1,463	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	280	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	660	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	600	1,000	0	456	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	1,110	0	536	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	4,200	0	1,048	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	0	5,765	0	2,514	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	0	0	1,628	90.02
91.00	09100	EMERGENCY	0	8,336	4,650	0	1,921	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	40,376	65,863	30,261	19,539	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	575	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	MOB	0	0	8,891	0	0	194.00
194.01	07951	POB	0	0	5,765	0	0	194.01
194.02	07952	WEST JAY CLINIC	3,300	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
194.05	07955	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.05
194.06	07956	TRI COUNTY	0	0	0	0	0	194.06

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/17/2016 10:07 am

		Cost Center Description	OPERATION OF PLANT-WJ (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
			7.03	8.00	9.00	10.00	11.00	
194.07	07957	HOSPITALIST	0	0	0	0	10	194.07
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)	4,770	122,021	619,297	634,228	347,706	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.445455	3.022117	7.636780	20.958594	17.786383	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	26	10,319	12,232	49,366	45,226	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.007879	0.255573	0.150837	1.631341	2.313469	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/17/2016 10:07 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING FTE)	CENTRAL SERVICES & SUPPLY (SUPPLY COST)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	14.00	16.00		
		GENERAL SERVICE COST CENTERS					
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP MOB					2.01
2.02	00202	NEW CAP REL COSTS-MVBLE EQUIP-POB					2.02
2.03	00203	NEW CAP REL COSTS-MVBLE EQUIP- WJ					2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	OPERATION OF PLANT-MOB					7.01
7.02	00702	OPERATION OF PLANT-POB					7.02
7.03	00703	OPERATION OF PLANT-WJ					7.03
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION	7,933				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,254,362			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,287	77,586,179		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	2,740	105,552	4,479,954		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		31.00
40.00	04000	SUBPROVIDER - IPF	1,503	10,206	1,535,860		40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0		41.00
42.00	04200	SUBPROVIDER	0	0	0		42.00
43.00	04300	NURSERY	301	0	124,872		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,439	608,935	12,825,886		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	29	0	135,946		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	134,360	24,990,154		54.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	0	602,790	16,859,240		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	8,090	778,391		65.00
66.00	06600	PHYSICAL THERAPY	0	8,922	2,147,569		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	380,176		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	57,123		68.00
69.00	06900	ELECTROCARDIOLOGY	0	31,524	1,565,690		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	19,405	3,777,557		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	0	68,798	290,392		90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	222,759	863,990		90.01
90.02	09002	JAY FAMILY MEDICINE	0	219,239	426,075		90.02
91.00	09100	EMERGENCY	1,921	115,023	6,347,304		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	0		99.10
		SPECIAL PURPOSE COST CENTERS					
106.00	10600	HEART ACQUISITION	0	0	0		106.00
109.00	10900	PANCREAS ACQUISITION	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0		111.00
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,933	2,157,890	77,586,179		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0	0		193.00
194.00	07950	MOB	0	0	0		194.00
194.01	07951	POB	0	0	0		194.01
194.02	07952	WEST JAY CLINIC	0	61,645	0		194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0		194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	0		194.04
194.05	07955	OTHER NONREIMBURSABLE COST CENTERS	0	0	0		194.05

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/17/2016 10:07 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING FTE)	CENTRAL SERVICES & SUPPLY (SUPPLY COST)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	14.00	16.00		
194.06	07956	TRI COUNTY	0	34,411	0		194.06
194.07	07957	HOSPITALIST	0	416	0		194.07
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)	1,744,268	267,072	752,441		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	219.874953	0.118469	0.009698		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	43,387	44,545	36,086		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	5.469179	0.019759	0.000465		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/17/2016 10:07 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	3,977,243		3,977,243	0	3,977,243	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	2,396,060		2,396,060	0	2,396,060	40.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	476,171		476,171	0	476,171	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,419,500		3,419,500	0	3,419,500	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	47,118		47,118	0	47,118	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,777,540		2,777,540	0	2,777,540	54.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	2,868,782		2,868,782	0	2,868,782	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	467,089	0	467,089	0	467,089	65.00
66.00	06600	PHYSICAL THERAPY	815,740	0	815,740	0	815,740	66.00
67.00	06700	OCCUPATIONAL THERAPY	139,067	0	139,067	0	139,067	67.00
68.00	06800	SPEECH PATHOLOGY	33,714	0	33,714	0	33,714	68.00
69.00	06900	ELECTROCARDIOLOGY	594,087		594,087	0	594,087	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,066,689		2,066,689	0	2,066,689	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	833,314		833,314	0	833,314	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1,473,551		1,473,551	0	1,473,551	90.01
90.02	09002	JAY FAMILY MEDICINE	1,119,963		1,119,963	0	1,119,963	90.02
91.00	09100	EMERGENCY	2,962,631		2,962,631	0	2,962,631	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	129,354		129,354		129,354	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0		0		0	99.10
		SPECIAL PURPOSE COST CENTERS						
106.00	10600	HEART ACQUISITION	0		0		0	106.00
109.00	10900	PANCREAS ACQUISITION	0		0		0	109.00
110.00	11000	INTESTINAL ACQUISITION	0		0		0	110.00
111.00	11100	ISLET ACQUISITION	0		0		0	111.00
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	26,597,613	0	26,597,613	0	26,597,613	200.00
201.00		Less Observation Beds	129,354		129,354		129,354	201.00
202.00		Total (see instructions)	26,468,259	0	26,468,259	0	26,468,259	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/17/2016 10:07 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	4,391,825		4,391,825			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
40.00	04000	SUBPROVIDER - IPF	1,535,860		1,535,860			40.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	124,872		124,872			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,404,370	10,421,516	12,825,886	0.266609	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	135,946	0	135,946	0.346594	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,502,041	23,488,113	24,990,154	0.111145	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	1,969,442	14,889,798	16,859,240	0.170161	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	561,975	216,416	778,391	0.600070	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	338,197	1,809,372	2,147,569	0.379843	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	167,782	212,394	380,176	0.365796	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	13,915	43,208	57,123	0.590200	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	132,279	1,433,411	1,565,690	0.379441	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,313,951	2,463,606	3,777,557	0.547097	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
90.00	09000	CLINIC	29,438	260,954	290,392	2.869618	0.000000	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	863,990	863,990	1.705519	0.000000	90.01
90.02	09002	JAY FAMILY MEDICINE	0	426,075	426,075	2.628558	0.000000	90.02
91.00	09100	EMERGENCY	229,548	6,117,756	6,347,304	0.466754	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	88,129	88,129	1.467780	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0			99.10
		SPECIAL PURPOSE COST CENTERS						
106.00	10600	HEART ACQUISITION	0	0	0			106.00
109.00	10900	PANCREAS ACQUISITION	0	0	0			109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0			110.00
111.00	11100	ISLET ACQUISITION	0	0	0			111.00
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	14,851,441	62,734,738	77,586,179			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	14,851,441	62,734,738	77,586,179			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/17/2016 10:07 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
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
42.00	04200	SUBPROVIDER			42.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.266609		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.346594		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.111145		54.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.170161		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
65.00	06500	RESPIRATORY THERAPY	0.600070		65.00
66.00	06600	PHYSICAL THERAPY	0.379843		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.365796		67.00
68.00	06800	SPEECH PATHOLOGY	0.590200		68.00
69.00	06900	ELECTROCARDIOLOGY	0.379441		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	0.547097		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	09000	CLINIC	2.869618		90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1.705519		90.01
90.02	09002	JAY FAMILY MEDICINE	2.628558		90.02
91.00	09100	EMERGENCY	0.466754		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.467780		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000		93.00
		OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF			99.10
		SPECIAL PURPOSE COST CENTERS			
106.00	10600	HEART ACQUISITION			106.00
109.00	10900	PANCREAS ACQUISITION			109.00
110.00	11000	INTESTINAL ACQUISITION			110.00
111.00	11100	ISLET ACQUISITION			111.00
113.00	11300	INTEREST EXPENSE			113.00
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: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/17/2016 10:07 am

Title XIX | 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	3,977,243		3,977,243	0	3,977,243	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	2,396,060		2,396,060	0	2,396,060	40.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	476,171		476,171	0	476,171	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,419,500		3,419,500	0	3,419,500	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	47,118		47,118	0	47,118	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,777,540		2,777,540	0	2,777,540	54.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	2,868,782		2,868,782	0	2,868,782	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	467,089	0	467,089	0	467,089	65.00
66.00	06600	PHYSICAL THERAPY	815,740	0	815,740	0	815,740	66.00
67.00	06700	OCCUPATIONAL THERAPY	139,067	0	139,067	0	139,067	67.00
68.00	06800	SPEECH PATHOLOGY	33,714	0	33,714	0	33,714	68.00
69.00	06900	ELECTROCARDIOLOGY	594,087		594,087	0	594,087	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,066,689		2,066,689	0	2,066,689	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	833,314		833,314	0	833,314	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1,473,551		1,473,551	0	1,473,551	90.01
90.02	09002	JAY FAMILY MEDICINE	1,119,963		1,119,963	0	1,119,963	90.02
91.00	09100	EMERGENCY	2,962,631		2,962,631	0	2,962,631	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	129,354		129,354		129,354	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0		0		0	99.10
		SPECIAL PURPOSE COST CENTERS						
106.00	10600	HEART ACQUISITION	0		0		0	106.00
109.00	10900	PANCREAS ACQUISITION	0		0		0	109.00
110.00	11000	INTESTINAL ACQUISITION	0		0		0	110.00
111.00	11100	ISLET ACQUISITION	0		0		0	111.00
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	26,597,613	0	26,597,613	0	26,597,613	200.00
201.00		Less Observation Beds	129,354		129,354		129,354	201.00
202.00		Total (see instructions)	26,468,259	0	26,468,259	0	26,468,259	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I | Date/Time Prepared: 2/17/2016 10:07 am

Title XIX | 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	4,391,825		4,391,825			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
40.00	04000	SUBPROVIDER - IPF	1,535,860		1,535,860			40.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	124,872		124,872			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,404,370	10,421,516	12,825,886	0.266609	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	135,946	0	135,946	0.346594	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,502,041	23,488,113	24,990,154	0.111145	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	1,969,442	14,889,798	16,859,240	0.170161	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	561,975	216,416	778,391	0.600070	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	338,197	1,809,372	2,147,569	0.379843	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	167,782	212,394	380,176	0.365796	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	13,915	43,208	57,123	0.590200	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	132,279	1,433,411	1,565,690	0.379441	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,313,951	2,463,606	3,777,557	0.547097	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
90.00	09000	CLINIC	29,438	260,954	290,392	2.869618	0.000000	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	863,990	863,990	1.705519	0.000000	90.01
90.02	09002	JAY FAMILY MEDICINE	0	426,075	426,075	2.628558	0.000000	90.02
91.00	09100	EMERGENCY	229,548	6,117,756	6,347,304	0.466754	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	88,129	88,129	1.467780	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0			99.10
		SPECIAL PURPOSE COST CENTERS						
106.00	10600	HEART ACQUISITION	0	0	0			106.00
109.00	10900	PANCREAS ACQUISITION	0	0	0			109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0			110.00
111.00	11100	ISLET ACQUISITION	0	0	0			111.00
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	14,851,441	62,734,738	77,586,179			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	14,851,441	62,734,738	77,586,179			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/17/2016 10:07 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
42.00	04200	SUBPROVIDER			42.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	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
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0.000000		90.01
90.02	09002	JAY FAMILY MEDICINE	0.000000		90.02
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000		93.00
		OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF			99.10
		SPECIAL PURPOSE COST CENTERS			
106.00	10600	HEART ACQUISITION			106.00
109.00	10900	PANCREAS ACQUISITION			109.00
110.00	11000	INTESTINAL ACQUISITION			110.00
111.00	11100	ISLET ACQUISITION			111.00
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part II Date/Time Prepared: 2/17/2016 10:07 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	239,901	12,825,886	0.018704	512,614	9,588	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,180	135,946	0.023392	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	164,069	24,990,154	0.006565	440,399	2,891	54.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	88,162	16,859,240	0.005229	624,302	3,264	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	8,964	778,391	0.011516	187,080	2,154	65.00
66.00	06600	PHYSICAL THERAPY	5,735	2,147,569	0.002670	87,012	232	66.00
67.00	06700	OCCUPATIONAL THERAPY	928	380,176	0.002441	30,447	74	67.00
68.00	06800	SPEECH PATHOLOGY	211	57,123	0.003694	2,546	9	68.00
69.00	06900	ELECTROCARDIOLOGY	26,763	1,565,690	0.017093	109,301	1,868	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	37,958	3,777,557	0.010048	316,753	3,183	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	96,870	290,392	0.333584	5,054	1,686	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	78,475	863,990	0.090829	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	14,178	426,075	0.033276	0	0	90.02
91.00	09100	EMERGENCY	133,617	6,347,304	0.021051	19,750	416	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	14,040	88,129	0.159312	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0	93.00
200.00		Total (lines 50-199)	913,051	71,533,622		2,335,258	25,365	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV | Date/Time Prepared: 2/17/2016 10:07 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		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
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	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
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	0	0	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV Date/Time Prepared: 2/17/2016 10:07 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	12,825,886	0.000000	0.000000	512,614	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	135,946	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	24,990,154	0.000000	0.000000	440,399	54.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	16,859,240	0.000000	0.000000	624,302	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	778,391	0.000000	0.000000	187,080	65.00
66.00	06600	PHYSICAL THERAPY	0	2,147,569	0.000000	0.000000	87,012	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	380,176	0.000000	0.000000	30,447	67.00
68.00	06800	SPEECH PATHOLOGY	0	57,123	0.000000	0.000000	2,546	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,565,690	0.000000	0.000000	109,301	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,777,557	0.000000	0.000000	316,753	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000	CLINIC	0	290,392	0.000000	0.000000	5,054	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	863,990	0.000000	0.000000	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0	426,075	0.000000	0.000000	0	90.02
91.00	09100	EMERGENCY	0	6,347,304	0.000000	0.000000	19,750	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	88,129	0.000000	0.000000	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0	93.00
200.00		Total (lines 50-199)	0	71,533,622			2,335,258	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV | Date/Time Prepared: 2/17/2016 10:07 am

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	0	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	0	0		90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	0		90.02
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		93.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part V Date/Time Prepared: 2/17/2016 10:07 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	0.266609	0	2,304,794	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.346594	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.111145	0	6,162,420	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.170161	0	4,679,228	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.600070	0	32,651	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.379843	0	485,561	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.365796	0	37,201	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.590200	0	10,396	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.379441	0	606,136	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	0.547097	0	886,180	52,966	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	2.869618	0	38,341	16,857	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1.705519	0	91,102	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	2.628558	0	116,014	0	0	90.02
91.00	09100	EMERGENCY	0.466754	0	1,033,750	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.467780	0	28,495	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	93.00
200.00		Subtotal (see instructions)		0	16,512,269	69,823	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	16,512,269	69,823	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part V Date/Time Prepared: 2/17/2016 10:07 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	614,479	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	684,922	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	796,222	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	19,593	0		65.00
66.00	06600	PHYSICAL THERAPY	184,437	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	13,608	0		67.00
68.00	06800	SPEECH PATHOLOGY	6,136	0		68.00
69.00	06900	ELECTROCARDIOLOGY	229,993	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	484,826	28,978		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	110,024	48,373		90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	155,376	0		90.01
90.02	09002	JAY FAMILY MEDICINE	304,950	0		90.02
91.00	09100	EMERGENCY	482,507	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	41,824	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
200.00		Subtotal (see instructions)	4,128,897	77,351		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	4,128,897	77,351		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 151320 | Component CCN: 15M320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part II | Date/Time Prepared: 2/17/2016 10:07 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	239,901	12,825,886	0.018704	29	1	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,180	135,946	0.023392	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	164,069	24,990,154	0.006565	92,801	609	54.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	88,162	16,859,240	0.005229	187,041	978	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	8,964	778,391	0.011516	50,278	579	65.00
66.00	06600	PHYSICAL THERAPY	5,735	2,147,569	0.002670	35,305	94	66.00
67.00	06700	OCCUPATIONAL THERAPY	928	380,176	0.002441	14,447	35	67.00
68.00	06800	SPEECH PATHOLOGY	211	57,123	0.003694	5,694	21	68.00
69.00	06900	ELECTROCARDIOLOGY	26,763	1,565,690	0.017093	16,511	282	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	37,958	3,777,557	0.010048	264,169	2,654	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	96,870	290,392	0.333584	23,421	7,813	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	78,475	863,990	0.090829	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	14,178	426,075	0.033276	0	0	90.02
91.00	09100	EMERGENCY	133,617	6,347,304	0.021051	7,580	160	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	88,129	0.000000	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0	93.00
200.00		Total (lines 50-199)	899,011	71,533,622		697,276	13,226	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151320 | Component CCN: 15M320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV | Date/Time Prepared: 2/17/2016 10:07 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		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
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	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
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	0	0	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151320 | Component CCN: 15M320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV | Date/Time Prepared: 2/17/2016 10:07 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	12,825,886	0.000000	0.000000	29	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	135,946	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	24,990,154	0.000000	0.000000	92,801	54.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	16,859,240	0.000000	0.000000	187,041	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	778,391	0.000000	0.000000	50,278	65.00
66.00	06600	PHYSICAL THERAPY	0	2,147,569	0.000000	0.000000	35,305	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	380,176	0.000000	0.000000	14,447	67.00
68.00	06800	SPEECH PATHOLOGY	0	57,123	0.000000	0.000000	5,694	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,565,690	0.000000	0.000000	16,511	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,777,557	0.000000	0.000000	264,169	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000	CLINIC	0	290,392	0.000000	0.000000	23,421	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	863,990	0.000000	0.000000	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0	426,075	0.000000	0.000000	0	90.02
91.00	09100	EMERGENCY	0	6,347,304	0.000000	0.000000	7,580	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	88,129	0.000000	0.000000	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0	93.00
200.00		Total (lines 50-199)	0	71,533,622			697,276	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151320 | Component CCN: 15M320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV | Date/Time Prepared: 2/17/2016 10:07 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	0	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	0	0		90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	0		90.02
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		93.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151320 | Component CCN: 15Z320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part V Date/Time Prepared: 2/17/2016 10:07 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.266609	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.346594	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.111145	0	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.170161	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.600070	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.379843	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.365796	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.590200	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.379441	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	0.547097	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	2.869618	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1.705519	0	0	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	2.628558	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.466754	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.467780	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	93.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151320 | Component CCN: 15Z320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part V | Date/Time Prepared: 2/17/2016 10:07 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	0		90.01
90.02	09002	JAY FAMILY MEDICINE	0	0		90.02
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/17/2016 10:07 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)	2,641	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,127	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)	2,042	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	121	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)	363	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	8	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)	22	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	839	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)	276	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	126.36	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	126.36	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,977,243	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)	1,011	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)	2,780	25.00
26.00	Total swing-bed cost (see instructions)	740,347	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,236,896	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)	3,236,896	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,521.81	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,276,799	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)	1,276,799	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/17/2016 10:07 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	0	0	0.00	0	0	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)	688,289	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,965,088	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	420,020	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	420,020	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)	85	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,521.81	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	129,354	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/17/2016 10:07 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	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	351,326	3,236,896	0.108538	129,354	14,040	90.00
91.00	Nursing School cost	0	3,236,896	0.000000	129,354	0	91.00
92.00	Allied health cost	0	3,236,896	0.000000	129,354	0	92.00
93.00	All other Medical Education	0	3,236,896	0.000000	129,354	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151320 Component CCN: 15M320	Period: From 10/01/2014 To 09/30/2015	Worksheet D-1 Date/Time Prepared: 2/17/2016 10:07 am
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,943	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,943	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,943	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,415	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,396,060	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,396,060	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,396,060	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,233.18	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,744,950	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)	1,744,950	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151320 | Component CCN: 15M320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/17/2016 10:07 am

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	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)	315,913	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,060,863	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)	13,226	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	13,226	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,047,637	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151320 | Component CCN: 15M320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/17/2016 10:07 am

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	0	2,396,060	0.000000	0	0	90.00
91.00	Nursing School cost	0	2,396,060	0.000000	0	0	91.00
92.00	Allied health cost	0	2,396,060	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,396,060	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/17/2016 10:07 am

Title XIX | 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)	2,641	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,127	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)	2,042	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	121	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)	363	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	8	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)	22	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	38	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)	153	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,977,243	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	737,258	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,239,985	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)	3,239,985	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,523.26	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	57,884	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)	57,884	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/17/2016 10:07 am

Title XIX | 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)	476,171	153	3,112.23	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	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)	19,325	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	77,209	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	85	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,523.27	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	129,478	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/17/2016 10:07 am

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	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	351,326	3,239,985	0.108434	129,478	14,040	90.00
91.00	Nursing School cost	0	3,239,985	0.000000	129,478	0	91.00
92.00	Allied health cost	0	3,239,985	0.000000	129,478	0	92.00
93.00	All other Medical Education	0	3,239,985	0.000000	129,478	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151320 Component CCN: 15M320	Period: From 10/01/2014 To 09/30/2015	Worksheet D-1 Date/Time Prepared: 2/17/2016 10:07 am
	Title XIX	Subprovider - IPF	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,943	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,943	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,943	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	40	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)	153	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,396,060	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,396,060	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,396,060	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,233.18	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	49,327	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)	49,327	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151320 | Component CCN: 15M320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/17/2016 10:07 am

Title XIX | Subprovider - IPF | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	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)	8,904	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	58,231	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151320 | Component CCN: 15M320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/17/2016 10:07 am

Title XIX | Subprovider - IPF | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	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	144,507	2,396,060	0.060310	0	0	90.00
91.00	Nursing School cost	0	2,396,060	0.000000	0	0	91.00
92.00	Allied health cost	0	2,396,060	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,396,060	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-3 | Date/Time Prepared: 2/17/2016 10:07 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,412,394		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.266609	512,614	136,668	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.346594	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.111145	440,399	48,948	54.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.170161	624,302	106,232	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.600070	187,080	112,261	65.00
66.00	06600	PHYSICAL THERAPY	0.379843	87,012	33,051	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.365796	30,447	11,137	67.00
68.00	06800	SPEECH PATHOLOGY	0.590200	2,546	1,503	68.00
69.00	06900	ELECTROCARDIOLOGY	0.379441	109,301	41,473	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.547097	316,753	173,295	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	2.869618	5,054	14,503	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1.705519	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	2.628558	0	0	90.02
91.00	09100	EMERGENCY	0.466754	19,750	9,218	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.467780	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
200.00		Total (sum of lines 50-94 and 96-98)		2,335,258	688,289	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)		2,335,258		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151320 | Component CCN: 15M320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-3 | Date/Time Prepared: 2/17/2016 10:07 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		1,089,100		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.266609	29	8	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.346594	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.111145	92,801	10,314	54.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.170161	187,041	31,827	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.600070	50,278	30,170	65.00
66.00	06600	PHYSICAL THERAPY	0.379843	35,305	13,410	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.365796	14,447	5,285	67.00
68.00	06800	SPEECH PATHOLOGY	0.590200	5,694	3,361	68.00
69.00	06900	ELECTROCARDIOLOGY	0.379441	16,511	6,265	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.547097	264,169	144,526	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	2.869618	23,421	67,209	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1.705519	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	2.628558	0	0	90.02
91.00	09100	EMERGENCY	0.466754	7,580	3,538	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.467780	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
200.00		Total (sum of lines 50-94 and 96-98)		697,276	315,913	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)		697,276		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-3

Component CCN: 15Z320 | Date/Time Prepared: 2/17/2016 10:07 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.266609	20	5	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.346594	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.111145	21,805	2,424	54.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.170161	27,201	4,629	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.600070	23,982	14,391	65.00
66.00	06600	PHYSICAL THERAPY	0.379843	94,888	36,043	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.365796	58,929	21,556	67.00
68.00	06800	SPEECH PATHOLOGY	0.590200	1,232	727	68.00
69.00	06900	ELECTROCARDIOLOGY	0.379441	6,467	2,454	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.547097	50,637	27,703	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	2.869618	963	2,763	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1.705519	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	2.628558	0	0	90.02
91.00	09100	EMERGENCY	0.466754	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.467780	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
200.00		Total (sum of lines 50-94 and 96-98)		286,124	112,695	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)		286,124		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-3 | Date/Time Prepared: 2/17/2016 10:07 am

Title XIX | 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		37,250		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.266609	33,156	8,840	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.346594	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.111145	9,182	1,021	54.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.170161	12,426	2,114	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.600070	1,985	1,191	65.00
66.00	06600	PHYSICAL THERAPY	0.379843	159	60	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.365796	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.590200	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.379441	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.547097	9,163	5,013	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
90.00	09000	CLINIC	2.869618	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1.705519	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	2.628558	0	0	90.02
91.00	09100	EMERGENCY	0.466754	2,327	1,086	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.467780	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
200.00		Total (sum of lines 50-94 and 96-98)		68,398	19,325	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)		68,398		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151320 | Component CCN: 15M320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-3 | Date/Time Prepared: 2/17/2016 10:07 am

Title XIX | Subprovider - IPF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		35,007		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.266609	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.346594	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.111145	4,499	500	54.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.170161	12,121	2,063	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.600070	138	83	65.00
66.00	06600	PHYSICAL THERAPY	0.379843	734	279	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.365796	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.590200	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.379441	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.547097	10,929	5,979	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
90.00	09000	CLINIC	2.869618	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1.705519	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	2.628558	0	0	90.02
91.00	09100	EMERGENCY	0.466754	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.467780	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
200.00		Total (sum of lines 50-94 and 96-98)		28,421	8,904	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)		28,421		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151320 | Component CCN: 15Z320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-3 | Date/Time Prepared: 2/17/2016 10:07 am

Title XIX | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.266609	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.346594	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.111145	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.170161	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.600070	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.379843	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.365796	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.590200	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.379441	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.547097	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
90.00	09000	CLINIC	2.869618	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1.705519	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	2.628558	0	0	90.02
91.00	09100	EMERGENCY	0.466754	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.467780	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
200.00		Total (sum of lines 50-94 and 96-98)		0	0	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)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151320	Period: From 10/01/2014 To 09/30/2015	Worksheet E Part B Date/Time Prepared: 2/17/2016 10:07 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,206,248	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
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 line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	4,206,248	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 (line 11 minus line 20) (for CAH see instructions)	4,248,310	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, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	59,930	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,411,143	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)	1,777,237	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	1,777,237	30.00
31.00	Primary payer payments	1,098	31.00
32.00	Subtotal (line 30 minus line 31)	1,776,139	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)	400,218	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	260,142	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	337,637	36.00
37.00	Subtotal (see instructions)	2,036,281	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)	0	39.50
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)	2,036,281	40.00
40.01	Sequestration adjustment (see instructions)	40,726	40.01
41.00	Interim payments	2,066,686	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-71,131	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E-1 Part I | Date/Time Prepared: 2/17/2016 10:07 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		1,730,047		1,853,486	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0	04/13/2015	213,200	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		213,200	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)		1,730,047		2,066,686	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		13,201		71,131	6.02
7.00	Total Medicare program liability (see instructions)		1,716,846		1,995,555	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: 151320 | Component CCN: 15M320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E-1 Part I | Date/Time Prepared: 2/17/2016 10:07 am

Title XVIII | Subprovider - IPF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,307,270		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,307,270		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		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,307,270		0	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: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E-1 Part I | Date/Time Prepared: 2/17/2016 10:07 am

Component CCN: 15Z320 | 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		524,077		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		524,077		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		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		931		0	6.02
7.00	Total Medicare program liability (see instructions)		523,146		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: 151320	Period: From 10/01/2014 To 09/30/2015	Worksheet E-1 Part II Date/Time Prepared: 2/17/2016 10:07 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	667	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	839	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	96	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	2,042	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	77,586,179	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	693,436	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 151320 Component CCN: 15Z320	Period: From 10/01/2014 To 09/30/2015	Worksheet E-2 Date/Time Prepared: 2/17/2016 10:07 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)	424,220	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	113,822	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	276	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)	538,042	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	538,042	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)	538,042	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	4,220	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	533,822	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
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)	533,822	0	19.00
19.01	Sequestration adjustment (see instructions)	10,676	0	19.01
20.00	Interim payments	524,077	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	-931	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 151320 | Component CCN: 15Z320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E-2 | Date/Time Prepared: 2/17/2016 10:07 am

Title XIX | 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)	0		1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)	0		2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	0		3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)	0.00		4.00
5.00	Program days	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)	0		8.00
9.00	Primary payer payments (see instructions)	0		9.00
10.00	Subtotal (line 8 minus line 9)	0		10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0		11.00
12.00	Subtotal (line 10 minus line 11)	0		12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0		13.00
14.00	80% of Part B costs (line 12 x 80%)	0		14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	0		15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0		16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0		17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0		17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0		18.00
19.00	Total (see instructions)	0		19.00
19.01	Sequestration adjustment (see instructions)	0		19.01
20.00	Interim payments	0		20.00
21.00	Tentative settlement (for contractor use only)	0		21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	0		22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0		23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151320	Period: From 10/01/2014 To 09/30/2015	Worksheet E-3 Part V Date/Time Prepared: 2/17/2016 10:07 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,965,088	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,965,088	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,978,058	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)	1,978,058	19.00
20.00	Deductibles (exclude professional component)	255,836	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,722,222	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,722,222	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	45,634	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	29,662	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	37,879	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,751,884	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (see instructions)	1,751,884	30.00
30.01	Sequestration adjustment (see instructions)	35,038	30.01
31.00	Interim payments	1,730,047	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 31, and 32)	-13,201	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151320 Component CCN: 15M320	Period: From 10/01/2014 To 09/30/2015	Worksheet E-3 Part II Date/Time Prepared: 2/17/2016 10:07 am
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	1,351,277	1.00
2.00	Net IPF PPS Outlier Payments	68,732	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	5.323288	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	1,420,009	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	1,420,009	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	1,420,009	18.00
19.00	Deductibles	83,540	19.00
20.00	Subtotal (line 18 minus line 19)	1,336,469	20.00
21.00	Coinsurance	2,520	21.00
22.00	Subtotal (line 20 minus line 21)	1,333,949	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	0	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	25.00
26.00	Subtotal (sum of lines 22 and 24)	1,333,949	26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	27.00
28.00	Other pass through costs (see instructions)	0	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.99	Recovery of Accelerated Depreciation	0	30.99
31.00	Total amount payable to the provider (see instructions)	1,333,949	31.00
31.01	Sequestration adjustment (see instructions)	26,679	31.01
32.00	Interim payments	1,307,270	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	68,732	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151320	Period: From 10/01/2014 To 09/30/2015	Worksheet E-3 Part VII Date/Time Prepared: 2/17/2016 10:07 am
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	77,209		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	77,209	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	77,209	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	37,250		8.00
9.00	Ancillary service charges	68,398	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	105,648	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	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	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	105,648	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	28,439	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	77,209	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	77,209	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	77,209	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	77,209	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	77,209	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	77,209	0	40.00
41.00	Interim payments	48,092	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	29,117	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151320 Component CCN: 15M320	Period: From 10/01/2014 To 09/30/2015	Worksheet E-3 Part VII Date/Time Prepared: 2/17/2016 10:07 am
	Title XIX	Subprovider - IPF	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	58,231		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	58,231	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	58,231	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	35,007		8.00
9.00	Ancillary service charges	28,421	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	63,428	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	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	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	63,428	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	5,197	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	58,231	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	58,231	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	58,231	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	58,231	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	58,231	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	58,231	0	40.00
41.00	Interim payments	34,675	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	23,556	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet G | Date/Time Prepared: 2/17/2016 10:07 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	2,296,619	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	16,141,374	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	749,555	0	0	0	7.00
8.00	Prepaid expenses	0	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)	19,187,548	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	347,733	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	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	12,579,294	0	0	0	23.00
24.00	Accumulated depreciation	0	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)	12,927,027	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	16,663,835	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	16,663,835	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	48,778,410	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	518,017	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,499,370	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	-14,678	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,002,709	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	2,198,076	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	2,198,076	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	4,200,785	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	44,577,625				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)	44,577,625	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	48,778,410	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet G-1 | Date/Time Prepared: 2/17/2016 10:07 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		42,581,623		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,996,002				2.00
3.00	Total (sum of line 1 and line 2)		44,577,625		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		44,577,625		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)		44,577,625		0		19.00

		Endowment Fund	Plant Fund			
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			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: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/17/2016 10:07 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	4,740,772		4,740,772	1.00
2.00	SUBPROVIDER - IPF	1,535,860		1,535,860	2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	0		0	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)	6,276,632		6,276,632	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	0		0	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)	6,276,632		6,276,632	17.00
18.00	Ancillary services	8,762,504	58,082,532	66,845,036	18.00
19.00	Outpatient services	495,741	18,443,092	18,938,833	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
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)	15,534,877	76,525,624	92,060,501	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		37,084,180		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)		37,084,180		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 151320 | Period: From 10/01/2014 To 09/30/2015 | Worksheet G-3 | Date/Time Prepared: 2/17/2016 10:07 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	92,060,501	1.00
2.00	Less contractual allowances and discounts on patients' accounts	53,099,389	2.00
3.00	Net patient revenues (line 1 minus line 2)	38,961,112	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	37,084,180	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,876,932	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	NONOP REV TRANSFER FOUND	119,070	24.00
25.00	Total other income (sum of lines 6-24)	119,070	25.00
26.00	Total (line 5 plus line 25)	1,996,002	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,996,002	29.00