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 10/01/2016 To 09/30/2017	Worksheet S Parts I-III Date/Time Prepared: 2/26/2018 2:05 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/26/2018 Time: 2:05 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by JAY COUNTY HOSPITAL (15-1320) for the cost reporting period beginning 10/01/2016 and ending 09/30/2017 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.

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

(Signed)_____
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	-771	-158,841	0	12,940	1.00
2.00	Subprovider - IPF	0	0	0		13,773	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVIDER I						4.00
5.00	Swing bed - SNF	0	12,292	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	11,521	-158,841	0	26,713	200.00

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents , please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 2/26/2018 1:56 pm

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

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	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)	10/01/2016	09/30/2017	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 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 2/26/2018 1:56 pm

		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)(i) or (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)(i) or (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(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	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

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

		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

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		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

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

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

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

	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 2/26/2018 1:56 pm

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

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	Y			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	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

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		1.00	2.00	3.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00
87.00	Is this hospital 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
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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		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 Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N	110.00

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

		1.00	2.00	3.00	
	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:	334,527	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	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
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			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 2/26/2018 1:56 pm

		1.00	2.00	
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.			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.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2016	09/30/2017	170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1320	Period: From 10/01/2016 To 09/30/2017	Worksheet S-2 Part I Date/Time Prepared: 2/26/2018 1:56 pm

		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 10/01/2016 To 09/30/2017 | Worksheet S-2 Part II | Date/Time Prepared: 2/26/2018 1:56 pm

		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	A	04/01/2018	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	01/05/2018	Y	01/05/2018	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 10/01/2016 To 09/30/2017 | Worksheet S-2 Part II | Date/Time Prepared: 2/26/2018 1:56 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				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.				Y	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.				N	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 10/01/2016 To 09/30/2017	Worksheet S-2 Part II Date/Time Prepared: 2/26/2018 1:56 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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 10/01/2016 To 09/30/2017 | Worksheet S-3 Part I Date/Time Prepared: 2/26/2018 1:56 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	57,408.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	57,408.00	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	33.00	0	0	0.00	0	10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	9,125	57,408.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	10	3,650		0	16.00
17.00	SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00	SUBPROVIDER	42.00	0	0		0	18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	99.10				0	25.10
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		35				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 2/26/2018 1:56 pm

	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)	1,058	16	2,392			1.00
2.00	HMO and other (see instructions)	102	0				2.00
3.00	HMO IPF Subprovider	33	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	249	0	351			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)	1,307	16	2,758			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	0	0	0			10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0	186			13.00
14.00	Total (see instructions)	1,307	16	2,944	0.00	296.16	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	673	21	1,069	0.00	14.31	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	310.47	27.00
28.00	Observation Bed Days		0	287			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	31			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 2/26/2018 1:56 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
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	338	8	816	1.00
2.00	HMO and other (see instructions)			32	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	338	8	816	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	67	2	148	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			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-10 | Date/Time Prepared: 2/26/2018 1:56 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.303001	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,013,156	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	11,629,851	6.00
7.00	Medicaid cost (line 1 times line 6)	3,523,856	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)	1,510,700	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,510,700	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	597,401	0	597,401	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	181,013	0	181,013	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	181,013	0	181,013	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	1,699,865	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	386,040	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	593,908	27.01
28.00	Non-Medicare bad debt expense (line 26 minus line 27.01)	1,105,957	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	542,974	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	723,987	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,234,687	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A | Date/Time Prepared: 2/26/2018 1:56 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		1,834,083	1,834,083	0	1,834,083	2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP MOB		8,689	8,689	0	8,689	2.01
2.02	00202	NEW CAP REL COSTS-MVBLE EQUIP-POB		101,949	101,949	0	101,949	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	2,665,450	2,665,450	0	2,665,450	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,296,687	5,492,795	7,789,482	0	7,789,482	5.00
7.00	00700	OPERATION OF PLANT	277,282	947,639	1,224,921	-22,813	1,202,108	7.00
7.01	00701	OPERATION OF PLANT-MOB	0	46,243	46,243	12,575	58,818	7.01
7.02	00702	OPERATION OF PLANT-POB	0	91,096	91,096	6,788	97,884	7.02
7.03	00703	OPERATION OF PLANT-WJ	0	0	0	3,450	3,450	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	56,001	44,153	100,154	0	100,154	8.00
9.00	00900	HOUSEKEEPING	395,845	60,551	456,396	0	456,396	9.00
10.00	01000	DIETARY	360,323	282,220	642,543	-269,407	373,136	10.00
11.00	01100	CAFETERIA	0	0	0	269,407	269,407	11.00
13.00	01300	NURSING ADMINISTRATION	1,033,328	13,746	1,047,074	0	1,047,074	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	63,011	7,780	70,791	0	70,791	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	335,105	60,922	396,027	0	396,027	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,424,263	176,448	1,600,711	-128,192	1,472,519	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
40.00	04000	SUBPROVIDER - IPF	676,362	175,381	851,743	0	851,743	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	103,605	103,605	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	812,211	595,221	1,407,432	-31,310	1,376,122	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	24,587	24,587	52.00
53.00	05300	ANESTHESIOLOGY	0	969,583	969,583	0	969,583	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	785,205	669,009	1,454,214	0	1,454,214	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	661,200	1,321,600	1,982,800	0	1,982,800	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	371,414	371,414	0	371,414	65.00
66.00	06600	PHYSICAL THERAPY	0	689,144	689,144	-93,412	595,732	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	74,188	74,188	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	19,224	19,224	68.00
69.00	06900	ELECTROCARDIOLOGY	186,604	164,190	350,794	0	350,794	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	31,310	31,310	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	434,970	1,715,286	2,150,256	0	2,150,256	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	164,046	164,046	0	164,046	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1,625,156	277,056	1,902,212	0	1,902,212	90.01
90.02	09002	JAY FAMILY MEDICINE	1,634,938	250,359	1,885,297	0	1,885,297	90.02
91.00	09100	EMERGENCY	2,098,925	416,664	2,515,589	0	2,515,589	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	771	18,979	19,750	0	19,750	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 through 117)	15,158,187	19,662,838	34,821,025	0	34,821,025	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	615,672	33,712	649,384	0	649,384	194.02
194.03	07953	CONVENIENT CARE	195,278	13,595	208,873	0	208,873	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

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A | Date/Time Prepared: 2/26/2018 1:56 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
194.06	07956	TRI COUNTY	245,418	1,228,124	1,473,542	0	1,473,542	194.06
194.07	07957	HOSPITALIST	431,393	95,834	527,227	0	527,227	194.07
194.08	07958	FAMILY FIRST HEALTH	799,007	107,558	906,565	0	906,565	194.08
194.09	07959	MERIDIAN HEALTH CONVENIENT CARE	0	0	0	0	0	194.09
200.00		TOTAL (SUM OF LINES 118 through 199)	17,444,955	21,141,661	38,586,616	0	38,586,616	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A | Date/Time Prepared: 2/26/2018 1:56 pm

		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	-128,348	1,705,735		2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP MOB	0	8,689		2.01
2.02	00202	NEW CAP REL COSTS-MVBLE EQUIP-POB	0	101,949		2.02
2.03	00203	NEW CAP REL COSTS-MVBLE EQUIP- WJ	0	31,142		2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,703,057	6,368,507		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,824,966	5,964,516		5.00
7.00	00700	OPERATION OF PLANT	0	1,202,108		7.00
7.01	00701	OPERATION OF PLANT-MOB	0	58,818		7.01
7.02	00702	OPERATION OF PLANT-POB	0	97,884		7.02
7.03	00703	OPERATION OF PLANT-WJ	0	3,450		7.03
8.00	00800	LAUNDRY & LINEN SERVICE	0	100,154		8.00
9.00	00900	HOUSEKEEPING	0	456,396		9.00
10.00	01000	DIETARY	0	373,136		10.00
11.00	01100	CAFETERIA	-193,217	76,190		11.00
13.00	01300	NURSING ADMINISTRATION	-15,834	1,031,240		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	70,791		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-14,803	381,224		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,472,519		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0		33.00
40.00	04000	SUBPROVIDER - IPF	0	851,743		40.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
42.00	04200	SUBPROVIDER	0	0		42.00
43.00	04300	NURSERY	0	103,605		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,376,122		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	24,587		52.00
53.00	05300	ANESTHESIOLOGY	-969,583	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,454,214		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	-65,000	1,917,800		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	371,414		65.00
66.00	06600	PHYSICAL THERAPY	-29,881	565,851		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	74,188		67.00
68.00	06800	SPEECH PATHOLOGY	0	19,224		68.00
69.00	06900	ELECTROCARDIOLOGY	-29,261	321,533		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	31,310		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-379,148	1,771,108		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	-115,970	48,076		90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	-1,548,676	353,536		90.01
90.02	09002	JAY FAMILY MEDICINE	-1,477,553	407,744		90.02
91.00	09100	EMERGENCY	-1,681,452	834,137		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	19,750		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 through 117)	-4,770,635	30,050,390		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	-649,384	0		194.02
194.03	07953	CONVENIENT CARE	-208,873	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	1,473,542		194.06

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A | Date/Time Prepared: 2/26/2018 1:56 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
194.07	07957	HOSPITALIST	0	527,227		194.07
194.08	07958	FAMILY FIRST HEALTH	0	906,565		194.08
194.09	07959	MERIDIAN HEALTH CONVENIENT CARE	0	0		194.09
200.00		TOTAL (SUM OF LINES 118 through 199)	-5,628,892	32,957,724		200.00

RECLASSIFICATIONS | Provider CCN: 15-1320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-6 | Date/Time Prepared: 2/26/2018 1:56 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - NURSERY RECLASS				
1.00	NURSERY	43.00	95,130	8,475	1.00
	TOTALS		95,130	8,475	
	B - LABOR & DELIVERY				
1.00	DELIVERY ROOM & LABOR ROOM	52.00	22,660	1,927	1.00
	TOTALS		22,660	1,927	
	C - CAFETERIA				
1.00	CAFETERIA	11.00	151,077	118,330	1.00
	TOTALS		151,077	118,330	
	D - MOB, POB, WEST JAY MAINT				
1.00	OPERATION OF PLANT-MOB	7.01	12,575	0	1.00
2.00	OPERATION OF PLANT-POB	7.02	6,788	0	2.00
3.00	OPERATION OF PLANT-WJ	7.03	3,450	0	3.00
	TOTALS		22,813	0	
	E - OT ST RECLASS				
1.00	OCCUPATIONAL THERAPY	67.00	0	74,188	1.00
2.00	SPEECH PATHOLOGY	68.00	0	19,224	2.00
	TOTALS		0	93,412	
	F - IMPLANTABLE DEVICES				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	31,310	1.00
	TOTALS		0	31,310	
500.00	Grand Total: Increases		291,680	253,454	500.00

RECLASSIFICATIONS | Provider CCN: 15-1320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-6 | Date/Time Prepared: 2/26/2018 1:56 pm

		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	95,130	8,475	0		1.00
	TOTALS		95,130	8,475			
	B - LABOR & DELIVERY						
1.00	ADULTS & PEDIATRICS	30.00	22,660	1,927	0		1.00
	TOTALS		22,660	1,927			
	C - CAFETERIA						
1.00	DIETARY	10.00	151,077	118,330	0		1.00
	TOTALS		151,077	118,330			
	D - MOB, POB, WEST JAY MAINT						
1.00	OPERATION OF PLANT	7.00	22,813	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		22,813	0			
	E - OT ST RECLASS						
1.00	PHYSICAL THERAPY	66.00	0	93,412	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	93,412			
	F - IMPLANTABLE DEVICES						
1.00	OPERATING ROOM	50.00	0	31,310	0		1.00
	TOTALS		0	31,310			
500.00	Grand Total: Decreases		291,680	253,454			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-7 Part I | Date/Time Prepared: 2/26/2018 1:56 pm

		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	24,038,676	3,081,069	0	3,081,069	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	18,320,218	2,205,013	0	2,205,013	1,019,492	5.00
6.00	Movable Equipment	0	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	43,658,959	5,286,082	0	5,286,082	1,019,492	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	43,658,959	5,286,082	0	5,286,082	1,019,492	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	27,119,745	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	19,505,739	0	5.00
6.00	Movable Equipment	0	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	47,925,549	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	47,925,549	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-7 Part II | Date/Time Prepared: 2/26/2018 1:56 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,826,406	0	7,677	0	0	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP MOB	8,689	0	0	0	0	2.01
2.02	NEW CAP REL COSTS-MVBLE EQUIP-POB	101,949	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)	1,968,186	0	7,677	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	1,834,083	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP MOB	0	8,689	2.01
2.02	NEW CAP REL COSTS-MVBLE EQUIP-POB	0	101,949	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	1,975,863	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-7 Part III Date/Time Prepared: 2/26/2018 1:56 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: 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	27,119,745	0	27,119,745	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)	27,119,745	0	27,119,745	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: 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	1,698,058	0	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP MOB	0	0	0	8,689	0	2.01
2.02	NEW CAP REL COSTS-MVBLE EQUIP-POB	0	0	0	101,949	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	1,839,838	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: 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	7,677	0	0	0	1,705,735	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP MOB	0	0	0	0	8,689	2.01
2.02	NEW CAP REL COSTS-MVBLE EQUIP-POB	0	0	0	0	101,949	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)	7,677	0	0	0	1,847,515	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8 | Date/Time Prepared: 2/26/2018 1:56 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	*** Cost Center Deleted ***	1.00	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
2.01	Investment income - NEW CAP REL COSTS-MVBLE EQUIP MOB (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP MOB	2.01	0	2.01
2.02	Investment income - NEW CAP REL COSTS-MVBLE EQUIP-POB (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP-POB	2.02	0	2.02
2.03	Investment income - NEW CAP REL COSTS-MVBLE EQUIP- WJ (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP- WJ	2.03	0	2.03
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-4,843,584			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	-29,881			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
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

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8 | Date/Time Prepared: 2/26/2018 1:56 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
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
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	CAFETERIA SALES	B	-195,130	CAFETERIA	11.00	0	33.00
33.01	MEDICAL RECORDS FEES	B	-12,574	MEDICAL RECORDS & LIBRARY	16.00	0	33.01
33.02	SUPPLY REBATES AND DISCOUNTS	B	-20,780	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	OTHER REVENUE	B	-52,559	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	DIABETIC COUNSELING	B	-15,834	NURSING ADMINISTRATION	13.00	0	33.04
33.05	CRNA OFFSET	A	-969,583	ANESTHESIOLOGY	53.00	0	33.05
33.06	PHYSICIAN RECRUITMENT	A	-282,511	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	ADVERTISING EXPENSE	A	-69,139	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	SENIOR PROGRAM	A	-14,811	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	SWITCHBOARD SALARY	A	-8,598	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	SWITCHBOARD EH&W	A	-2,803	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.10
33.11	PAT TELEPHONE EXPENSE	A	-15,598	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	PAT TELEPHONE DEPRECIATION	A	-3,996	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	33.12
33.13	HEALTH EDUCATION	B	-118,313	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	VENDING MACHINE REVENUE	B	1,913	CAFETERIA	11.00	0	33.14
33.15	PHARMACY EMPLOYEE SALES	B	-80,427	DRUGS CHARGED TO PATIENTS	73.00	0	33.15
33.16	IHA AND AHA DUES	A	-687	ADMINISTRATIVE & GENERAL	5.00	0	33.16
33.17	LAND RENT	B	-3,005	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	CLINIC RENTAL	B	-29,261	ELECTROCARDIOLOGY	69.00	0	33.18
33.19	CONFERENCE ROOM RENTAL	B	-200	ADMINISTRATIVE & GENERAL	5.00	0	33.19
33.20	VENDOR/CONTRACT REV	B	-37,787	ADMINISTRATIVE & GENERAL	5.00	0	33.20
33.21	OTHER REVENUE	B	-2,229	MEDICAL RECORDS & LIBRARY	16.00	0	33.21
33.22	EHR DEPRECIATION	A	-120,004	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	33.22
33.23	HAF	A	-1,200,978	ADMINISTRATIVE & GENERAL	5.00	0	33.23
33.24	340B OFFSET	B	-298,721	DRUGS CHARGED TO PATIENTS	73.00	0	33.24
33.25	JAY COUNTY ER REIMBURSEMENT	B	-45,067	EMERGENCY	91.00	0	33.25
33.26	MERIDIAN HEALTH WEST JAY REIMB	B	-649,384	WEST JAY CLINIC	194.02	0	33.26
33.27	MERIDIAN HEALTH CONV CARE REIMB	B	-208,873	CONVENIENT CARE	194.03	0	33.27
33.28	INTEREST REVENUE	B	-4,348	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	33.28
33.29	PENSION EXPENSE	A	3,705,860	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.29
33.30	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.30
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-5,628,892				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 10/01/2016 To 09/30/2017 | Worksheet A-8-1 | Date/Time Prepared: 2/26/2018 1:56 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	66.00	PHYSICAL THERAPY	RENT/LEASE EXPENSE	30,119	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.			30,119	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 10/01/2016 To 09/30/2017	Worksheet A-8-1 Date/Time Prepared: 2/26/2018 1:56 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	-29,881	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	-29,881			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 10/01/2016 To 09/30/2017 | Worksheet A-8-2 | Date/Time Prepared: 2/26/2018 1:56 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	60.00	LABORATORY	65,000	65,000	0	0	0	1.00
2.00	90.00	CLINIC	115,970	115,970	0	0	0	2.00
3.00	90.01	FAMILY PRACTICE OF JAY COUNTY	1,548,676	1,548,676	0	0	0	3.00
4.00	90.02	JAY FAMILY MEDICINE	1,477,553	1,477,553	0	0	0	4.00
5.00	91.00	EMERGENCY	1,971,548	1,636,385	335,163	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			5,178,747	4,843,584	335,163		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	60.00	LABORATORY	0	0	0	0	0	1.00
2.00	90.00	CLINIC	0	0	0	0	0	2.00
3.00	90.01	FAMILY PRACTICE OF JAY COUNTY	0	0	0	0	0	3.00
4.00	90.02	JAY FAMILY MEDICINE	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	60.00	LABORATORY	0	0	0	65,000		1.00
2.00	90.00	CLINIC	0	0	0	115,970		2.00
3.00	90.01	FAMILY PRACTICE OF JAY COUNTY	0	0	0	1,548,676		3.00
4.00	90.02	JAY FAMILY MEDICINE	0	0	0	1,477,553		4.00
5.00	91.00	EMERGENCY	0	0	0	1,636,385		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	4,843,584		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 15-1320	Period: From 10/01/2016 To 09/30/2017	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/26/2018 1:56 pm

		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	122.00	3,190.00	2,090.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	92.52	80.45	52.30	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)	40.23	40.23	26.15			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)	11,287	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	256,636	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	109,307	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	377,230	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)	377,230	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)	377,230	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 10/01/2016 To 09/30/2017 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 2/26/2018 1:56 pm

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)	80.45	52.30	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)	377,230		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)	377,230		63.00
64.00	Total cost of outside supplier services (from your records)	249,582		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 10/01/2016 To 09/30/2017	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/26/2018 1:56 pm

		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	2,094.00	6,242.00	0.00	1,970.00	0.00	9.00
10.00	AHSEA (see instructions)	72.73	63.25	0.00	47.43	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)	31.63	31.63	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)	152,297	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	394,807	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)	547,104	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	93,437	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)	640,541	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)	640,541	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)	5.00	0.00	7.00	0.00	12.00	47.00
48.00	Overtime rate (see instructions)	94.88	0.00	71.15	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	474.40	0.00	498.05	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)	41.67	0.00	58.33	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)	866.74	0.00	1,213.26	0.00	2,080.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	63.25	0.00	47.43	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	54,821	0	57,545	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	474	0	498	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	316	0	332	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.)	158	0	166	0	324	56.00

			1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)		640,541	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)		324	60.00
61.00	Equipment cost (see instructions)		0	61.00
62.00	Supplies (see instructions)		5,655	62.00
63.00	Total allowance (sum of lines 57-62)		646,520	63.00
64.00	Total cost of outside supplier services (from your records)		354,571	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	0.00	1,605.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	76.27	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)	38.14	38.14	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)		122,413	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)		122,413	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)		122,413	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)		122,413	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)	76.27	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)		122,413	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)		122,413	63.00
64.00	Total cost of outside supplier services (from your records)		74,188	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 10/01/2016 To 09/30/2017	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/26/2018 1:56 pm

		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	438.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	73.31	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)	36.66	36.66	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)		32,110	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)		32,110	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)		32,110	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)		73.31	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)		57,182	22.00
23.00	Total salary equivalency (see instructions)		57,182	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 10/01/2016 To 09/30/2017 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 2/26/2018 1:56 pm

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)	73.31	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)	57,182	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)	57,182	63.00
64.00	Total cost of outside supplier services (from your records)	19,224	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 10/01/2016 To 09/30/2017 | Worksheet B Part I | Date/Time Prepared: 2/26/2018 1:56 pm

		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	1,705,735	1,705,735				2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP MOB	8,689	0	8,689			2.01
2.02	00202	NEW CAP REL COSTS-MVBLE EQUIP-POB	101,949	0	0	101,949		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	6,368,507	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,964,516	179,916	1,526	8,476	0	5.00
7.00	00700	OPERATION OF PLANT	1,202,108	122,878	1,276	6,116	0	7.00
7.01	00701	OPERATION OF PLANT-MOB	58,818	0	0	0	0	7.01
7.02	00702	OPERATION OF PLANT-POB	97,884	0	0	0	0	7.02
7.03	00703	OPERATION OF PLANT-WJ	3,450	0	0	0	0	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	100,154	9,766	0	0	0	8.00
9.00	00900	HOUSEKEEPING	456,396	10,907	0	0	0	9.00
10.00	01000	DIETARY	373,136	45,714	0	0	0	10.00
11.00	01100	CAFETERIA	76,190	45,100	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,031,240	36,585	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	70,791	27,608	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	381,224	31,164	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,472,519	261,557	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
40.00	04000	SUBPROVIDER - IPF	851,743	100,821	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	103,605	22,671	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,376,122	118,730	0	45,843	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	24,587	2,787	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,454,214	137,582	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	1,917,800	56,117	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	371,414	12,246	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	565,851	2,392	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	74,188	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	19,224	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	321,533	43,937	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	31,310	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,771,108	22,517	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	48,076	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	353,536	0	5,887	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	407,744	189,616	0	0	0	90.02
91.00	09100	EMERGENCY	834,137	99,680	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	19,750	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 through 117)	30,050,390	1,580,291	8,689	60,435	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	19,883	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

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I Date/Time Prepared: 2/26/2018 1:56 pm

		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	
194.03	07953	CONVENIENT CARE	0	20,673	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	1,473,542	0	0	41,514	0	194.06
194.07	07957	HOSPITALIST	527,227	0	0	0	0	194.07
194.08	07958	FAMILY FIRST HEALTH	906,565	84,888	0	0	0	194.08
194.09	07959	MERIDIAN HEALTH CONVENIENT CARE	0	0	0	0	0	194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	32,957,724	1,705,735	8,689	101,949	31,142	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I Date/Time Prepared: 2/26/2018 1:56 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT-MOB	
			4.00	4A	5.00	7.00	7.01	
		GENERAL SERVICE COST CENTERS						
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	6,368,507					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	838,437	6,992,871	6,992,871			5.00
7.00	00700	OPERATION OF PLANT	92,897	1,425,275	383,856	1,809,131		7.00
7.01	00701	OPERATION OF PLANT-MOB	4,591	63,409	17,077	0	80,486	7.01
7.02	00702	OPERATION OF PLANT-POB	2,478	100,362	27,030	0	0	7.02
7.03	00703	OPERATION OF PLANT-WJ	1,259	4,709	1,268	0	0	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	20,444	130,364	35,110	12,594	0	8.00
9.00	00900	HOUSEKEEPING	144,508	611,811	164,774	14,065	0	9.00
10.00	01000	DIETARY	76,388	495,238	133,378	58,950	0	10.00
11.00	01100	CAFETERIA	55,153	176,443	47,520	58,157	0	11.00
13.00	01300	NURSING ADMINISTRATION	377,230	1,445,055	389,184	47,177	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	23,003	121,402	32,696	35,602	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	122,334	534,722	144,012	40,187	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	476,945	2,211,021	595,474	337,285	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
40.00	04000	SUBPROVIDER - IPF	246,915	1,199,479	323,045	130,012	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	34,728	161,004	43,362	29,234	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	296,508	1,837,203	494,797	153,105	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,272	35,646	9,600	3,594	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	286,649	1,878,445	505,905	177,415	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	241,380	2,215,297	596,616	72,364	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	383,660	103,328	15,792	0	65.00
66.00	06600	PHYSICAL THERAPY	0	568,243	153,040	3,085	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	74,188	19,980	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	19,224	5,177	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	68,122	433,592	116,775	56,657	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	31,310	8,432	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	158,791	1,952,416	525,827	29,036	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	48,076	12,948	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	593,284	952,707	256,584	0	80,486	90.01
90.02	09002	JAY FAMILY MEDICINE	596,855	1,194,215	321,627	244,515	0	90.02
91.00	09100	EMERGENCY	766,240	1,700,057	457,861	128,540	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	281	20,031	5,395	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 through 117)	5,533,692	29,017,475	5,931,678	1,647,366	80,486	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	19,883	5,355	25,640	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	224,759	255,901	68,920	0	0	194.02
194.03	07953	CONVENIENT CARE	71,289	91,962	24,767	26,659	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	89,593	1,604,649	432,166	0	0	194.06

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I Date/Time Prepared: 2/26/2018 1:56 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT-MOB	
			4.00	4A	5.00	7.00	7.01	
194.07	07957	HOSPITALIST	157,486	684,713	184,408	0	0	194.07
194.08	07958	FAMILY FIRST HEALTH	291,688	1,283,141	345,577	109,466	0	194.08
194.09	07959	MERIDIAN HEALTH CONVENIENT CARE	0	0	0	0	0	194.09
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	6,368,507	32,957,724	6,992,871	1,809,131	80,486	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I | Date/Time Prepared: 2/26/2018 1:56 pm

		Cost Center Description	OPERATION OF PLANT-POB	OPERATION OF PLANT-WJ	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			7.02	7.03	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
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	127,392					7.02
7.03	00703	OPERATION OF PLANT-WJ	0	5,977				7.03
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	178,068			8.00
9.00	00900	HOUSEKEEPING	0	0	21,563	812,213		9.00
10.00	01000	DIETARY	0	0	5,565	22,099	715,230	10.00
11.00	01100	CAFETERIA	0	0	0	21,801	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	17,685	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	13,346	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	15,065	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	81,634	126,437	515,447	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
40.00	04000	SUBPROVIDER - IPF	0	0	4,405	48,738	199,783	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	3,227	10,959	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	66,853	0	18,549	107,490	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,347	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	14,143	66,508	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	27,127	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	5,920	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,159	1,156	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	3,710	21,239	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	10,885	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	58,551	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	0	91,662	0	90.02
91.00	09100	EMERGENCY	0	0	24,113	48,186	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 through 117)	66,853	0	178,068	716,201	715,230	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	9,612	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	5,977	0	0	0	194.02
194.03	07953	CONVENIENT CARE	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	60,539	0	0	45,364	0	194.06
194.07	07957	HOSPITALIST	0	0	0	0	0	194.07

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I Date/Time Prepared: 2/26/2018 1:56 pm

		Cost Center Description	OPERATION OF PLANT-POB	OPERATION OF PLANT-WJ	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			7.02	7.03	8.00	9.00	10.00	
194.08	07958	FAMILY FIRST HEALTH	0	0	0	41,036	0	194.08
194.09	07959	MERIDIAN HEALTH CONVENIENT CARE	0	0	0	0	0	194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	127,392	5,977	178,068	812,213	715,230	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I | Date/Time Prepared: 2/26/2018 1:56 pm

		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	303,921					11.00
13.00	01300	NURSING ADMINISTRATION	31,312	1,930,413				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,550	0	207,596			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	19,069	0	281	753,336		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	58,467	699,741	12,695	47,372	4,685,573	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
40.00	04000	SUBPROVIDER - IPF	29,596	354,202	790	7,250	2,297,300	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	3,661	43,811	0	1,283	296,541	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	30,092	360,142	50,261	115,061	3,233,553	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	745	8,911	0	1,753	61,596	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,962	0	20,612	233,844	2,924,834	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	32,884	0	55,536	160,073	3,159,897	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	1,558	8,009	518,267	65.00
66.00	06600	PHYSICAL THERAPY	0	0	580	19,102	746,365	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,334	97,502	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	697	25,098	68.00
69.00	06900	ELECTROCARDIOLOGY	13,940	0	3,236	22,016	671,165	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	722	40,464	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,906	0	1,502	43,585	2,576,157	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	1,921	54	62,999	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	0	22,017	9,161	1,379,506	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	13,295	6,491	1,871,805	90.02
91.00	09100	EMERGENCY	38,737	463,606	10,390	73,201	2,944,691	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	328	25,754	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 through 117)	303,921	1,930,413	194,674	753,336	27,619,067	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	60,490	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	443	0	331,241	194.02
194.03	07953	CONVENIENT CARE	0	0	1,032	0	144,420	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	2,258	0	2,144,976	194.06

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I Date/Time Prepared: 2/26/2018 1:56 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	Subtotal	
			11.00	13.00	14.00	16.00	24.00	
194.07	07957	HOSPITALIST	0	0	0	0	869,121	194.07
194.08	07958	FAMILY FIRST HEALTH	0	0	9,189	0	1,788,409	194.08
194.09	07959	MERIDIAN HEALTH CONVENIENT CARE	0	0	0	0	0	194.09
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	303,921	1,930,413	207,596	753,336	32,957,724	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I | Date/Time Prepared: 2/26/2018 1:56 pm

		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	4,685,573		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0		33.00
40.00	04000	SUBPROVIDER - IPF	0	2,297,300		40.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
42.00	04200	SUBPROVIDER	0	0		42.00
43.00	04300	NURSERY	0	296,541		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	3,233,553		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	61,596		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,924,834		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	3,159,897		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	518,267		65.00
66.00	06600	PHYSICAL THERAPY	0	746,365		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	97,502		67.00
68.00	06800	SPEECH PATHOLOGY	0	25,098		68.00
69.00	06900	ELECTROCARDIOLOGY	0	671,165		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	40,464		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,576,157		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	62,999		90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	1,379,506		90.01
90.02	09002	JAY FAMILY MEDICINE	0	1,871,805		90.02
91.00	09100	EMERGENCY	0	2,944,691		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	25,754		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 through 117)	0	27,619,067		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	60,490		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	0	331,241		194.02
194.03	07953	CONVENIENT CARE	0	144,420		194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.04

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I Date/Time Prepared: 2/26/2018 1:56 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
194.05	07955	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.05
194.06	07956	TRI COUNTY	0	2,144,976		194.06
194.07	07957	HOSPITALIST	0	869,121		194.07
194.08	07958	FAMILY FIRST HEALTH	0	1,788,409		194.08
194.09	07959	MERIDIAN HEALTH CONVENIENT CARE	0	0		194.09
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	32,957,724		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II | Date/Time Prepared: 2/26/2018 1:56 pm

		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	179,916	1,526	8,476	0	5.00
7.00	00700	OPERATION OF PLANT	0	122,878	1,276	6,116	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	9,766	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	10,907	0	0	0	9.00
10.00	01000	DIETARY	0	45,714	0	0	0	10.00
11.00	01100	CAFETERIA	0	45,100	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	36,585	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	27,608	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	31,164	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	261,557	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
40.00	04000	SUBPROVIDER - IPF	0	100,821	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	22,671	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	118,730	0	45,843	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,787	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	137,582	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	56,117	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	12,246	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	2,392	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	43,937	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	22,517	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	5,887	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0	189,616	0	0	0	90.02
91.00	09100	EMERGENCY	0	99,680	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 through 117)	0	1,580,291	8,689	60,435	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	19,883	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	CONVENIENT CARE	0	20,673	0	0	0	194.03

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II Date/Time Prepared: 2/26/2018 1:56 pm

		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	
194.04	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	41,514	0	194.06
194.07	07957	HOSPITALIST	0	0	0	0	0	194.07
194.08	07958	FAMILY FIRST HEALTH	0	84,888	0	0	0	194.08
194.09	07959	MERIDIAN HEALTH CONVENIENT CARE	0	0	0	0	0	194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,705,735	8,689	101,949	31,142	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II Date/Time Prepared: 2/26/2018 1:56 pm

		Cost Center Description	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT-MOB	
			2A	4.00	5.00	7.00	7.01	
		GENERAL SERVICE COST CENTERS						
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	189,918	0	189,918			5.00
7.00	00700	OPERATION OF PLANT	130,270	0	10,424	140,694		7.00
7.01	00701	OPERATION OF PLANT-MOB	0	0	464	0	464	7.01
7.02	00702	OPERATION OF PLANT-POB	0	0	734	0	0	7.02
7.03	00703	OPERATION OF PLANT-WJ	0	0	34	0	0	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	9,766	0	953	979	0	8.00
9.00	00900	HOUSEKEEPING	10,907	0	4,475	1,094	0	9.00
10.00	01000	DIETARY	45,714	0	3,622	4,584	0	10.00
11.00	01100	CAFETERIA	45,100	0	1,291	4,523	0	11.00
13.00	01300	NURSING ADMINISTRATION	36,585	0	10,569	3,669	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	27,608	0	888	2,769	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	31,164	0	3,911	3,125	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	261,557	0	16,171	26,230	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
40.00	04000	SUBPROVIDER - IPF	100,821	0	8,773	10,111	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	22,671	0	1,178	2,274	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	164,573	0	13,437	11,907	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,787	0	261	280	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	137,582	0	13,739	13,797	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	56,117	0	16,214	5,628	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	12,246	0	2,806	1,228	0	65.00
66.00	06600	PHYSICAL THERAPY	2,392	0	4,156	240	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	543	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	141	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	43,937	0	3,171	4,406	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	229	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,517	0	14,280	2,258	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	352	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	5,887	0	6,968	0	464	90.01
90.02	09002	JAY FAMILY MEDICINE	189,616	0	8,734	19,016	0	90.02
91.00	09100	EMERGENCY	99,680	0	12,434	9,996	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	147	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 through 117)	1,649,415	0	161,099	128,114	464	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19,883	0	145	1,994	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	1,872	0	0	194.02
194.03	07953	CONVENIENT CARE	20,673	0	673	2,073	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	41,514	0	11,736	0	0	194.06

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II Date/Time Prepared: 2/26/2018 1:56 pm

		Cost Center Description	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT-MOB	
			2A	4.00	5.00	7.00	7.01	
194.07	07957	HOSPITALIST	0	0	5,008	0	0	194.07
194.08	07958	FAMILY FIRST HEALTH	84,888	0	9,385	8,513	0	194.08
194.09	07959	MERIDIAN HEALTH CONVENIENT CARE	0	0	0	0	0	194.09
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,847,515	0	189,918	140,694	464	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II | Date/Time Prepared: 2/26/2018 1:56 pm

		Cost Center Description	OPERATION OF PLANT-POB	OPERATION OF PLANT-WJ	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			7.02	7.03	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
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	734					7.02
7.03	00703	OPERATION OF PLANT-WJ	0	34				7.03
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	11,698			8.00
9.00	00900	HOUSEKEEPING	0	0	1,417	17,893		9.00
10.00	01000	DIETARY	0	0	366	487	54,773	10.00
11.00	01100	CAFETERIA	0	0	0	480	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	390	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	294	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	332	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	5,362	2,785	39,473	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
40.00	04000	SUBPROVIDER - IPF	0	0	289	1,074	15,300	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	212	241	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	385	0	1,219	2,368	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	30	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	929	1,465	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	598	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	130	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	76	25	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	244	468	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	240	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	1,290	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	0	2,019	0	90.02
91.00	09100	EMERGENCY	0	0	1,584	1,062	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 through 117)	385	0	11,698	15,778	54,773	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	212	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	34	0	0	0	194.02
194.03	07953	CONVENIENT CARE	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	349	0	0	999	0	194.06
194.07	07957	HOSPITALIST	0	0	0	0	0	194.07

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II Date/Time Prepared: 2/26/2018 1:56 pm

		Cost Center Description	OPERATION OF PLANT-POB	OPERATION OF PLANT-WJ	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			7.02	7.03	8.00	9.00	10.00	
194.08	07958	FAMILY FIRST HEALTH	0	0	0	904	0	194.08
194.09	07959	MERIDIAN HEALTH CONVENIENT CARE	0	0	0	0	0	194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	734	34	11,698	17,893	54,773	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II | Date/Time Prepared: 2/26/2018 1:56 pm

		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	51,394					11.00
13.00	01300	NURSING ADMINISTRATION	5,295	56,508				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	769	0	32,328			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,225	0	44	41,801		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,887	20,484	1,977	2,631	386,557	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
40.00	04000	SUBPROVIDER - IPF	5,005	10,368	123	403	152,267	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	619	1,282	0	71	28,548	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,089	10,542	7,827	6,390	223,737	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	126	261	0	97	3,842	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,728	0	3,210	12,951	188,401	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	5,561	0	8,648	8,890	101,656	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	243	445	17,098	65.00
66.00	06600	PHYSICAL THERAPY	0	0	90	1,061	8,040	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	185	728	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	39	180	68.00
69.00	06900	ELECTROCARDIOLOGY	2,357	0	504	1,223	56,310	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	40	269	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,182	0	234	2,420	44,131	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	299	3	654	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	0	3,428	509	18,546	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	2,070	360	221,815	90.02
91.00	09100	EMERGENCY	6,551	13,571	1,618	4,065	150,561	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	18	165	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 through 117)	51,394	56,508	30,315	41,801	1,603,505	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	22,234	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	69	0	33,117	194.02
194.03	07953	CONVENIENT CARE	0	0	161	0	23,580	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	352	0	54,950	194.06

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II Date/Time Prepared: 2/26/2018 1:56 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	Subtotal	
			11.00	13.00	14.00	16.00	24.00	
194.07	07957	HOSPITALIST	0	0	0	0	5,008	194.07
194.08	07958	FAMILY FIRST HEALTH	0	0	1,431	0	105,121	194.08
194.09	07959	MERIDIAN HEALTH CONVENIENT CARE	0	0	0	0	0	194.09
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	51,394	56,508	32,328	41,801	1,847,515	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II | Date/Time Prepared: 2/26/2018 1:56 pm

		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	386,557		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0		33.00
40.00	04000	SUBPROVIDER - IPF	0	152,267		40.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
42.00	04200	SUBPROVIDER	0	0		42.00
43.00	04300	NURSERY	0	28,548		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	223,737		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,842		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	188,401		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	101,656		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	17,098		65.00
66.00	06600	PHYSICAL THERAPY	0	8,040		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	728		67.00
68.00	06800	SPEECH PATHOLOGY	0	180		68.00
69.00	06900	ELECTROCARDIOLOGY	0	56,310		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	269		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	44,131		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	654		90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	18,546		90.01
90.02	09002	JAY FAMILY MEDICINE	0	221,815		90.02
91.00	09100	EMERGENCY	0	150,561		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	165		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 through 117)	0	1,603,505		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	22,234		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	0	33,117		194.02
194.03	07953	CONVENIENT CARE	0	23,580		194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.04

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II Date/Time Prepared: 2/26/2018 1:56 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
194.05	07955	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.05
194.06	07956	TRI COUNTY	0	54,950		194.06
194.07	07957	HOSPITALIST	0	5,008		194.07
194.08	07958	FAMILY FIRST HEALTH	0	105,121		194.08
194.09	07959	MERIDIAN HEALTH CONVENIENT CARE	0	0		194.09
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,847,515		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/26/2018 1:56 pm

		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	77,723					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	17,444,955	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,198	1,431	873	0	2,296,687	5.00
7.00	00700	OPERATION OF PLANT	5,599	1,196	630	0	254,469	7.00
7.01	00701	OPERATION OF PLANT-MOB	0	0	0	0	12,575	7.01
7.02	00702	OPERATION OF PLANT-POB	0	0	0	0	6,788	7.02
7.03	00703	OPERATION OF PLANT-WJ	0	0	0	0	3,450	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	445	0	0	0	56,001	8.00
9.00	00900	HOUSEKEEPING	497	0	0	0	395,845	9.00
10.00	01000	DIETARY	2,083	0	0	0	209,246	10.00
11.00	01100	CAFETERIA	2,055	0	0	0	151,077	11.00
13.00	01300	NURSING ADMINISTRATION	1,667	0	0	0	1,033,328	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,258	0	0	0	63,011	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,420	0	0	0	335,105	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,918	0	0	0	1,306,473	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
40.00	04000	SUBPROVIDER - IPF	4,594	0	0	0	676,362	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	95,130	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,410	0	4,722	0	812,211	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	127	0	0	0	22,660	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,269	0	0	0	785,205	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	661,200	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	186,604	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	1,026	0	0	0	434,970	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	5,519	0	0	1,625,156	90.01
90.02	09002	JAY FAMILY MEDICINE	8,640	0	0	0	1,634,938	90.02
91.00	09100	EMERGENCY	4,542	0	0	0	2,098,925	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	771	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 through 117)	72,007	8,146	6,225	0	15,158,187	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	615,672	194.02

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/26/2018 1:56 pm

		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	
194.03	07953	CONVENIENT CARE	942	0	0	0	195,278	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	4,276	0	245,418	194.06
194.07	07957	HOSPITALIST	0	0	0	0	431,393	194.07
194.08	07958	FAMILY FIRST HEALTH	3,868	0	0	0	799,007	194.08
194.09	07959	MERIDIAN HEALTH CONVENIENT CARE	0	0	0	0	0	194.09
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)	1,705,735	8,689	101,949	31,142	6,368,507	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	21.946335	1.066658	9.708504	9.436970	0.365063	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 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/26/2018 1:56 pm

		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	-6,992,871	25,964,853				5.00
7.00	00700	OPERATION OF PLANT	0	1,425,275	63,926			7.00
7.01	00701	OPERATION OF PLANT-MOB	0	63,409	0	5,519		7.01
7.02	00702	OPERATION OF PLANT-POB	0	100,362	0	0	8,998	7.02
7.03	00703	OPERATION OF PLANT-WJ	0	4,709	0	0	0	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	0	130,364	445	0	0	8.00
9.00	00900	HOUSEKEEPING	0	611,811	497	0	0	9.00
10.00	01000	DIETARY	0	495,238	2,083	0	0	10.00
11.00	01100	CAFETERIA	0	176,443	2,055	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,445,055	1,667	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	121,402	1,258	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	534,722	1,420	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,211,021	11,918	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
40.00	04000	SUBPROVIDER - IPF	0	1,199,479	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	161,004	1,033	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,837,203	5,410	0	4,722	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	35,646	127	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,878,445	6,269	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	2,215,297	2,557	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	383,660	558	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	568,243	109	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	74,188	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	19,224	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	433,592	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	31,310	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,952,416	1,026	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	48,076	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	952,707	0	5,519	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0	1,194,215	8,640	0	0	90.02
91.00	09100	EMERGENCY	0	1,700,057	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	20,031	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 through 117)	-6,992,871	22,024,604	58,210	5,519	4,722	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	19,883	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	255,901	0	0	0	194.02
194.03	07953	CONVENIENT CARE	0	91,962	942	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

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/26/2018 1:56 pm

		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	
194.06	07956	TRI COUNTY	0	1,604,649	0	0	4,276	194.06
194.07	07957	HOSPITALIST	0	684,713	0	0	0	194.07
194.08	07958	FAMILY FIRST HEALTH	0	1,283,141	3,868	0	0	194.08
194.09	07959	MERIDIAN HEALTH CONVENIENT CARE	0	0	0	0	0	194.09
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)		6,992,871	1,809,131	80,486	127,392	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.269321	28.300394	14.583439	14.157813	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		189,918	140,694	464	734	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.007314	2.200889	0.084073	0.081574	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/26/2018 1:56 pm

		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	46,080				8.00
9.00	00900	HOUSEKEEPING	0	5,580	76,559			9.00
10.00	01000	DIETARY	0	1,440	2,083	38,335		10.00
11.00	01100	CAFETERIA	0	0	2,055	0	14,695	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	1,667	0	1,514	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	1,258	0	220	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	1,420	0	922	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	21,125	11,918	27,627	2,827	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
40.00	04000	SUBPROVIDER - IPF	0	1,140	4,594	10,708	1,431	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	835	1,033	0	177	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,800	10,132	0	1,455	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	127	0	36	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,660	6,269	0	1,352	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	2,557	0	1,590	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	558	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	300	109	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	960	2,002	0	674	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	1,026	0	624	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	5,519	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	8,640	0	0	90.02
91.00	09100	EMERGENCY	0	6,240	4,542	0	1,873	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 through 117)	0	46,080	67,509	38,335	14,695	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	906	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	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	3,300	0	0	0	0	194.02
194.03	07953	CONVENIENT CARE	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

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/26/2018 1:56 pm

		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	
194.06	07956	TRI COUNTY	0	0	4,276	0	0	194.06
194.07	07957	HOSPITALIST	0	0	0	0	0	194.07
194.08	07958	FAMILY FIRST HEALTH	0	0	3,868	0	0	194.08
194.09	07959	MERIDIAN HEALTH CONVENIENT CARE	0	0	0	0	0	194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	5,977	178,068	812,213	715,230	303,921	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.811212	3.864323	10.608981	18.657363	20.681933	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	34	11,698	17,893	54,773	51,394	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.010303	0.253863	0.233715	1.428799	3.497380	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/26/2018 1:56 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING FTE)	CENTRAL SERVICES & SUPPLY (SUPPLY COST)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	14.00	16.00		
		GENERAL SERVICE COST CENTERS					
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP MOB					2.01
2.02	00202	NEW CAP REL COSTS-MVBLE EQUIP-POB					2.02
2.03	00203	NEW CAP REL COSTS-MVBLE EQUIP- WJ					2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	OPERATION OF PLANT-MOB					7.01
7.02	00702	OPERATION OF PLANT-POB					7.02
7.03	00703	OPERATION OF PLANT-WJ					7.03
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION	7,799				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,243,692			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,042	91,151,824		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	2,827	137,205	5,731,662		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0		33.00
40.00	04000	SUBPROVIDER - IPF	1,431	8,534	877,200		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	177	0	155,190		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,455	543,224	13,921,505		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	36	0	212,077		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	222,779	28,297,398		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	600,217	19,367,602		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	16,843	969,022		65.00
66.00	06600	PHYSICAL THERAPY	0	6,264	2,311,157		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	403,351		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	84,381		68.00
69.00	06900	ELECTROCARDIOLOGY	0	34,978	2,663,778		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	87,387		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	16,238	5,273,419		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	20,766	6,512		90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	237,955	1,108,429		90.01
90.02	09002	JAY FAMILY MEDICINE	0	143,696	785,333		90.02
91.00	09100	EMERGENCY	1,873	112,293	8,856,702		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	39,719		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 through 117)	7,799	2,104,034	91,151,824		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	4,790	0		194.02
194.03	07953	CONVENIENT CARE	0	11,149	0		194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	0		194.04

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/26/2018 1:56 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING FTE)	CENTRAL SERVICES & SUPPLY (SUPPLY COST)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	14.00	16.00		
194.05	07955	OTHER NONREIMBURSABLE COST CENTERS	0	0	0		194.05
194.06	07956	TRI COUNTY	0	24,403	0		194.06
194.07	07957	HOSPITALIST	0	0	0		194.07
194.08	07958	FAMILY FIRST HEALTH	0	99,316	0		194.08
194.09	07959	MERIDIAN HEALTH CONVENIENT CARE	0	0	0		194.09
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)	1,930,413	207,596	753,336		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	247.520580	0.092524	0.008265		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	56,508	32,328	41,801		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	7.245544	0.014408	0.000459		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/26/2018 1:56 pm

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	4,685,573		4,685,573	0	4,685,573	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0	0	0	33.00
40.00	04000	SUBPROVIDER - IPF	2,297,300		2,297,300	0	2,297,300	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	296,541		296,541	0	296,541	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,233,553		3,233,553	0	3,233,553	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	61,596		61,596	0	61,596	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,924,834		2,924,834	0	2,924,834	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	3,159,897		3,159,897	0	3,159,897	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	518,267	0	518,267	0	518,267	65.00
66.00	06600	PHYSICAL THERAPY	746,365	0	746,365	0	746,365	66.00
67.00	06700	OCCUPATIONAL THERAPY	97,502	0	97,502	0	97,502	67.00
68.00	06800	SPEECH PATHOLOGY	25,098	0	25,098	0	25,098	68.00
69.00	06900	ELECTROCARDIOLOGY	671,165		671,165	0	671,165	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	40,464		40,464	0	40,464	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,576,157		2,576,157	0	2,576,157	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	62,999		62,999	0	62,999	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1,379,506		1,379,506	0	1,379,506	90.01
90.02	09002	JAY FAMILY MEDICINE	1,871,805		1,871,805	0	1,871,805	90.02
91.00	09100	EMERGENCY	2,944,691		2,944,691	0	2,944,691	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	443,619		443,619		443,619	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	25,754		25,754	0	25,754	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)	28,062,686	0	28,062,686	0	28,062,686	200.00
201.00		Less Observation Beds	443,619		443,619		443,619	201.00
202.00		Total (see instructions)	27,619,067	0	27,619,067	0	27,619,067	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/26/2018 1:56 pm

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	5,355,003		5,355,003			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0			33.00
40.00	04000	SUBPROVIDER - IPF	877,200		877,200			40.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	155,190		155,190			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,817,069	11,104,436	13,921,505	0.232270	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	212,077	0	212,077	0.290442	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,624,672	26,672,726	28,297,398	0.103361	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	2,397,146	16,970,456	19,367,602	0.163154	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	610,879	358,143	969,022	0.534835	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	486,522	1,824,635	2,311,157	0.322940	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	125,952	277,399	403,351	0.241730	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	20,740	63,641	84,381	0.297437	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	176,756	2,487,022	2,663,778	0.251960	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	285	87,102	87,387	0.463044	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,615,091	3,658,328	5,273,419	0.488517	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	0	6,512	6,512	9.674294	0.000000	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	12,130	1,096,299	1,108,429	1.244560	0.000000	90.01
90.02	09002	JAY FAMILY MEDICINE	9,634	775,699	785,333	2.383454	0.000000	90.02
91.00	09100	EMERGENCY	366,324	8,490,378	8,856,702	0.332482	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,400	372,259	376,659	1.177774	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	39,719	39,719	0.648405	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)	16,867,070	74,284,754	91,151,824			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	16,867,070	74,284,754	91,151,824			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/26/2018 1:56 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
33.00	03300	BURN INTENSIVE CARE UNIT			33.00
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	0.232270		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.290442		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.103361		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	0.163154		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
65.00	06500	RESPIRATORY THERAPY	0.534835		65.00
66.00	06600	PHYSICAL THERAPY	0.322940		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.241730		67.00
68.00	06800	SPEECH PATHOLOGY	0.297437		68.00
69.00	06900	ELECTROCARDIOLOGY	0.251960		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.463044		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.488517		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	9.674294		90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1.244560		90.01
90.02	09002	JAY FAMILY MEDICINE	2.383454		90.02
91.00	09100	EMERGENCY	0.332482		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.177774		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.648405		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 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/26/2018 1:56 pm

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	4,685,573		4,685,573	0	4,685,573	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0	0	0	33.00
40.00	04000	SUBPROVIDER - IPF	2,297,300		2,297,300	0	2,297,300	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	296,541		296,541	0	296,541	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,233,553		3,233,553	0	3,233,553	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	61,596		61,596	0	61,596	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,924,834		2,924,834	0	2,924,834	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	3,159,897		3,159,897	0	3,159,897	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	518,267	0	518,267	0	518,267	65.00
66.00	06600	PHYSICAL THERAPY	746,365	0	746,365	0	746,365	66.00
67.00	06700	OCCUPATIONAL THERAPY	97,502	0	97,502	0	97,502	67.00
68.00	06800	SPEECH PATHOLOGY	25,098	0	25,098	0	25,098	68.00
69.00	06900	ELECTROCARDIOLOGY	671,165		671,165	0	671,165	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	40,464		40,464	0	40,464	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,576,157		2,576,157	0	2,576,157	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	62,999		62,999	0	62,999	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1,379,506		1,379,506	0	1,379,506	90.01
90.02	09002	JAY FAMILY MEDICINE	1,871,805		1,871,805	0	1,871,805	90.02
91.00	09100	EMERGENCY	2,944,691		2,944,691	0	2,944,691	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	443,619		443,619		443,619	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	25,754		25,754	0	25,754	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)	28,062,686	0	28,062,686	0	28,062,686	200.00
201.00		Less Observation Beds	443,619		443,619		443,619	201.00
202.00		Total (see instructions)	27,619,067	0	27,619,067	0	27,619,067	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/26/2018 1:56 pm

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	5,355,003		5,355,003			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0			33.00
40.00	04000	SUBPROVIDER - IPF	877,200		877,200			40.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	155,190		155,190			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,817,069	11,104,436	13,921,505	0.232270	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	212,077	0	212,077	0.290442	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,624,672	26,672,726	28,297,398	0.103361	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	2,397,146	16,970,456	19,367,602	0.163154	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	610,879	358,143	969,022	0.534835	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	486,522	1,824,635	2,311,157	0.322940	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	125,952	277,399	403,351	0.241730	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	20,740	63,641	84,381	0.297437	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	176,756	2,487,022	2,663,778	0.251960	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	285	87,102	87,387	0.463044	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,615,091	3,658,328	5,273,419	0.488517	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	0	6,512	6,512	9.674294	0.000000	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	12,130	1,096,299	1,108,429	1.244560	0.000000	90.01
90.02	09002	JAY FAMILY MEDICINE	9,634	775,699	785,333	2.383454	0.000000	90.02
91.00	09100	EMERGENCY	366,324	8,490,378	8,856,702	0.332482	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,400	372,259	376,659	1.177774	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	39,719	39,719	0.648405	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)	16,867,070	74,284,754	91,151,824			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	16,867,070	74,284,754	91,151,824			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/26/2018 1:56 pm

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
33.00	03300	BURN INTENSIVE CARE UNIT			33.00
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 10/01/2016 To 09/30/2017 | Worksheet D Part II Date/Time Prepared: 2/26/2018 1:56 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	223,737	13,921,505	0.016071	787,348	12,653	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,842	212,077	0.018116	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	188,401	28,297,398	0.006658	507,534	3,379	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	101,656	19,367,602	0.005249	788,957	4,141	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	17,098	969,022	0.017645	247,664	4,370	65.00
66.00	06600	PHYSICAL THERAPY	8,040	2,311,157	0.003479	115,438	402	66.00
67.00	06700	OCCUPATIONAL THERAPY	728	403,351	0.001805	68,081	123	67.00
68.00	06800	SPEECH PATHOLOGY	180	84,381	0.002133	15,267	33	68.00
69.00	06900	ELECTROCARDIOLOGY	56,310	2,663,778	0.021139	146,540	3,098	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	269	87,387	0.003078	285	1	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	44,131	5,273,419	0.008369	536,668	4,491	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	654	6,512	0.100430	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	18,546	1,108,429	0.016732	2,837	47	90.01
90.02	09002	JAY FAMILY MEDICINE	221,815	785,333	0.282447	2,010	568	90.02
91.00	09100	EMERGENCY	150,561	8,856,702	0.017000	3,093	53	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	36,598	376,659	0.097165	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	165	39,719	0.004154	0	0	93.00
200.00		Total (lines 50 through 199)	1,072,731	84,764,431		3,221,722	33,359	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV Date/Time Prepared: 2/26/2018 1:56 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/26/2018 1:56 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	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)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	13,921,505	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	212,077	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	28,297,398	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	19,367,602	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	969,022	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,311,157	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	403,351	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	84,381	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,663,778	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	87,387	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,273,419	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	6,512	0.000000	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	0	0	1,108,429	0.000000	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	0	785,333	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	8,856,702	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	376,659	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	39,719	0.000000	93.00
200.00		Total (lines 50 through 199)	0	0	0	84,764,431		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV Date/Time Prepared: 2/26/2018 1:56 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	787,348	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	507,534	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	0.000000	788,957	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.000000	247,664	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	115,438	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	68,081	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	15,267	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	146,540	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	285	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	536,668	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0.000000	2,837	0	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0.000000	2,010	0	0	0	90.02
91.00	09100	EMERGENCY	0.000000	3,093	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	93.00
200.00		Total (lines 50 through 199)		3,221,722	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part V Date/Time Prepared: 2/26/2018 1:56 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.232270	0	2,920,352	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.290442	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.103361	0	7,817,671	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	0.163154	0	5,913,116	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.534835	0	42,751	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.322940	0	722,372	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.241730	0	47,876	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.297437	0	12,979	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.251960	0	1,354,230	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	0.463044	0	53,169	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.488517	0	1,414,679	74,132	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	9.674294	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1.244560	0	190,814	11,285	0	90.01
90.02	09002	JAY FAMILY MEDICINE	2.383454	0	135,193	7,995	0	90.02
91.00	09100	EMERGENCY	0.332482	0	1,615,150	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.177774	0	160,889	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.648405	0	0	0	0	93.00
200.00		Subtotal (see instructions)		0	22,401,241	93,412	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	22,401,241	93,412	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part V Date/Time Prepared: 2/26/2018 1:56 pm

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	678,310	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	808,042	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	964,749	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	22,865	0		65.00
66.00	06600	PHYSICAL THERAPY	233,283	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	11,573	0		67.00
68.00	06800	SPEECH PATHOLOGY	3,860	0		68.00
69.00	06900	ELECTROCARDIOLOGY	341,212	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24,620	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	691,095	36,215		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	237,479	14,045		90.01
90.02	09002	JAY FAMILY MEDICINE	322,226	19,056		90.02
91.00	09100	EMERGENCY	537,008	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	189,491	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
200.00		Subtotal (see instructions)	5,065,813	69,316		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	5,065,813	69,316		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-1320 | Component CCN: 15-M320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part II | Date/Time Prepared: 2/26/2018 1:56 pm

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	223,737	13,921,505	0.016071	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,842	212,077	0.018116	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	188,401	28,297,398	0.006658	61,353	408	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	101,656	19,367,602	0.005249	153,756	807	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	17,098	969,022	0.017645	27,308	482	65.00
66.00	06600	PHYSICAL THERAPY	8,040	2,311,157	0.003479	8,158	28	66.00
67.00	06700	OCCUPATIONAL THERAPY	728	403,351	0.001805	3,030	5	67.00
68.00	06800	SPEECH PATHOLOGY	180	84,381	0.002133	2,108	4	68.00
69.00	06900	ELECTROCARDIOLOGY	56,310	2,663,778	0.021139	12,427	263	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	269	87,387	0.003078	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	44,131	5,273,419	0.008369	187,606	1,570	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	654	6,512	0.100430	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	18,546	1,108,429	0.016732	8,135	136	90.01
90.02	09002	JAY FAMILY MEDICINE	221,815	785,333	0.282447	5,763	1,628	90.02
91.00	09100	EMERGENCY	150,561	8,856,702	0.017000	28,186	479	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	376,659	0.000000	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	165	39,719	0.004154	0	0	93.00
200.00		Total (lines 50 through 199)	1,036,133	84,764,431		497,830	5,810	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1320 | Component CCN: 15-M320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV Date/Time Prepared: 2/26/2018 1:56 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1320 | Component CCN: 15-M320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/26/2018 1:56 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	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)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	13,921,505	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	212,077	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	28,297,398	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	19,367,602	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	969,022	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,311,157	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	403,351	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	84,381	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,663,778	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	87,387	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,273,419	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	6,512	0.000000	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	0	0	1,108,429	0.000000	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	0	785,333	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	8,856,702	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	376,659	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	39,719	0.000000	93.00
200.00		Total (lines 50 through 199)	0	0	0	84,764,431		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1320 | Component CCN: 15-M320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/26/2018 1:56 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	61,353	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	0.000000	153,756	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.000000	27,308	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	8,158	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	3,030	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	2,108	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	12,427	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	187,606	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0.000000	8,135	0	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0.000000	5,763	0	0	0	90.02
91.00	09100	EMERGENCY	0.000000	28,186	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	93.00
200.00		Total (lines 50 through 199)		497,830	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1320 | Component CCN: 15-Z320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part V Date/Time Prepared: 2/26/2018 1:56 pm

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	0.232270	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.290442	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.103361	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	0.163154	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.534835	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.322940	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.241730	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.297437	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.251960	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	0.463044	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.488517	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	9.674294	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1.244560	0	0	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	2.383454	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.332482	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.177774	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.648405	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 10/01/2016 To 09/30/2017 | Worksheet D Part V | Date/Time Prepared: 2/26/2018 1:56 pm

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 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/26/2018 1:56 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,045	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,679	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)	2,392	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)	351	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	4	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)	11	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,058	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)	249	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	137.32	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	137.32	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,685,573	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)	549	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)	1,511	25.00
26.00	Total swing-bed cost (see instructions)	544,604	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,140,969	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,140,969	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)	1,545.71	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,635,361	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)	1,635,361	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/26/2018 1:56 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT	0	0	0.00	0	0	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)	863,369	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,498,730	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)	384,882	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	384,882	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)	287	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,545.71	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	443,619	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/26/2018 1:56 pm

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	386,557	4,685,573	0.082499	443,619	36,598	90.00
91.00	Nursing School cost	0	4,685,573	0.000000	443,619	0	91.00
92.00	Allied health cost	0	4,685,573	0.000000	443,619	0	92.00
93.00	All other Medical Education	0	4,685,573	0.000000	443,619	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1320 Component CCN: 15-M320	Period: From 10/01/2016 To 09/30/2017	Worksheet D-1 Date/Time Prepared: 2/26/2018 1:56 pm
	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)	1,069	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,069	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)	1,069	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)	673	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)	2,297,300	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)	2,297,300	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)	2,297,300	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,149.02	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,446,290	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)	1,446,290	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-1320 | Component CCN: 15-M320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/26/2018 1:56 pm

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	0	0	0.00	0	0	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)	178,038	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,624,328	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)	5,810	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	5,810	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,618,518	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 10/01/2016 To 09/30/2017	Worksheet D-1 Date/Time Prepared: 2/26/2018 1:56 pm
	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	2,297,300	0.000000	0	0	90.00
91.00	Nursing School cost	0	2,297,300	0.000000	0	0	91.00
92.00	Allied health cost	0	2,297,300	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,297,300	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/26/2018 1:56 pm

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)	3,045	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,679	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)	2,392	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)	351	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	4	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)	11	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	16	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)	186	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)	4,685,573	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)	542,783	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,142,790	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,142,790	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)	1,546.39	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	24,742	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	24,742	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/26/2018 1:56 pm

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)	296,541	186	1,594.31	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	0	0	0.00	0	0	45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	17,558	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	42,300	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)	287	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,546.39	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	443,814	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/26/2018 1:56 pm

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	386,557	4,685,573	0.082499	443,814	36,614	90.00
91.00	Nursing School cost	0	4,685,573	0.000000	443,814	0	91.00
92.00	Allied health cost	0	4,685,573	0.000000	443,814	0	92.00
93.00	All other Medical Education	0	4,685,573	0.000000	443,814	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1320 Component CCN: 15-M320	Period: From 10/01/2016 To 09/30/2017	Worksheet D-1 Date/Time Prepared: 2/26/2018 1:56 pm
	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)	1,069	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,069	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)	1,069	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)	21	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)	186	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)	2,297,300	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)	2,297,300	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)	2,297,300	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,149.02	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	45,129	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)	45,129	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-1320 | Component CCN: 15-M320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/26/2018 1:56 pm

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	0	0	0.00	0	0	45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	8,868	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	53,997	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 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/26/2018 1:56 pm

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	152,267	2,297,300	0.066281	0	0	90.00
91.00	Nursing School cost	0	2,297,300	0.000000	0	0	91.00
92.00	Allied health cost	0	2,297,300	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,297,300	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-3 | Date/Time Prepared: 2/26/2018 1:56 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,831,860		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
33.00	03300	BURN INTENSIVE CARE UNIT		0		33.00
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	0.232270	787,348	182,877	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.290442	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.103361	507,534	52,459	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	0.163154	788,957	128,721	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.534835	247,664	132,459	65.00
66.00	06600	PHYSICAL THERAPY	0.322940	115,438	37,280	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.241730	68,081	16,457	67.00
68.00	06800	SPEECH PATHOLOGY	0.297437	15,267	4,541	68.00
69.00	06900	ELECTROCARDIOLOGY	0.251960	146,540	36,922	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.463044	285	132	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.488517	536,668	262,171	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	9.674294	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1.244560	2,837	3,531	90.01
90.02	09002	JAY FAMILY MEDICINE	2.383454	2,010	4,791	90.02
91.00	09100	EMERGENCY	0.332482	3,093	1,028	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.177774	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.648405	0	0	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		3,221,722	863,369	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		3,221,722		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1320 | Component CCN: 15-M320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-3 | Date/Time Prepared: 2/26/2018 1:56 pm

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
33.00	03300	BURN INTENSIVE CARE UNIT		0		33.00
40.00	04000	SUBPROVIDER - IPF		538,400		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	0.232270	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.290442	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.103361	61,353	6,342	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	0.163154	153,756	25,086	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.534835	27,308	14,605	65.00
66.00	06600	PHYSICAL THERAPY	0.322940	8,158	2,635	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.241730	3,030	732	67.00
68.00	06800	SPEECH PATHOLOGY	0.297437	2,108	627	68.00
69.00	06900	ELECTROCARDIOLOGY	0.251960	12,427	3,131	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.463044	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.488517	187,606	91,649	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	9.674294	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1.244560	8,135	10,124	90.01
90.02	09002	JAY FAMILY MEDICINE	2.383454	5,763	13,736	90.02
91.00	09100	EMERGENCY	0.332482	28,186	9,371	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.177774	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.648405	0	0	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		497,830	178,038	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)		497,830		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1320 | Component CCN: 15-Z320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-3 | Date/Time Prepared: 2/26/2018 1:56 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
33.00	03300	BURN INTENSIVE CARE UNIT		0		33.00
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	0.232270	40	9	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.290442	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.103361	12,327	1,274	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	0.163154	39,399	6,428	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.534835	35,990	19,249	65.00
66.00	06600	PHYSICAL THERAPY	0.322940	67,978	21,953	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.241730	54,841	13,257	67.00
68.00	06800	SPEECH PATHOLOGY	0.297437	3,365	1,001	68.00
69.00	06900	ELECTROCARDIOLOGY	0.251960	4,615	1,163	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.463044	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.488517	60,417	29,515	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	9.674294	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1.244560	251	312	90.01
90.02	09002	JAY FAMILY MEDICINE	2.383454	177	422	90.02
91.00	09100	EMERGENCY	0.332482	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.177774	4,400	5,182	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.648405	0	0	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		283,800	99,765	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)		283,800		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-3 | Date/Time Prepared: 2/26/2018 1:56 pm

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		22,421		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
33.00	03300	BURN INTENSIVE CARE UNIT		0		33.00
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	0.232270	28,146	6,537	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.290442	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.103361	9,123	943	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	0.163154	10,233	1,670	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.534835	1,915	1,024	65.00
66.00	06600	PHYSICAL THERAPY	0.322940	156	50	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.241730	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.297437	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.251960	317	80	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.463044	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.488517	6,660	3,254	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	9.674294	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1.244560	863	1,074	90.01
90.02	09002	JAY FAMILY MEDICINE	2.383454	629	1,499	90.02
91.00	09100	EMERGENCY	0.332482	4,292	1,427	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.177774	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.648405	0	0	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		62,334	17,558	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)		62,334		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1320 | Component CCN: 15-M320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-3 | Date/Time Prepared: 2/26/2018 1:56 pm

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
33.00	03300	BURN INTENSIVE CARE UNIT		0		33.00
40.00	04000	SUBPROVIDER - IPF		16,705		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	0.232270	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.290442	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.103361	1,874	194	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	0.163154	10,902	1,779	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.534835	448	240	65.00
66.00	06600	PHYSICAL THERAPY	0.322940	164	53	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.241730	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.297437	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.251960	68	17	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.463044	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.488517	6,639	3,243	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	9.674294	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1.244560	35	44	90.01
90.02	09002	JAY FAMILY MEDICINE	2.383454	995	2,372	90.02
91.00	09100	EMERGENCY	0.332482	2,785	926	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.177774	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.648405	0	0	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		23,910	8,868	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)		23,910		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1320 | Component CCN: 15-Z320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-3 | Date/Time Prepared: 2/26/2018 1:56 pm

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
33.00	03300	BURN INTENSIVE CARE UNIT		0		33.00
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	0.232270	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.290442	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.103361	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	0.163154	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.534835	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.322940	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.241730	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.297437	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.251960	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	0.463044	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.488517	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	9.674294	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1.244560	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	2.383454	0	0	90.02
91.00	09100	EMERGENCY	0.332482	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.177774	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.648405	0	0	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 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 10/01/2016 To 09/30/2017	Worksheet E Part B Date/Time Prepared: 2/26/2018 1:56 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,135,129	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	5,135,129	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) (see instructions)	5,186,480	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	97,144	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	3,307,980	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)	1,781,356	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)	1,781,356	30.00
31.00	Primary payer payments	708	31.00
32.00	Subtotal (line 30 minus line 31)	1,780,648	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)	576,206	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	374,534	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	540,492	36.00
37.00	Subtotal (see instructions)	2,155,182	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
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,155,182	40.00
40.01	Sequestration adjustment (see instructions)	43,104	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	2,270,919	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-158,841	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 10/01/2016 To 09/30/2017 | Worksheet E-1 Part I Date/Time Prepared: 2/26/2018 1:56 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,177,511		2,190,719	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	03/20/2017	80,200	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		80,200	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,177,511		2,270,919	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		771		158,841	6.02
7.00	Total Medicare program liability (see instructions)		2,176,740		2,112,078	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 10/01/2016 To 09/30/2017 | Worksheet E-1 Part I | Date/Time Prepared: 2/26/2018 1:56 pm

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		660,231		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)		660,231		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		660,231		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 10/01/2016 To 09/30/2017 | Worksheet E-1 Part I | Date/Time Prepared: 2/26/2018 1:56 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		463,900		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)		463,900		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		12,292		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		476,192		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1320	Period: From 10/01/2016 To 09/30/2017	Worksheet E-1 Part II Date/Time Prepared: 2/26/2018 1:56 pm
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 15-1320 | Component CCN: 15-Z320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E-2 | Date/Time Prepared: 2/26/2018 1:56 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	388,731	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)	100,763	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	249	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)	489,494	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	489,494	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)	489,494	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	3,584	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)	485,910	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	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	485,910	0	19.00
19.01	Sequestration adjustment (see instructions)	9,718	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	463,900	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)	12,292	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
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-1320 Component CCN: 15-Z320	Period: From 10/01/2016 To 09/30/2017	Worksheet E-2 Date/Time Prepared: 2/26/2018 1:56 pm
	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	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)			16.55
16.99	Demonstration payment adjustment amount before sequestration	0		16.99
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
19.02	Demonstration payment adjustment amount after sequestration)	0		19.02
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
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1320	Period: From 10/01/2016 To 09/30/2017	Worksheet E-3 Part V Date/Time Prepared: 2/26/2018 1:56 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	2,498,730	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)	2,498,730	4.00
5.00	Primary payer payments	7,719	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,515,998	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)	2,515,998	19.00
20.00	Deductibles (exclude professional component)	302,064	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	2,213,934	22.00
23.00	Coinsurance	4,277	23.00
24.00	Subtotal (line 22 minus line 23)	2,209,657	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	17,702	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	11,506	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	10,507	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	2,221,163	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	2,221,163	30.00
30.01	Sequestration adjustment (see instructions)	44,423	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	2,177,511	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	-771	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 10/01/2016 To 09/30/2017	Worksheet E-3 Part II Date/Time Prepared: 2/26/2018 1:56 pm
	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)	635,769	1.00
2.00	Net IPF PPS Outlier Payments	99,781	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)	2.928767	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)	735,550	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)	735,550	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	735,550	18.00
19.00	Deductibles	60,200	19.00
20.00	Subtotal (line 18 minus line 19)	675,350	20.00
21.00	Coinsurance	1,645	21.00
22.00	Subtotal (line 20 minus line 21)	673,705	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)	673,705	26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	27.00
28.00	Other pass through costs (see instructions)	0	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	30.99
31.00	Total amount payable to the provider (see instructions)	673,705	31.00
31.01	Sequestration adjustment (see instructions)	13,474	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	31.02
32.00	Interim payments	660,231	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	99,781	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 10/01/2016 To 09/30/2017	Worksheet E-3 Part VII Date/Time Prepared: 2/26/2018 1:56 pm
	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	42,300		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)	42,300	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)	42,300	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	62,334	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)	62,334	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)	62,334	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	20,034	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)	42,300	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)	42,300	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)	42,300	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)	42,300	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	42,300	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)	42,300	0	40.00
41.00	Interim payments	29,360	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	12,940	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 10/01/2016 To 09/30/2017	Worksheet E-3 Part VII Date/Time Prepared: 2/26/2018 1:56 pm
	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	53,997		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)	53,997	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)	53,997	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	23,910	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)	23,910	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)	23,910	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)	30,087	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)	23,910	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)	23,910	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	30,087	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	23,910	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)	23,910	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	23,910	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)	23,910	0	40.00
41.00	Interim payments	10,137	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	13,773	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 10/01/2016 To 09/30/2017 | Worksheet G | Date/Time Prepared: 2/26/2018 1:56 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	5,151,106	0	0	0	1.00
2.00	Temporary investments	-17,389,072	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	23,490,483	0	0	0	4.00
5.00	Other receivable	750,910	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	6,066,460	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)	18,069,887	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	25,412,220	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	2,464,521	0	0	0	19.00
20.00	Accumulated depreciation	-30,853,903	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	15,078,667	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)	13,401,570	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	6,602,987	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	6,602,987	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	38,074,444	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,615,416	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,710,582	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	337,966	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,663,964	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)	4,663,964	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	33,410,480				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)	33,410,480	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	38,074,444	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet G-1 | Date/Time Prepared: 2/26/2018 1:56 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		31,562,436		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,848,044				2.00
3.00	Total (sum of line 1 and line 2)		33,410,480		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)		33,410,480		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)		33,410,480		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 10/01/2016 To 09/30/2017 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/26/2018 1:56 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	5,510,193		5,510,193	1.00
2.00	SUBPROVIDER - IPF	877,200		877,200	2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	6,387,393		6,387,393	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	0		0	13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	6,387,393		6,387,393	17.00
18.00	Ancillary services	9,940,497	63,650,580	73,591,077	18.00
19.00	Outpatient services	366,324	10,807,030	11,173,354	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	PRO FEES	2,332,729	15,263,401	17,596,130	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	19,026,943	89,721,011	108,747,954	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		38,586,616		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)		38,586,616		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1320 | Period: From 10/01/2016 To 09/30/2017 | Worksheet G-3 | Date/Time Prepared: 2/26/2018 1:56 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	108,747,954	1.00
2.00	Less contractual allowances and discounts on patients' accounts	71,262,425	2.00
3.00	Net patient revenues (line 1 minus line 2)	37,485,529	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	38,586,616	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,101,087	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 REV	2,742,679	24.00
24.01	OTHER NON OPERATING REV	206,452	24.01
25.00	Total other income (sum of lines 6-24)	2,949,131	25.00
26.00	Total (line 5 plus line 25)	1,848,044	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,848,044	29.00