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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-1320	Period: From 10/01/2015 To 09/30/2016	Worksheet S Parts I-III Date/Time Prepared: 2/27/2017 10:39 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/27/2017 Time: 10:39 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 (15-1320) for the cost reporting period beginning 10/01/2015 and ending 09/30/2016 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	-60,885	-345,780	0	0	1.00
2.00	Subprovider - IPF	0	6	0		-2,832	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVIDER I						4.00
5.00	Swing bed - SNF	0	-54,232	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	-115,111	-345,780	0	-2,832	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: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 2/27/2017 10:37 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)	10/01/2015	09/30/2016	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 §412.106(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: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 2/27/2017 10:37 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
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 2/27/2017 10:37 am

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
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

		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: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 2/27/2017 10:37 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:	285,425	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
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 2/27/2017 10:37 am

		1.00	2.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1320	Period: From 10/01/2015 To 09/30/2016	Worksheet S-2 Part I Date/Time Prepared: 2/27/2017 10:37 am

		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)	10/01/2015	09/30/2016	170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part II | Date/Time Prepared: 2/27/2017 10:37 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		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	01/18/2017	Y	01/18/2017	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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part II Date/Time Prepared: 2/27/2017 10:37 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				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: 15-1320	Period: From 10/01/2015 To 09/30/2016	Worksheet S-2 Part II Date/Time Prepared: 2/27/2017 10:37 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part I Date/Time Prepared: 2/27/2017 10:37 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	9,150	60,288.00	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	9,150	60,288.00	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	9,150	60,288.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	10	3,660		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: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 2/27/2017 10:37 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)	1,264	0	2,512			1.00
2.00	HMO and other (see instructions)	76	86				2.00
3.00	HMO IPF Subprovider	46	35				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	560	0	683			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	15			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,824	0	3,210			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	126			13.00
14.00	Total (see instructions)	1,824	0	3,336	0.00	292.36	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	848	24	1,495	0.00	14.92	16.00
17.00	SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00	SUBPROVIDER		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	307.28	27.00
28.00	Observation Bed Days		0	145			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: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part I Date/Time Prepared: 2/27/2017 10:37 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	362	43	779	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	362	43	779	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	78	4	174	16.00
17.00	SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00	SUBPROVIDER	0.00	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)						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: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-10 | Date/Time Prepared: 2/27/2017 10:37 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)	0.318752	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	755,629	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	6,514,438	6.00
7.00	Medicaid cost (line 1 times line 6)	2,076,490	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)	1,320,861	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	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 , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,320,861	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Charity care charges for the entire facility (see instructions)	424,392	0	424,392	20.00
21.00	Cost of patients approved for charity care (line 1 times line 20)	135,276	0	135,276	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)	135,276	0	135,276	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)	351,662	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	-351,662	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	-112,093	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	23,183	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,344,044	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A | Date/Time Prepared: 2/27/2017 10:37 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		1,562,111	1,562,111	0	1,562,111	2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP MOB		8,676	8,676	0	8,676	2.01
2.02	00202	NEW CAP REL COSTS-MVBLE EQUIP-POB		106,456	106,456	0	106,456	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	6,953,613	6,953,613	0	6,953,613	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,344,722	4,562,614	6,907,336	0	6,907,336	5.00
7.00	00700	OPERATION OF PLANT	311,093	907,509	1,218,602	-16,619	1,201,983	7.00
7.01	00701	OPERATION OF PLANT-MOB	0	34,570	34,570	5,513	40,083	7.01
7.02	00702	OPERATION OF PLANT-POB	0	146,133	146,133	8,561	154,694	7.02
7.03	00703	OPERATION OF PLANT-WJ	0	0	0	2,545	2,545	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	27,038	41,414	68,452	0	68,452	8.00
9.00	00900	HOUSEKEEPING	421,774	80,355	502,129	0	502,129	9.00
10.00	01000	DIETARY	361,053	319,403	680,456	-309,722	370,734	10.00
11.00	01100	CAFETERIA	0	0	0	309,722	309,722	11.00
13.00	01300	NURSING ADMINISTRATION	1,034,141	11,018	1,045,159	0	1,045,159	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	61,737	120,088	181,825	0	181,825	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	368,481	56,963	425,444	0	425,444	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,456,517	212,344	1,668,861	-122,835	1,546,026	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	698,062	251,269	949,331	0	949,331	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	105,107	105,107	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	864,045	743,967	1,608,012	0	1,608,012	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	17,728	17,728	52.00
53.00	05300	ANESTHESIOLOGY	0	833,474	833,474	0	833,474	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	805,442	546,850	1,352,292	0	1,352,292	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	667,091	1,252,913	1,920,004	0	1,920,004	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	356,309	356,309	0	356,309	65.00
66.00	06600	PHYSICAL THERAPY	0	807,762	807,762	-136,362	671,400	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	110,695	110,695	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	25,667	25,667	68.00
69.00	06900	ELECTROCARDIOLOGY	217,726	377,194	594,920	0	594,920	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	411,655	1,167,714	1,579,369	0	1,579,369	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	339,080	221,511	560,591	0	560,591	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1,644,595	260,362	1,904,957	0	1,904,957	90.01
90.02	09002	JAY FAMILY MEDICINE	1,689,420	296,960	1,986,380	0	1,986,380	90.02
91.00	09100	EMERGENCY	2,337,768	315,005	2,652,773	0	2,652,773	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	11,050	11,050	0	11,050	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)	16,061,440	22,596,749	38,658,189	0	38,658,189	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	0	0	0	0	194.00
194.01	07951	POB	0	0	0	0	0	194.01
194.02	07952	WEST JAY CLINIC	483,051	39,218	522,269	0	522,269	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	171,962	1,182,766	1,354,728	0	1,354,728	194.06

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A | Date/Time Prepared: 2/27/2017 10:37 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	478,379	12,151	490,530	0	490,530	194.07
194.08	07958	FAMILY FIRST HEALTH	150,215	42,235	192,450	0	192,450	194.08
200.00		TOTAL (SUM OF LINES 118-199)	17,345,047	23,873,119	41,218,166	0	41,218,166	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A | Date/Time Prepared: 2/27/2017 10:37 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	-325,842	1,236,269		2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP MOB	0	8,676		2.01
2.02	00202	NEW CAP REL COSTS-MVBLE EQUIP-POB	0	106,456		2.02
2.03	00203	NEW CAP REL COSTS-MVBLE EQUIP- WJ	0	31,142		2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-311,332	6,642,281		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,102,128	5,805,208		5.00
7.00	00700	OPERATION OF PLANT	0	1,201,983		7.00
7.01	00701	OPERATION OF PLANT-MOB	0	40,083		7.01
7.02	00702	OPERATION OF PLANT-POB	0	154,694		7.02
7.03	00703	OPERATION OF PLANT-WJ	0	2,545		7.03
8.00	00800	LAUNDRY & LINEN SERVICE	0	68,452		8.00
9.00	00900	HOUSEKEEPING	-36,360	465,769		9.00
10.00	01000	DIETARY	0	370,734		10.00
11.00	01100	CAFETERIA	-190,751	118,971		11.00
13.00	01300	NURSING ADMINISTRATION	-9,984	1,035,175		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	181,825		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-20,001	405,443		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,546,026		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
40.00	04000	SUBPROVIDER - IPF	0	949,331		40.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
42.00	04200	SUBPROVIDER	0	0		42.00
43.00	04300	NURSERY	0	105,107		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,608,012		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	17,728		52.00
53.00	05300	ANESTHESIOLOGY	-833,474	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,352,292		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	1,865,004		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	356,309		65.00
66.00	06600	PHYSICAL THERAPY	-35,288	636,112		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	110,695		67.00
68.00	06800	SPEECH PATHOLOGY	0	25,667		68.00
69.00	06900	ELECTROCARDIOLOGY	-31,538	563,382		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	-87,933	1,491,436		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	-350,774	209,817		90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	-1,528,870	376,087		90.01
90.02	09002	JAY FAMILY MEDICINE	-1,488,302	498,078		90.02
91.00	09100	EMERGENCY	-1,887,109	765,664		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	11,050		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)	-8,294,686	30,363,503		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	0		194.00
194.01	07951	POB	0	0		194.01
194.02	07952	WEST JAY CLINIC	-483,942	38,327		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	1,354,728		194.06
194.07	07957	HOSPITALIST	0	490,530		194.07
194.08	07958	FAMILY FIRST HEALTH	0	192,450		194.08

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A | Date/Time Prepared: 2/27/2017 10:37 am

	Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
200.00	TOTAL (SUM OF LINES 118-199)	-8,778,628	32,439,538		200.00

RECLASSIFICATIONS | Provider CCN: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-6 | Date/Time Prepared: 2/27/2017 10:37 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - NURSERY RECLASS				
1.00	NURSERY	43.00	90,721	14,386	1.00
	0		90,721	14,386	
	B - LABOR & DELIVERY RECLASS				
1.00	DELIVERY ROOM & LABOR ROOM	52.00	15,377	2,351	1.00
	0		15,377	2,351	
	C - CAFETERIA RECLASS				
1.00	CAFETERIA	11.00	164,340	145,382	1.00
	0		164,340	145,382	
	D - MOB, POB, WEST JAY MAINT RECLASS				
1.00	OPERATION OF PLANT-MOB	7.01	5,513	0	1.00
2.00	OPERATION OF PLANT-POB	7.02	8,561	0	2.00
3.00	OPERATION OF PLANT-WJ	7.03	2,545	0	3.00
	0		16,619	0	
	F - OCCUPATIONAL AND SPEECH THERAPY RECL				
1.00	OCCUPATIONAL THERAPY	67.00	0	110,695	1.00
2.00	SPEECH PATHOLOGY	68.00	0	25,667	2.00
	0		0	136,362	
500.00	Grand Total: Increases		287,057	298,481	500.00

RECLASSIFICATIONS | Provider CCN: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-6 | Date/Time Prepared: 2/27/2017 10:37 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	90,721	14,386	0		1.00
	0		90,721	14,386			
	B - LABOR & DELIVERY RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	15,377	2,351	0		1.00
	0		15,377	2,351			
	C - CAFETERIA RECLASS						
1.00	DIETARY	10.00	164,340	145,382	0		1.00
	0		164,340	145,382			
	D - MOB, POB, WEST JAY MAINT RECLASS						
1.00	OPERATION OF PLANT	7.00	16,619	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	0		16,619	0			
	F - OCCUPATIONAL AND SPEECH THERAPY RECL						
1.00	PHYSICAL THERAPY	66.00	0	136,362	0		1.00
2.00		0.00	0	0	0		2.00
	0		0	136,362			
500.00	Grand Total: Decreases		287,057	298,481			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-7 Part I | Date/Time Prepared: 2/27/2017 10:37 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	347,733	0	0	0	0	1.00
2.00	Land Improvements	952,332	0	0	0	0	2.00
3.00	Buildings and Fixtures	25,114,962	0	0	0	1,788,705	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	2,426,508	1,233,359	0	1,233,359	0	5.00
6.00	Movable Equipment	13,931,159	0	0	0	709,427	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	42,772,694	1,233,359	0	1,233,359	2,498,132	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	42,772,694	1,233,359	0	1,233,359	2,498,132	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	13,221,732	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	41,507,921	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	41,507,921	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-7 Part II | Date/Time Prepared: 2/27/2017 10:37 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	1,562,111	0	0	0	0	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP MOB	8,676	0	0	0	0	2.01
2.02	NEW CAP REL COSTS-MVBLE EQUIP-POB	106,456	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)	1,708,385	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	1,562,111		2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP MOB	0	8,676		2.01
2.02	NEW CAP REL COSTS-MVBLE EQUIP-POB	0	106,456		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	1,708,385		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-7 Part III Date/Time Prepared: 2/27/2017 10:37 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	23,326,257	0	23,326,257	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)	23,326,257	0	23,326,257	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	1,236,269	0	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP MOB	0	0	0	8,676	0	2.01
2.02	NEW CAP REL COSTS-MVBLE EQUIP-POB	0	0	0	106,456	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	1,382,543	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	1,236,269	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP MOB	0	0	0	0	8,676	2.01
2.02	NEW CAP REL COSTS-MVBLE EQUIP-POB	0	0	0	0	106,456	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	1,382,543	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8 | Date/Time Prepared: 2/27/2017 10:37 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	-5,310,055			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	-35,288			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-191,980	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	-18,809	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: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8 | Date/Time Prepared: 2/27/2017 10:37 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			0		0.00	0	33.00
33.01	SUPPLY REBATES AND DISCOUNTS	B	-51,121	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	OTHER REVENUE	B	-13,448	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	OTHER REVENUE-DIABETIC COUNSELING	B	-9,984	NURSING ADMINISTRATION	13.00	0	33.03
33.04	CRNA OFFSET	A	-833,474	ANESTHESIOLOGY	53.00	0	33.04
33.05	PHYSICIAN RECRUITMENT	A	-31,885	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	ADVERTISING EXPENSE	A	-145,082	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	SENIOR PROGRAM	A	-14,557	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	SWITCHBOARD SALARY	A	-8,348	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	SWITCHBOARD EH&W	A	-2,721	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	-166,748	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	VENDING MACHINE REVENUE	B	1,256	CAFETERIA	11.00	0	33.13
33.14	PHARMACY EMPLOYEE SALES	B	-87,933	DRUGS CHARGED TO PATIENTS	73.00	0	33.14
33.16	HOUSEKEEPING WAGES	A	-36,360	HOUSEKEEPING	9.00	0	33.16
33.17	IHA DUES	A	-702	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	LAND RENT	B	-3,881	ADMINISTRATIVE & GENERAL	5.00	0	33.18
33.19	CLINIC RENTAL	B	-31,538	ELECTROCARDIOLOGY	69.00	0	33.19
33.20	CONFERENCE ROOM RENTAL	B	-280	ADMINISTRATIVE & GENERAL	5.00	0	33.20
33.21	VENDOR/CONTRACT REV	B	-14,970	ADMINISTRATIVE & GENERAL	5.00	0	33.21
33.22	EHR DEPRECIATION	A	-321,846	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	33.22
33.23	HOSPITAL ASSESSMENT FEE	A	-635,508	ADMINISTRATIVE & GENERAL	5.00	0	33.23
33.24	OTHER REVENUE	B	-27	CAFETERIA	11.00	0	33.24
33.25	OTHER REVENUE	B	-1,192	MEDICAL RECORDS & LIBRARY	16.00	0	33.25
33.26	MERIDIAN HEALTH WAGE REIMBURSEMENT	B	-483,942	WEST JAY CLINIC	194.02	0	33.26
33.27	PENSION EXPENSE	A	-308,611	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.27
33.28	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.28
33.29	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.29
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-8,778,628				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8-1 | Date/Time Prepared: 2/27/2017 10:37 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	24,712	60,000	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.			24,712	60,000	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: 15-1320	Period: From 10/01/2015 To 09/30/2016	Worksheet A-8-1 Date/Time Prepared: 2/27/2017 10:37 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	-35,288	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	-35,288			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: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8-2 | Date/Time Prepared: 2/27/2017 10:37 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	91.00	EMERGENCY	2,144,442	1,887,109	257,333	0	0	1.00
2.00	60.00	LABORATORY	55,000	55,000	0	0	0	2.00
3.00	90.00	CLINIC	350,774	350,774	0	0	0	3.00
4.00	90.01	FAMILY PRACTICE OF JAY COUNTY	1,528,870	1,528,870	0	0	0	4.00
5.00	90.02	JAY FAMILY MEDICINE	1,488,302	1,488,302	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			5,567,388	5,310,055	257,333		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	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	60.00	LABORATORY	0	0	0	0	0	2.00
3.00	90.00	CLINIC	0	0	0	0	0	3.00
4.00	90.01	FAMILY PRACTICE OF JAY COUNTY	0	0	0	0	0	4.00
5.00	90.02	JAY FAMILY MEDICINE	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	91.00	EMERGENCY	0	0	0	1,887,109		1.00
2.00	60.00	LABORATORY	0	0	0	55,000		2.00
3.00	90.00	CLINIC	0	0	0	350,774		3.00
4.00	90.01	FAMILY PRACTICE OF JAY COUNTY	0	0	0	1,528,870		4.00
5.00	90.02	JAY FAMILY MEDICINE	0	0	0	1,488,302		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	5,310,055		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 15-1320	Period: From 10/01/2015 To 09/30/2016	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/27/2017 10:37 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	2,193.00	3,834.00	2,100.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	91.25	79.35	51.58	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)	39.68	39.68	25.79				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)						200,111	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)						304,228	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)						108,318	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)						612,657	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)						612,657	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)						612,657	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: 15-1320	Period: From 10/01/2015 To 09/30/2016	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/27/2017 10:37 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)	79.35	51.58	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)	612,657		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)	612,657		63.00
64.00	Total cost of outside supplier services (from your records)	485,780		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: 15-1320	Period: From 10/01/2015 To 09/30/2016	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/27/2017 10:37 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	1,901.00	5,790.00	0.00	1,852.00	0.00	9.00
10.00	AHSEA (see instructions)	71.73	62.38	0.00	46.78	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)	31.19	31.19	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)	136,359	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	361,180	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)	497,539	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	86,637	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)	584,176	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)	584,176	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

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		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)	8.00	0.00	32.00	0.00	40.00	47.00
48.00	Overtime rate (see instructions)	93.57	0.00	70.17	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	748.56	0.00	2,245.44	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)	20.00	0.00	80.00	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)	416.00	0.00	1,664.00	0.00	2,080.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	62.38	0.00	46.78	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	25,950	0	77,842	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	749	0	2,245	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	499	0	1,497	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.)	250	0	748	0	998	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	584,176		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)	998		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	1,747		62.00
63.00	Total allowance (sum of lines 57-62)	586,921		63.00
64.00	Total cost of outside supplier services (from your records)	345,050		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	1.00	1,885.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	82.74	75.22	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)	37.61	37.61	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)	83	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	141,790	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)	141,873	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)	141,873	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)	141,873	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

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		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)	75.22	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)		141,873	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)		141,873	63.00
64.00	Total cost of outside supplier services (from your records)		110,616	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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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	276.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	72.30	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)	36.15	36.15	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)					19,955	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)					19,955	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)					19,955	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)					72.30	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					56,394	22.00
23.00	Total salary equivalency (see instructions)					56,394	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: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 2/27/2017 10:37 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)	72.30	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)	56,394	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)	56,394	63.00
64.00	Total cost of outside supplier services (from your records)	25,667	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: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I | Date/Time Prepared: 2/27/2017 10:37 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	1,236,269	1,236,269				2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP MOB	8,676	0	8,676			2.01
2.02	00202	NEW CAP REL COSTS-MVBLE EQUIP-POB	106,456	0	0	106,456		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	6,642,281	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,805,208	125,557	1,524	8,850	0	5.00
7.00	00700	OPERATION OF PLANT	1,201,983	100,179	1,274	6,387	0	7.00
7.01	00701	OPERATION OF PLANT-MOB	40,083	0	0	0	0	7.01
7.02	00702	OPERATION OF PLANT-POB	154,694	0	0	0	0	7.02
7.03	00703	OPERATION OF PLANT-WJ	2,545	0	0	0	0	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	68,452	6,815	0	0	0	8.00
9.00	00900	HOUSEKEEPING	465,769	7,612	0	0	0	9.00
10.00	01000	DIETARY	370,734	31,902	0	0	0	10.00
11.00	01100	CAFETERIA	118,971	31,473	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,035,175	25,531	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	181,825	19,267	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	405,443	21,748	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,546,026	182,530	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	949,331	70,360	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	105,107	15,821	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,608,012	82,857	0	47,870	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	17,728	1,945	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,352,292	9,588	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	1,865,004	39,162	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	356,309	8,546	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	636,112	1,669	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	110,695	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	25,667	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	563,382	30,662	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	1,491,436	148,040	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	209,817	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	376,087	0	5,878	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	498,078	132,326	0	0	0	90.02
91.00	09100	EMERGENCY	765,664	69,563	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	11,050	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)	30,363,503	1,163,153	8,676	63,107	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,876	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	0	0	0	194.00
194.01	07951	POB	0	0	0	0	0	194.01
194.02	07952	WEST JAY CLINIC	38,327	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: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I Date/Time Prepared: 2/27/2017 10:37 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	1,354,728	0	0	43,349	0	194.06
194.07	07957	HOSPITALIST	490,530	0	0	0	0	194.07
194.08	07958	FAMILY FIRST HEALTH	192,450	59,240	0	0	0	194.08
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)	32,439,538	1,236,269	8,676	106,456	31,142	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I | Date/Time Prepared: 2/27/2017 10:37 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	6,642,281					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	897,908	6,839,047	6,839,047			5.00
7.00	00700	OPERATION OF PLANT	112,769	1,422,592	380,038	1,802,630		7.00
7.01	00701	OPERATION OF PLANT-MOB	2,111	42,194	11,272	0	53,466	7.01
7.02	00702	OPERATION OF PLANT-POB	3,278	157,972	42,201	0	0	7.02
7.03	00703	OPERATION OF PLANT-WJ	975	3,520	940	0	0	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	10,354	85,621	22,873	12,158	0	8.00
9.00	00900	HOUSEKEEPING	161,518	634,899	169,610	13,578	0	9.00
10.00	01000	DIETARY	75,331	477,967	127,686	56,908	0	10.00
11.00	01100	CAFETERIA	62,934	213,378	57,003	56,144	0	11.00
13.00	01300	NURSING ADMINISTRATION	396,024	1,456,730	389,158	45,543	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	23,642	224,734	60,037	34,369	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	141,110	568,301	151,819	38,795	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	517,143	2,245,699	599,932	325,605	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	267,323	1,287,014	343,819	125,510	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	34,742	155,670	41,586	28,222	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	330,886	2,069,625	552,890	147,804	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,889	25,562	6,829	3,470	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	308,444	1,670,324	446,219	17,103	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	255,462	2,159,628	576,934	69,858	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	364,855	97,469	15,245	0	65.00
66.00	06600	PHYSICAL THERAPY	0	637,781	170,380	2,978	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	110,695	29,572	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	25,667	6,857	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	83,378	677,422	180,970	54,696	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	157,643	1,797,119	480,091	264,079	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	129,851	339,668	90,741	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	629,798	1,011,763	270,287	0	53,466	90.01
90.02	09002	JAY FAMILY MEDICINE	646,963	1,277,367	341,242	236,049	0	90.02
91.00	09100	EMERGENCY	895,248	1,730,475	462,288	124,089	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	11,050	2,952	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)	6,150,724	29,724,339	6,113,695	1,672,203	53,466	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,876	3,707	24,752	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	0	0	194.00
194.01	07951	POB	0	0	0	0	0	194.01
194.02	07952	WEST JAY CLINIC	184,984	254,453	67,976	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	65,853	1,463,930	391,082	0	0	194.06
194.07	07957	HOSPITALIST	183,195	673,725	179,982	0	0	194.07

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I Date/Time Prepared: 2/27/2017 10:37 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	
194.08	07958	FAMILY FIRST HEALTH	57,525	309,215	82,605	105,675	0	194.08
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)	6,642,281	32,439,538	6,839,047	1,802,630	53,466	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I Date/Time Prepared: 2/27/2017 10:37 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	200,173					7.02
7.03	00703	OPERATION OF PLANT-WJ	0	4,460				7.03
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	120,652			8.00
9.00	00900	HOUSEKEEPING	0	0	10,566	828,653		9.00
10.00	01000	DIETARY	0	0	3,579	21,867	688,007	10.00
11.00	01100	CAFETERIA	0	0	0	20,999	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	14,888	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	20,641	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	14,459	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	33,343	136,775	469,395	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	9,202	47,373	218,612	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	57	10,556	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	105,047	0	31,015	121,957	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,298	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	9,373	63,916	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	24,524	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,861	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	2,045	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	852	10,218	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	11,342	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	42,917	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	0	0	58,909	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	20,620	47,516	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)	105,047	0	120,652	673,016	688,007	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	5,876	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	90,852	0	194.00
194.01	07951	POB	0	0	0	58,909	0	194.01
194.02	07952	WEST JAY CLINIC	0	4,460	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	95,126	0	0	0	0	194.06
194.07	07957	HOSPITALIST	0	0	0	0	0	194.07
194.08	07958	FAMILY FIRST HEALTH	0	0	0	0	0	194.08

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I Date/Time Prepared: 2/27/2017 10:37 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	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	200,173	4,460	120,652	828,653	688,007	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I | Date/Time Prepared: 2/27/2017 10:37 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	347,524					11.00
13.00	01300	NURSING ADMINISTRATION	25,599	1,931,918				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,903	0	343,684			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16,900	0	590	790,864		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	53,089	720,242	24,569	50,977	4,659,626	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	25,651	347,992	2,131	10,696	2,418,000	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	3,267	44,315	0	3,164	286,837	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	26,029	353,124	97,228	119,737	3,624,456	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	430	5,831	0	1,082	44,502	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,018	0	26,952	243,270	2,501,175	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	27,697	0	88,403	163,012	3,110,056	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	1,374	7,570	489,374	65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,177	19,773	834,134	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,596	143,863	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	909	33,433	68.00
69.00	06900	ELECTROCARDIOLOGY	9,473	0	6,797	23,437	963,865	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	10,625	0	4,206	37,740	2,605,202	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	14,132	0	6,259	1,919	495,636	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	35,364	0	31,845	12,088	1,473,722	90.01
90.02	09002	JAY FAMILY MEDICINE	37,410	0	22,471	8,109	1,922,648	90.02
91.00	09100	EMERGENCY	33,937	460,414	19,394	83,785	2,982,518	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	101	0	14,103	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)	347,524	1,931,918	333,497	790,864	28,603,150	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	48,211	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	90,852	194.00
194.01	07951	POB	0	0	0	0	58,909	194.01
194.02	07952	WEST JAY CLINIC	0	0	0	0	326,889	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	4,949	0	1,955,087	194.06
194.07	07957	HOSPITALIST	0	0	16	0	853,723	194.07

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I Date/Time Prepared: 2/27/2017 10:37 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	Subtotal	
			11.00	13.00	14.00	16.00	24.00	
194.08	07958	FAMILY FIRST HEALTH	0	0	5,222	0	502,717	194.08
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)	347,524	1,931,918	343,684	790,864	32,439,538	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I | Date/Time Prepared: 2/27/2017 10:37 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	4,659,626		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
40.00	04000	SUBPROVIDER - IPF	0	2,418,000		40.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
42.00	04200	SUBPROVIDER	0	0		42.00
43.00	04300	NURSERY	0	286,837		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	3,624,456		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	44,502		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,501,175		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	3,110,056		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	489,374		65.00
66.00	06600	PHYSICAL THERAPY	0	834,134		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	143,863		67.00
68.00	06800	SPEECH PATHOLOGY	0	33,433		68.00
69.00	06900	ELECTROCARDIOLOGY	0	963,865		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	2,605,202		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	495,636		90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	1,473,722		90.01
90.02	09002	JAY FAMILY MEDICINE	0	1,922,648		90.02
91.00	09100	EMERGENCY	0	2,982,518		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	14,103		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	28,603,150		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	48,211		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	90,852		194.00
194.01	07951	POB	0	58,909		194.01
194.02	07952	WEST JAY CLINIC	0	326,889		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: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I Date/Time Prepared: 2/27/2017 10:37 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
194.06	07956	TRI COUNTY	0	1,955,087		194.06
194.07	07957	HOSPITALIST	0	853,723		194.07
194.08	07958	FAMILY FIRST HEALTH	0	502,717		194.08
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	32,439,538		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II Date/Time Prepared: 2/27/2017 10:37 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	125,557	1,524	8,850	0	5.00
7.00	00700	OPERATION OF PLANT	0	100,179	1,274	6,387	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	6,815	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	7,612	0	0	0	9.00
10.00	01000	DIETARY	0	31,902	0	0	0	10.00
11.00	01100	CAFETERIA	0	31,473	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	25,531	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	19,267	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	21,748	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	182,530	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	70,360	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	15,821	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	82,857	0	47,870	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,945	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,588	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	39,162	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	8,546	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,669	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	30,662	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	148,040	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	5,878	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0	132,326	0	0	0	90.02
91.00	09100	EMERGENCY	0	69,563	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	1,163,153	8,676	63,107	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,876	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	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	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: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II Date/Time Prepared: 2/27/2017 10:37 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	43,349	0	194.06
194.07	07957	HOSPITALIST	0	0	0	0	0	194.07
194.08	07958	FAMILY FIRST HEALTH	0	59,240	0	0	0	194.08
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	1,236,269	8,676	106,456	31,142	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II | Date/Time Prepared: 2/27/2017 10:37 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	135,931	0	135,931			5.00
7.00	00700	OPERATION OF PLANT	107,840	0	7,554	115,394		7.00
7.01	00701	OPERATION OF PLANT-MOB	0	0	224	0	224	7.01
7.02	00702	OPERATION OF PLANT-POB	0	0	839	0	0	7.02
7.03	00703	OPERATION OF PLANT-WJ	0	0	19	0	0	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	6,815	0	455	778	0	8.00
9.00	00900	HOUSEKEEPING	7,612	0	3,371	869	0	9.00
10.00	01000	DIETARY	31,902	0	2,538	3,643	0	10.00
11.00	01100	CAFETERIA	31,473	0	1,133	3,594	0	11.00
13.00	01300	NURSING ADMINISTRATION	25,531	0	7,735	2,915	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	19,267	0	1,193	2,200	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	21,748	0	3,018	2,483	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	182,530	0	11,916	20,844	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	70,360	0	6,834	8,034	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	15,821	0	827	1,807	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	130,727	0	10,990	9,462	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,945	0	136	222	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,588	0	8,869	1,095	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	39,162	0	11,468	4,472	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	8,546	0	1,937	976	0	65.00
66.00	06600	PHYSICAL THERAPY	1,669	0	3,387	191	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	588	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	136	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	30,662	0	3,597	3,501	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	148,040	0	9,543	16,905	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	1,804	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	5,878	0	5,372	0	224	90.01
90.02	09002	JAY FAMILY MEDICINE	132,326	0	6,783	15,110	0	90.02
91.00	09100	EMERGENCY	69,563	0	9,189	7,943	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	59	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)	1,234,936	0	121,514	107,044	224	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	13,876	0	74	1,585	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	0	0	194.00
194.01	07951	POB	0	0	0	0	0	194.01
194.02	07952	WEST JAY CLINIC	31,142	0	1,351	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	43,349	0	7,773	0	0	194.06
194.07	07957	HOSPITALIST	0	0	3,577	0	0	194.07

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II Date/Time Prepared: 2/27/2017 10:37 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	
194.08	07958	FAMILY FIRST HEALTH	59,240	0	1,642	6,765	0	194.08
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)	1,382,543	0	135,931	115,394	224	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II Date/Time Prepared: 2/27/2017 10:37 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	839					7.02
7.03	00703	OPERATION OF PLANT-WJ	0	19				7.03
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	8,048			8.00
9.00	00900	HOUSEKEEPING	0	0	705	12,557		9.00
10.00	01000	DIETARY	0	0	239	331	38,653	10.00
11.00	01100	CAFETERIA	0	0	0	318	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	226	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	313	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	219	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	2,224	2,071	26,371	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	614	718	12,282	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	4	160	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	440	0	2,069	1,848	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	20	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	625	969	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	372	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	43	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	136	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	57	155	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	172	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	650	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	0	0	893	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	1,375	720	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)	440	0	8,048	10,198	38,653	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	89	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	1,377	0	194.00
194.01	07951	POB	0	0	0	893	0	194.01
194.02	07952	WEST JAY CLINIC	0	19	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	399	0	0	0	0	194.06
194.07	07957	HOSPITALIST	0	0	0	0	0	194.07
194.08	07958	FAMILY FIRST HEALTH	0	0	0	0	0	194.08

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II Date/Time Prepared: 2/27/2017 10:37 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	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	839	19	8,048	12,557	38,653	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II | Date/Time Prepared: 2/27/2017 10:37 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	36,518					11.00
13.00	01300	NURSING ADMINISTRATION	2,690	39,097				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	410	0	23,383			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,776	0	40	29,284		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,581	14,576	1,672	1,886	269,671	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	2,695	7,042	145	396	109,120	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	343	897	0	117	19,976	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,735	7,146	6,615	4,429	176,461	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	45	118	0	40	2,526	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,524	0	1,834	9,028	34,532	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	2,910	0	6,015	6,030	70,429	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	93	280	11,875	65.00
66.00	06600	PHYSICAL THERAPY	0	0	80	731	6,194	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	133	721	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	34	170	68.00
69.00	06900	ELECTROCARDIOLOGY	995	0	462	867	40,296	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	1,116	0	286	1,396	177,458	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	1,485	0	426	71	4,436	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	3,716	0	2,167	447	18,697	90.01
90.02	09002	JAY FAMILY MEDICINE	3,931	0	1,529	300	159,979	90.02
91.00	09100	EMERGENCY	3,566	9,318	1,319	3,099	106,092	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	7	0	66	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)	36,518	39,097	22,690	29,284	1,208,699	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	15,624	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	1,377	194.00
194.01	07951	POB	0	0	0	0	893	194.01
194.02	07952	WEST JAY CLINIC	0	0	0	0	32,512	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	337	0	51,858	194.06
194.07	07957	HOSPITALIST	0	0	1	0	3,578	194.07

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II Date/Time Prepared: 2/27/2017 10:37 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	Subtotal	
			11.00	13.00	14.00	16.00	24.00	
194.08	07958	FAMILY FIRST HEALTH	0	0	355	0	68,002	194.08
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)	36,518	39,097	23,383	29,284	1,382,543	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II | Date/Time Prepared: 2/27/2017 10:37 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	269,671		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
40.00	04000	SUBPROVIDER - IPF	0	109,120		40.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
42.00	04200	SUBPROVIDER	0	0		42.00
43.00	04300	NURSERY	0	19,976		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	176,461		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,526		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	34,532		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	70,429		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	11,875		65.00
66.00	06600	PHYSICAL THERAPY	0	6,194		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	721		67.00
68.00	06800	SPEECH PATHOLOGY	0	170		68.00
69.00	06900	ELECTROCARDIOLOGY	0	40,296		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	177,458		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	4,436		90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	18,697		90.01
90.02	09002	JAY FAMILY MEDICINE	0	159,979		90.02
91.00	09100	EMERGENCY	0	106,092		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	66		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	1,208,699		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	15,624		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	1,377		194.00
194.01	07951	POB	0	893		194.01
194.02	07952	WEST JAY CLINIC	0	32,512		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: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II Date/Time Prepared: 2/27/2017 10:37 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
194.06	07956	TRI COUNTY	0	51,858		194.06
194.07	07957	HOSPITALIST	0	3,578		194.07
194.08	07958	FAMILY FIRST HEALTH	0	68,002		194.08
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	1,382,543		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 2/27/2017 10:37 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	80,720					2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP MOB	0	8,146				2.01
2.02	00202	NEW CAP REL COSTS-MVBLE EQUIP-POB	0	0	10,501			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	17,345,047	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,198	1,431	873	0	2,344,722	5.00
7.00	00700	OPERATION OF PLANT	6,541	1,196	630	0	294,474	7.00
7.01	00701	OPERATION OF PLANT-MOB	0	0	0	0	5,513	7.01
7.02	00702	OPERATION OF PLANT-POB	0	0	0	0	8,561	7.02
7.03	00703	OPERATION OF PLANT-WJ	0	0	0	0	2,545	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	445	0	0	0	27,038	8.00
9.00	00900	HOUSEKEEPING	497	0	0	0	421,774	9.00
10.00	01000	DIETARY	2,083	0	0	0	196,713	10.00
11.00	01100	CAFETERIA	2,055	0	0	0	164,340	11.00
13.00	01300	NURSING ADMINISTRATION	1,667	0	0	0	1,034,141	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,258	0	0	0	61,737	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,420	0	0	0	368,481	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,918	0	0	0	1,350,419	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	4,594	0	0	0	698,062	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	90,721	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,410	0	4,722	0	864,045	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	127	0	0	0	15,377	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	626	0	0	0	805,442	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	2,557	0	0	0	667,091	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	558	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	109	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	2,002	0	0	0	217,726	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	9,666	0	0	0	411,655	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	339,080	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	5,519	0	0	1,644,595	90.01
90.02	09002	JAY FAMILY MEDICINE	8,640	0	0	0	1,689,420	90.02
91.00	09100	EMERGENCY	4,542	0	0	0	2,337,768	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)	75,946	8,146	6,225	0	16,061,440	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	906	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MOB	0	0	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	483,051	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.03

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 2/27/2017 10:37 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	4,276	0	171,962	194.06
194.07	07957	HOSPITALIST	0	0	0	0	478,379	194.07
194.08	07958	FAMILY FIRST HEALTH	3,868	0	0	0	150,215	194.08
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)	1,236,269	8,676	106,456	31,142	6,642,281	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	15.315523	1.065063	10.137701	9.436970	0.382950	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: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 2/27/2017 10:37 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	-6,839,047	25,600,491				5.00
7.00	00700	OPERATION OF PLANT	0	1,422,592	65,981			7.00
7.01	00701	OPERATION OF PLANT-MOB	0	42,194	0	5,519		7.01
7.02	00702	OPERATION OF PLANT-POB	0	157,972	0	0	8,998	7.02
7.03	00703	OPERATION OF PLANT-WJ	0	3,520	0	0	0	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	0	85,621	445	0	0	8.00
9.00	00900	HOUSEKEEPING	0	634,899	497	0	0	9.00
10.00	01000	DIETARY	0	477,967	2,083	0	0	10.00
11.00	01100	CAFETERIA	0	213,378	2,055	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,456,730	1,667	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	224,734	1,258	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	568,301	1,420	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,245,699	11,918	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	1,287,014	4,594	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	155,670	1,033	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,069,625	5,410	0	4,722	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	25,562	127	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,670,324	626	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	2,159,628	2,557	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	364,855	558	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	637,781	109	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	110,695	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	25,667	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	677,422	2,002	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,797,119	9,666	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	339,668	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	1,011,763	0	5,519	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0	1,277,367	8,640	0	0	90.02
91.00	09100	EMERGENCY	0	1,730,475	4,542	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	11,050	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)	-6,839,047	22,885,292	61,207	5,519	4,722	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,876	906	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MOB	0	0	0	0	0	194.00
194.01	07951	POB	0	0	0	0	0	194.01
194.02	07952	WEST JAY CLINIC	0	254,453	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	1,463,930	0	0	4,276	194.06

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 2/27/2017 10:37 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	673,725	0	0	0	194.07
194.08	07958	FAMILY FIRST HEALTH	0	309,215	3,868	0	0	194.08
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)		6,839,047	1,802,630	53,466	200,173	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.267145	27.320441	9.687625	22.246388	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		135,931	115,394	224	839	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.005310	1.748897	0.040587	0.093243	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 2/27/2017 10:37 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	42,480				8.00
9.00	00900	HOUSEKEEPING	0	3,720	81,094			9.00
10.00	01000	DIETARY	0	1,260	2,140	35,906		10.00
11.00	01100	CAFETERIA	0	0	2,055	0	20,214	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	1,457	0	1,489	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	983	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	11,740	13,385	24,497	3,088	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	3,240	4,636	11,409	1,492	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	1,033	0	190	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	10,920	11,935	0	1,514	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	127	0	25	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,300	6,255	0	1,397	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	1,611	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	720	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	300	1,000	0	551	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	618	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	822	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	0	5,765	0	2,057	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	0	0	2,176	90.02
91.00	09100	EMERGENCY	0	7,260	4,650	0	1,974	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	42,480	65,863	35,906	20,214	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: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 2/27/2017 10:37 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	0	194.07
194.08	07958	FAMILY FIRST HEALTH	0	0	0	0	0	194.08
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)	4,460	120,652	828,653	688,007	347,524	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.351515	2.840207	10.218426	19.161338	17.192243	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	19	8,048	12,557	38,653	36,518	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.005758	0.189454	0.154845	1.076505	1.806570	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 2/27/2017 10:37 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	8,283				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,379,941			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,089	89,734,939		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	3,088	170,136	5,784,245		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		31.00
40.00	04000	SUBPROVIDER - IPF	1,492	14,756	1,213,680		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	190	0	359,043		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,514	673,292	13,586,361		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	25	0	122,755		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	186,640	27,600,300		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	612,173	18,496,728		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	9,512	858,965		65.00
66.00	06600	PHYSICAL THERAPY	0	8,147	2,243,584		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	408,036		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	103,117		68.00
69.00	06900	ELECTROCARDIOLOGY	0	47,066	2,659,347		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	29,128	4,282,338		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	43,340	217,737		90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	220,519	1,371,652		90.01
90.02	09002	JAY FAMILY MEDICINE	0	155,605	920,089		90.02
91.00	09100	EMERGENCY	1,974	134,296	9,506,962		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	698	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)	8,283	2,309,397	89,734,939		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	0	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: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 2/27/2017 10:37 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	34,269	0		194.06
194.07	07957	HOSPITALIST	0	113	0		194.07
194.08	07958	FAMILY FIRST HEALTH	0	36,162	0		194.08
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)	1,931,918	343,684	790,864		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	233.238923	0.144409	0.008813		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	39,097	23,383	29,284		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.720150	0.009825	0.000326		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 2/27/2017 10:37 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,659,626		4,659,626	0	4,659,626	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	2,418,000		2,418,000	0	2,418,000	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	286,837		286,837	0	286,837	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,624,456		3,624,456	0	3,624,456	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	44,502		44,502	0	44,502	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,501,175		2,501,175	0	2,501,175	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	3,110,056		3,110,056	0	3,110,056	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	489,374	0	489,374	0	489,374	65.00
66.00	06600	PHYSICAL THERAPY	834,134	0	834,134	0	834,134	66.00
67.00	06700	OCCUPATIONAL THERAPY	143,863	0	143,863	0	143,863	67.00
68.00	06800	SPEECH PATHOLOGY	33,433	0	33,433	0	33,433	68.00
69.00	06900	ELECTROCARDIOLOGY	963,865		963,865	0	963,865	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	2,605,202		2,605,202	0	2,605,202	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	495,636		495,636	0	495,636	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1,473,722		1,473,722	0	1,473,722	90.01
90.02	09002	JAY FAMILY MEDICINE	1,922,648		1,922,648	0	1,922,648	90.02
91.00	09100	EMERGENCY	2,982,518		2,982,518	0	2,982,518	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	202,207		202,207		202,207	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	14,103		14,103	0	14,103	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)	28,805,357	0	28,805,357	0	28,805,357	200.00
201.00		Less Observation Beds	202,207		202,207		202,207	201.00
202.00		Total (see instructions)	28,603,150	0	28,603,150	0	28,603,150	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 2/27/2017 10:37 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	5,648,973		5,648,973			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
40.00	04000	SUBPROVIDER - IPF	1,213,680		1,213,680			40.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	359,043		359,043			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,355,663	10,230,698	13,586,361	0.266772	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	122,755	0	122,755	0.362527	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,884,314	25,715,986	27,600,300	0.090621	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	2,869,463	15,627,265	18,496,728	0.168141	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	592,525	266,440	858,965	0.569725	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	709,385	1,534,199	2,243,584	0.371786	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	200,958	207,078	408,036	0.352574	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	21,324	81,793	103,117	0.324224	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	258,269	2,401,078	2,659,347	0.362444	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	1,732,121	2,550,217	4,282,338	0.608360	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	12,916	204,821	217,737	2.276306	0.000000	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	1,371,652	1,371,652	1.074414	0.000000	90.01
90.02	09002	JAY FAMILY MEDICINE	0	920,089	920,089	2.089633	0.000000	90.02
91.00	09100	EMERGENCY	308,915	9,198,047	9,506,962	0.313719	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	135,272	135,272	1.494818	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)	19,290,304	70,444,635	89,734,939			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	19,290,304	70,444,635	89,734,939			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 2/27/2017 10:37 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	0.266772		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.362527		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.090621		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	0.168141		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
65.00	06500	RESPIRATORY THERAPY	0.569725		65.00
66.00	06600	PHYSICAL THERAPY	0.371786		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.352574		67.00
68.00	06800	SPEECH PATHOLOGY	0.324224		68.00
69.00	06900	ELECTROCARDIOLOGY	0.362444		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	0.608360		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	2.276306		90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1.074414		90.01
90.02	09002	JAY FAMILY MEDICINE	2.089633		90.02
91.00	09100	EMERGENCY	0.313719		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.494818		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: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 2/27/2017 10:37 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	4,659,626		4,659,626	0	4,659,626	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	2,418,000		2,418,000	0	2,418,000	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	286,837		286,837	0	286,837	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,624,456		3,624,456	0	3,624,456	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	44,502		44,502	0	44,502	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,501,175		2,501,175	0	2,501,175	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	3,110,056		3,110,056	0	3,110,056	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	489,374	0	489,374	0	489,374	65.00
66.00	06600	PHYSICAL THERAPY	834,134	0	834,134	0	834,134	66.00
67.00	06700	OCCUPATIONAL THERAPY	143,863	0	143,863	0	143,863	67.00
68.00	06800	SPEECH PATHOLOGY	33,433	0	33,433	0	33,433	68.00
69.00	06900	ELECTROCARDIOLOGY	963,865		963,865	0	963,865	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	2,605,202		2,605,202	0	2,605,202	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	495,636		495,636	0	495,636	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1,473,722		1,473,722	0	1,473,722	90.01
90.02	09002	JAY FAMILY MEDICINE	1,922,648		1,922,648	0	1,922,648	90.02
91.00	09100	EMERGENCY	2,982,518		2,982,518	0	2,982,518	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	202,207		202,207		202,207	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	14,103		14,103	0	14,103	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)	28,805,357	0	28,805,357	0	28,805,357	200.00
201.00		Less Observation Beds	202,207		202,207		202,207	201.00
202.00		Total (see instructions)	28,603,150	0	28,603,150	0	28,603,150	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 2/27/2017 10:37 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	5,648,973		5,648,973			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
40.00	04000	SUBPROVIDER - IPF	1,213,680		1,213,680			40.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	359,043		359,043			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,355,663	10,230,698	13,586,361	0.266772	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	122,755	0	122,755	0.362527	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,884,314	25,715,986	27,600,300	0.090621	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	2,869,463	15,627,265	18,496,728	0.168141	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	592,525	266,440	858,965	0.569725	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	709,385	1,534,199	2,243,584	0.371786	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	200,958	207,078	408,036	0.352574	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	21,324	81,793	103,117	0.324224	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	258,269	2,401,078	2,659,347	0.362444	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	1,732,121	2,550,217	4,282,338	0.608360	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	12,916	204,821	217,737	2.276306	0.000000	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	1,371,652	1,371,652	1.074414	0.000000	90.01
90.02	09002	JAY FAMILY MEDICINE	0	920,089	920,089	2.089633	0.000000	90.02
91.00	09100	EMERGENCY	308,915	9,198,047	9,506,962	0.313719	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	135,272	135,272	1.494818	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)	19,290,304	70,444,635	89,734,939			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	19,290,304	70,444,635	89,734,939			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 2/27/2017 10:37 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: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part II Date/Time Prepared: 2/27/2017 10:37 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	176,461	13,586,361	0.012988	1,027,275	13,342	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,526	122,755	0.020578	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	34,532	27,600,300	0.001251	721,138	902	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	70,429	18,496,728	0.003808	1,070,376	4,076	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	11,875	858,965	0.013825	236,951	3,276	65.00
66.00	06600	PHYSICAL THERAPY	6,194	2,243,584	0.002761	142,529	394	66.00
67.00	06700	OCCUPATIONAL THERAPY	721	408,036	0.001767	70,645	125	67.00
68.00	06800	SPEECH PATHOLOGY	170	103,117	0.001649	10,103	17	68.00
69.00	06900	ELECTROCARDIOLOGY	40,296	2,659,347	0.015153	238,456	3,613	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	177,458	4,282,338	0.041440	609,729	25,267	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	4,436	217,737	0.020373	1,937	39	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	18,697	1,371,652	0.013631	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	159,979	920,089	0.173873	0	0	90.02
91.00	09100	EMERGENCY	106,092	9,506,962	0.011159	6,962	78	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	11,703	135,272	0.086515	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	66	0	0.000000	0	0	93.00
200.00		Total (lines 50-199)	821,635	82,513,243		4,136,101	51,129	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV | Date/Time Prepared: 2/27/2017 10:37 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: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV Date/Time Prepared: 2/27/2017 10:37 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	13,586,361	0.000000	0.000000	1,027,275	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	122,755	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	27,600,300	0.000000	0.000000	721,138	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	18,496,728	0.000000	0.000000	1,070,376	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	858,965	0.000000	0.000000	236,951	65.00
66.00	06600	PHYSICAL THERAPY	0	2,243,584	0.000000	0.000000	142,529	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	408,036	0.000000	0.000000	70,645	67.00
68.00	06800	SPEECH PATHOLOGY	0	103,117	0.000000	0.000000	10,103	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,659,347	0.000000	0.000000	238,456	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	4,282,338	0.000000	0.000000	609,729	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	217,737	0.000000	0.000000	1,937	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	1,371,652	0.000000	0.000000	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0	920,089	0.000000	0.000000	0	90.02
91.00	09100	EMERGENCY	0	9,506,962	0.000000	0.000000	6,962	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	135,272	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	82,513,243			4,136,101	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV | Date/Time Prepared: 2/27/2017 10:37 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: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part V Date/Time Prepared: 2/27/2017 10:37 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	0.266772	0	2,386,661	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.362527	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.090621	0	7,645,978	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	0.168141	0	5,554,306	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.569725	0	32,772	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.371786	0	654,086	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.352574	0	26,873	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.324224	0	17,432	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.362444	0	1,078,140	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	0.608360	0	1,061,132	115,066	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	2.276306	0	17,170	23,593	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1.074414	0	118,097	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	2.089633	0	166,161	0	0	90.02
91.00	09100	EMERGENCY	0.313719	0	1,684,859	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.494818	0	66,226	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	20,509,893	138,659	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	20,509,893	138,659	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part V Date/Time Prepared: 2/27/2017 10:37 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	636,694	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	692,886	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	933,907	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	18,671	0		65.00
66.00	06600	PHYSICAL THERAPY	243,180	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	9,475	0		67.00
68.00	06800	SPEECH PATHOLOGY	5,652	0		68.00
69.00	06900	ELECTROCARDIOLOGY	390,765	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	645,550	70,002		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	39,084	53,705		90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	126,885	0		90.01
90.02	09002	JAY FAMILY MEDICINE	347,216	0		90.02
91.00	09100	EMERGENCY	528,572	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	98,996	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
200.00		Subtotal (see instructions)	4,717,533	123,707		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	4,717,533	123,707		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-1320 | Component CCN: 15-M320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part II | Date/Time Prepared: 2/27/2017 10:37 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	176,461	13,586,361	0.012988	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,526	122,755	0.020578	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	34,532	27,600,300	0.001251	49,863	62	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	70,429	18,496,728	0.003808	171,914	655	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	11,875	858,965	0.013825	14,024	194	65.00
66.00	06600	PHYSICAL THERAPY	6,194	2,243,584	0.002761	17,255	48	66.00
67.00	06700	OCCUPATIONAL THERAPY	721	408,036	0.001767	6,443	11	67.00
68.00	06800	SPEECH PATHOLOGY	170	103,117	0.001649	8,540	14	68.00
69.00	06900	ELECTROCARDIOLOGY	40,296	2,659,347	0.015153	11,964	181	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	177,458	4,282,338	0.041440	152,490	6,319	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	4,436	217,737	0.020373	9,548	195	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	18,697	1,371,652	0.013631	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	159,979	920,089	0.173873	0	0	90.02
91.00	09100	EMERGENCY	106,092	9,506,962	0.011159	16,224	181	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	135,272	0.000000	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	66	0	0.000000	0	0	93.00
200.00		Total (lines 50-199)	809,932	82,513,243		458,265	7,860	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1320 | Component CCN: 15-M320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV | Date/Time Prepared: 2/27/2017 10:37 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: 15-1320 | Component CCN: 15-M320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV | Date/Time Prepared: 2/27/2017 10:37 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	13,586,361	0.000000	0.000000	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	122,755	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	27,600,300	0.000000	0.000000	49,863	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	18,496,728	0.000000	0.000000	171,914	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	858,965	0.000000	0.000000	14,024	65.00
66.00	06600	PHYSICAL THERAPY	0	2,243,584	0.000000	0.000000	17,255	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	408,036	0.000000	0.000000	6,443	67.00
68.00	06800	SPEECH PATHOLOGY	0	103,117	0.000000	0.000000	8,540	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,659,347	0.000000	0.000000	11,964	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	4,282,338	0.000000	0.000000	152,490	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	217,737	0.000000	0.000000	9,548	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	1,371,652	0.000000	0.000000	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0	920,089	0.000000	0.000000	0	90.02
91.00	09100	EMERGENCY	0	9,506,962	0.000000	0.000000	16,224	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	135,272	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	82,513,243			458,265	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-1320 Component CCN: 15-M320	Period: From 10/01/2015 To 09/30/2016	Worksheet D Part IV Date/Time Prepared: 2/27/2017 10:37 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: 15-1320 | Component CCN: 15-Z320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part V Date/Time Prepared: 2/27/2017 10:37 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	0.266772	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.362527	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.090621	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	0.168141	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.569725	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.371786	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.352574	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.324224	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.362444	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	0.608360	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	2.276306	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1.074414	0	0	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	2.089633	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.313719	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.494818	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: 15-1320 | Component CCN: 15-Z320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part V | Date/Time Prepared: 2/27/2017 10:37 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: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/27/2017 10:37 am

Title XVIII | Hospital

	Cost Center Description	Cost	
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,355	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,657	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)	2,512	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)	683	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	15	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)	1,264	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)	560	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)	4,659,626	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)	1,895	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)	954,359	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,705,267	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)	3,705,267	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)	1,394.53	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,762,686	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)	1,762,686	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/27/2017 10:37 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)	1,199,498	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,962,184	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)	780,937	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	780,937	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)	145	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,394.53	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	202,207	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/27/2017 10:37 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	269,671	4,659,626	0.057874	202,207	11,703	90.00
91.00	Nursing School cost	0	4,659,626	0.000000	202,207	0	91.00
92.00	Allied health cost	0	4,659,626	0.000000	202,207	0	92.00
93.00	All other Medical Education	0	4,659,626	0.000000	202,207	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1320 Component CCN: 15-M320	Period: From 10/01/2015 To 09/30/2016	Worksheet D-1 Date/Time Prepared: 2/27/2017 10:37 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)	1,495	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,495	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)	1,495	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)	848	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)	2,418,000	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)	2,418,000	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)	2,418,000	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)	1,617.39	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,371,547	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)	1,371,547	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-1320 | Component CCN: 15-M320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/27/2017 10:37 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)	176,800	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,548,347	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)	7,860	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	7,860	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,540,487	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-1320 | Component CCN: 15-M320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/27/2017 10:37 am

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	0	2,418,000	0.000000	0	0	90.00
91.00	Nursing School cost	0	2,418,000	0.000000	0	0	91.00
92.00	Allied health cost	0	2,418,000	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,418,000	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/27/2017 10:37 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)	3,355	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,657	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)	2,512	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)	683	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	15	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)	0	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)	126	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)	4,659,626	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)	952,853	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,706,773	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)	3,706,773	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)	1,395.10	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	0	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)	0	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/27/2017 10:37 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)	286,837	126	2,276.48	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)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	0	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)	145	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,395.10	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	202,290	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/27/2017 10:37 am

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	269,671	4,659,626	0.057874	202,290	11,707	90.00
91.00	Nursing School cost	0	4,659,626	0.000000	202,290	0	91.00
92.00	Allied health cost	0	4,659,626	0.000000	202,290	0	92.00
93.00	All other Medical Education	0	4,659,626	0.000000	202,290	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1320 Component CCN: 15-M320	Period: From 10/01/2015 To 09/30/2016	Worksheet D-1 Date/Time Prepared: 2/27/2017 10:37 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)	1,495	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,495	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)	1,495	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)	24	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)	126	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)	2,418,000	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)	2,418,000	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)	2,418,000	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)	1,617.39	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	38,817	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)	38,817	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-1320 | Component CCN: 15-M320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/27/2017 10:37 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)	5,286	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	44,103	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1320 Component CCN: 15-M320	Period: From 10/01/2015 To 09/30/2016	Worksheet D-1 Date/Time Prepared: 2/27/2017 10:37 am
	Title XIX	Subprovider - IPF	Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	109,120	2,418,000	0.045128	0	0	90.00
91.00	Nursing School cost	0	2,418,000	0.000000	0	0	91.00
92.00	Allied health cost	0	2,418,000	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,418,000	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-3 | Date/Time Prepared: 2/27/2017 10:37 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		2,243,240		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	0.266772	1,027,275	274,048	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.362527	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.090621	721,138	65,350	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	0.168141	1,070,376	179,974	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.569725	236,951	134,997	65.00
66.00	06600	PHYSICAL THERAPY	0.371786	142,529	52,990	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.352574	70,645	24,908	67.00
68.00	06800	SPEECH PATHOLOGY	0.324224	10,103	3,276	68.00
69.00	06900	ELECTROCARDIOLOGY	0.362444	238,456	86,427	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	0.608360	609,729	370,935	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	2.276306	1,937	4,409	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1.074414	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	2.089633	0	0	90.02
91.00	09100	EMERGENCY	0.313719	6,962	2,184	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.494818	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)		4,136,101	1,199,498	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)		4,136,101		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1320 | Component CCN: 15-M320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-3 | Date/Time Prepared: 2/27/2017 10:37 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		678,400		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	0.266772	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.362527	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.090621	49,863	4,519	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	0.168141	171,914	28,906	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.569725	14,024	7,990	65.00
66.00	06600	PHYSICAL THERAPY	0.371786	17,255	6,415	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.352574	6,443	2,272	67.00
68.00	06800	SPEECH PATHOLOGY	0.324224	8,540	2,769	68.00
69.00	06900	ELECTROCARDIOLOGY	0.362444	11,964	4,336	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	0.608360	152,490	92,769	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	2.276306	9,548	21,734	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1.074414	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	2.089633	0	0	90.02
91.00	09100	EMERGENCY	0.313719	16,224	5,090	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.494818	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)		458,265	176,800	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)		458,265		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1320 | Component CCN: 15-Z320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-3 | Date/Time Prepared: 2/27/2017 10:37 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	0.266772	141	38	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.362527	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.090621	32,066	2,906	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	0.168141	96,087	16,156	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.569725	65,889	37,539	65.00
66.00	06600	PHYSICAL THERAPY	0.371786	173,255	64,414	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.352574	123,870	43,673	67.00
68.00	06800	SPEECH PATHOLOGY	0.324224	2,681	869	68.00
69.00	06900	ELECTROCARDIOLOGY	0.362444	7,849	2,845	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	0.608360	138,954	84,534	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	2.276306	1,431	3,257	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1.074414	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	2.089633	0	0	90.02
91.00	09100	EMERGENCY	0.313719	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.494818	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)		642,223	256,231	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)		642,223		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-3 | Date/Time Prepared: 2/27/2017 10:37 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		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	0.266772	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.362527	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.090621	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	0.168141	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.569725	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.371786	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.352574	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.324224	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.362444	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	0.608360	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	2.276306	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1.074414	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	2.089633	0	0	90.02
91.00	09100	EMERGENCY	0.313719	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.494818	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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1320 | Component CCN: 15-M320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-3 | Date/Time Prepared: 2/27/2017 10:37 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		21,385		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	0.266772	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.362527	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.090621	2,216	201	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	0.168141	9,019	1,516	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.569725	543	309	65.00
66.00	06600	PHYSICAL THERAPY	0.371786	475	177	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.352574	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.324224	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.362444	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	0.608360	5,068	3,083	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	2.276306	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1.074414	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	2.089633	0	0	90.02
91.00	09100	EMERGENCY	0.313719	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.494818	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)		17,321	5,286	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)		17,321		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1320 | Component CCN: 15-Z320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-3 | Date/Time Prepared: 2/27/2017 10:37 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	0.266772	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.362527	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.090621	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	0.168141	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.569725	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.371786	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.352574	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.324224	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.362444	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	0.608360	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	2.276306	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1.074414	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	2.089633	0	0	90.02
91.00	09100	EMERGENCY	0.313719	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.494818	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: 15-1320	Period: From 10/01/2015 To 09/30/2016	Worksheet E Part B Date/Time Prepared: 2/27/2017 10:37 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,841,240	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)	4,841,240	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)	4,889,652	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)	86,032	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	3,031,510	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)	1,772,110	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)	1,772,110	30.00
31.00	Primary payer payments	2,282	31.00
32.00	Subtotal (line 30 minus line 31)	1,769,828	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)	498,066	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	323,743	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	461,616	36.00
37.00	Subtotal (see instructions)	2,093,571	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)	2,093,571	40.00
40.01	Sequestration adjustment (see instructions)	41,871	40.01
41.00	Interim payments	2,397,480	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-345,780	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet E-1 Part I Date/Time Prepared: 2/27/2017 10:37 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		2,665,449		2,397,480	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)		2,665,449		2,397,480	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		60,885		345,780	6.02
7.00	Total Medicare program liability (see instructions)		2,604,564		2,051,700	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1320 | Component CCN: 15-M320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet E-1 Part I | Date/Time Prepared: 2/27/2017 10:37 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		756,059		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)		756,059		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		6		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		756,065		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: 15-1320 | Component CCN: 15-Z320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet E-1 Part I | Date/Time Prepared: 2/27/2017 10:37 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,077,514		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)		1,077,514		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		54,232		0	6.02
7.00	Total Medicare program liability (see instructions)		1,023,282		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 - SWING BEDS	Provider CCN: 15-1320 Component CCN: 15-Z320	Period: From 10/01/2015 To 09/30/2016	Worksheet E-2 Date/Time Prepared: 2/27/2017 10:37 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)	788,746	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)	258,793	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	560	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)	1,047,539	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,047,539	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)	1,047,539	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	3,374	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)	1,044,165	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)	1,044,165	0	19.00
19.01	Sequestration adjustment (see instructions)	20,883	0	19.01
20.00	Interim payments	1,077,514	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)	-54,232	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: 15-1320 | Component CCN: 15-Z320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet E-2 | Date/Time Prepared: 2/27/2017 10:37 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: 15-1320	Period: From 10/01/2015 To 09/30/2016	Worksheet E-3 Part V Date/Time Prepared: 2/27/2017 10:37 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	2,962,184	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	2,962,184	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,971,959	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	2,971,959	19.00
20.00	Deductibles (exclude professional component)	342,160	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	2,629,799	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	2,629,799	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	42,953	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	27,919	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	29,643	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	2,657,718	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)	2,657,718	30.00
30.01	Sequestration adjustment (see instructions)	53,154	30.01
31.00	Interim payments	2,665,449	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)	-60,885	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: 15-1320 Component CCN: 15-M320	Period: From 10/01/2015 To 09/30/2016	Worksheet E-3 Part II Date/Time Prepared: 2/27/2017 10:37 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)	807,553	1.00
2.00	Net IPF PPS Outlier Payments	40,144	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)	4.084699	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)	847,697	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)	847,697	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	847,697	18.00
19.00	Deductibles	62,748	19.00
20.00	Subtotal (line 18 minus line 19)	784,949	20.00
21.00	Coinsurance	13,454	21.00
22.00	Subtotal (line 20 minus line 21)	771,495	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)	771,495	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)	771,495	31.00
31.01	Sequestration adjustment (see instructions)	15,430	31.01
32.00	Interim payments	756,059	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)	6	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	40,144	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: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet E-3 Part VII | Date/Time Prepared: 2/27/2017 10:37 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	0		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)	0	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)	0	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	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)	0	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)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	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)	0	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)	0	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)	0	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)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	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)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	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: 15-1320 Component CCN: 15-M320	Period: From 10/01/2015 To 09/30/2016	Worksheet E-3 Part VII Date/Time Prepared: 2/27/2017 10:37 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	44,103		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)	44,103	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)	44,103	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	17,321	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)	17,321	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)	17,321	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	26,782	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)	17,321	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)	17,321	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	26,782	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	17,321	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)	17,321	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	17,321	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)	17,321	0	40.00
41.00	Interim payments	20,153	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-2,832	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: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet G | Date/Time Prepared: 2/27/2017 10:37 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	2,988,608	0	0	0	1.00
2.00	Temporary investments	-9,624,424	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	25,494,955	0	0	0	4.00
5.00	Other receivable	304,455	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	2,731,770	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)	21,895,364	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	347,733	0	0	0	12.00
13.00	Land improvements	952,332	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	25,114,962	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	2,426,508	0	0	0	19.00
20.00	Accumulated depreciation	-28,882,882	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	13,931,159	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)	13,889,812	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	11,341,395	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	11,341,395	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	47,126,571	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	767,852	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,563,097	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	4,890,201	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	7,221,150	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	7,221,150	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	39,905,421				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)	39,905,421	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	47,126,571	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet G-1 | Date/Time Prepared: 2/27/2017 10:37 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		44,117,089		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-4,211,668				2.00
3.00	Total (sum of line 1 and line 2)		39,905,421		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)		39,905,421		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)		39,905,421		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: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet G-2 Parts I & II | Date/Time Prepared: 2/27/2017 10:37 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	6,266,043		6,266,043	1.00
2.00	SUBPROVIDER - IPF	1,213,680		1,213,680	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)	7,479,723		7,479,723	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)	7,479,723		7,479,723	17.00
18.00	Ancillary services	12,349,317	61,639,867	73,989,184	18.00
19.00	Outpatient services	867,521	17,967,540	18,835,061	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	PHYSICIANS'S PRIVATE OFFICES	0	2,509,478	2,509,478	27.00
27.01	WEST JAY CLINIC	2,215	74,981	77,196	27.01
27.02	TRI COUNTY	844,631	2,733,556	3,578,187	27.02
27.03	HOSPITALIST	290,273	117,035	407,308	27.03
27.04	FAMILY FIRST HEALTH	1,522	119,028	120,550	27.04
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	21,835,202	85,161,485	106,996,687	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		41,218,166		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		41,218,166		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1320 | Period: From 10/01/2015 To 09/30/2016 | Worksheet G-3 | Date/Time Prepared: 2/27/2017 10:37 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	106,996,687	1.00
2.00	Less contractual allowances and discounts on patients' accounts	71,423,138	2.00
3.00	Net patient revenues (line 1 minus line 2)	35,573,549	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	41,218,166	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-5,644,617	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	1,264,019	24.00
24.01	NON-OPERATING INCOME	168,930	24.01
25.00	Total other income (sum of lines 6-24)	1,432,949	25.00
26.00	Total (line 5 plus line 25)	-4,211,668	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)	-4,211,668	29.00