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 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-1320	Period: From 01/01/2019 To 12/31/2019	Worksheet S Parts I-III Date/Time Prepared: 6/29/2020 8:10 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 6/29/2020 Time: 8:10 am
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full 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 IU HEALTH JAY HOSPITAL (15-1320) for the cost reporting period beginning 01/01/2019 and ending 12/31/2019 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.

[X] 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) JONATHAN VANATOR
Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER
Title

(Dated when report is electronically signed.)
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	-416,623	-312,528	0	0	1.00
2.00	Subprovider - IPF	0	-1	4		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	-19,151	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	-435,775	-312,524	0	0	200.00

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The 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 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 6/29/2020 8:10 am

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

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	IU HEALTH JAY HOSPITAL	151320	99915	1	01/01/2004	N	O	P	3.00
4.00	Subprovider - IPF	IU HEALTH JAY 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	IUHP SWING BEDS	15Z320	99915		01/01/2004	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2019	12/31/2019	20.00
21.00	Type of Control (see instructions)	2		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N		22.00
22.01	Did this hospital receive interim 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	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I | Date/Time Prepared: 6/29/2020 8:10 am

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00

		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.	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.				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustement? Enter "Y" for yes or "N" for no in column 2.	N			60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I | Date/Time Prepared: 6/29/2020 8:10 am

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 6/29/2020 8:10 am

		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
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1320	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 6/29/2020 8:10 am

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N	87.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

		1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N	110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1320	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 6/29/2020 8:10 am

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

		1.00	2.00	3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N			112.00
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	102,143	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.00	122.00
	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	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15H059	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 6/29/2020 8:10 am

		1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.				
141.00	Name: INDIANA UNIVERSITY HEALTH		Contractor's Name: WISCONSIN PHYSICIAN SERVICES	Contractor's Number: 08101	141.00
142.00	Street: 340 WEST TENTH STREET		PO Box:		142.00
143.00	City: INDIANAPOLIS		State: IN	Zip Code: 46204	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.			145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

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

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

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)		168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)	N	168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

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

		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	Y	14	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part II | Date/Time Prepared: 6/29/2020 8:10 am

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	03/20/2020	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	04/01/2020	Y	04/01/2020	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part II Date/Time Prepared: 6/29/2020 8:10 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				Y	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.					33.00
	Provider-Based Physicians					
34.00	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?			Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			Y		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RHONDA		UTTER		41.00
42.00	Enter the employer/company name of the cost report preparer.	INDIANA UNIVERSITY HEALTH				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-962-1093		RUTTER@IUHEALTH.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1320	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Prepared: 6/29/2020 8:10 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I | Date/Time Prepared: 6/29/2020 8:10 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	48,552.00	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	48,552.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	9,125	48,552.00	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						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		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 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I | Date/Time Prepared: 6/29/2020 8:10 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	778	3	2,023			1.00
2.00	HMO and other (see instructions)	256	471				2.00
3.00	HMO IPF Subprovider	24	439				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	145	0	145			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	61			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	923	3	2,229			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		7	152			13.00
14.00	Total (see instructions)	923	10	2,381	0.00	228.25	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	391	58	1,250	0.00	14.26	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			40			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	242.51	27.00
28.00	Observation Bed Days		11	842			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I | Date/Time Prepared: 6/29/2020 8:10 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	264	2	670	1.00
2.00	HMO and other (see instructions)			71	126		2.00
3.00	HMO IPF Subprovider				84		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	264	2	670	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	43	7	203	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-1320	Period: From 01/01/2019 To 12/31/2019	Worksheet S-10 Date/Time Prepared: 6/29/2020 8:10 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.351987	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,392,759	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	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	21,552,190	6.00
7.00	Medicaid cost (line 1 times line 6)	7,586,091	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	5,193,332	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)	12,145	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	4,275	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)	4,275	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	5,197,607	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)	3,179,389	42,165	3,221,554	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,119,104	42,165	1,161,269	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)	1,119,104	42,165	1,161,269	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	3,432,226	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	544,186	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	837,209	27.01
28.00	Non-Medicare bad debt expense (see instructions)	2,595,017	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,206,435	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,367,704	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	7,565,311	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A | Date/Time Prepared: 6/29/2020 8:10 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	1,209,449	1,209,449	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MOB		0	0	75,227	75,227	1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT-POB		0	0	35,030	35,030	1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT-WJ		0	0	24,153	24,153	1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT-INTEREST		0	0	0	0	1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP		261,330	261,330	1,354,579	1,615,909	2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB		0	0	6,333	6,333	2.01
2.02	00202	CAP REL COSTS-MVBLE EQUIP - POB		0	0	0	0	2.02
2.03	00203	CAP REL COSTS-MVBLE EQUIP - WJ		0	0	0	0	2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	137,375	28,317	165,692	2,656,631	2,822,323	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	425,408	7,862,807	8,288,215	-200,799	8,087,416	5.00
7.00	00700	OPERATION OF PLANT	310,937	3,064,494	3,375,431	-1,324,685	2,050,746	7.00
7.01	00701	OPERATION OF PLANT - MOB	0	152,257	152,257	-81,560	70,697	7.01
7.02	00702	OPERATION OF PLANT - POB	0	83,859	83,859	-35,030	48,829	7.02
7.03	00703	OPERATION OF PLANT - WJ	0	32,790	32,790	-14,720	18,070	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	44,630	13,933	58,563	31,348	89,911	8.00
9.00	00900	HOUSEKEEPING	384,987	256,660	641,647	-150,796	490,851	9.00
10.00	01000	DIETARY	322,997	464,366	787,363	-553,087	234,276	10.00
11.00	01100	CAFETERIA	0	0	0	414,420	414,420	11.00
13.00	01300	NURSING ADMINISTRATION	1,188,820	315,923	1,504,743	-211,466	1,293,277	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	160	11,636	11,796	646,680	658,476	14.00
15.00	01500	PHARMACY	480,020	1,472,699	1,952,719	-1,222,190	730,529	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,606,372	1,439,807	3,046,179	-733,477	2,312,702	30.00
40.00	04000	SUBPROVIDER - IPF	898,072	504,915	1,402,987	-183,975	1,219,012	40.00
43.00	04300	NURSERY	0	0	0	63,467	63,467	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,256,143	2,758,734	4,014,877	-1,009,360	3,005,517	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	24,867	24,867	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	734,829	1,089,722	1,824,551	-870,531	954,020	54.00
60.00	06000	LABORATORY	0	1,837,470	1,837,470	-31,744	1,805,726	60.00
65.00	06500	RESPIRATORY THERAPY	383,727	159,718	543,445	-127,169	416,276	65.00
66.00	06600	PHYSICAL THERAPY	476,558	8,601	485,159	-4,436	480,723	66.00
67.00	06700	OCCUPATIONAL THERAPY	87,175	646	87,821	-273	87,548	67.00
68.00	06800	SPEECH PATHOLOGY	17,435	0	17,435	0	17,435	68.00
69.00	06900	ELECTROCARDIOLOGY	0	22,462	22,462	-709	21,753	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	240,803	240,803	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	28,318	28,318	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,516,241	1,516,241	73.00
76.00	03160	CARDIOPULMONARY	109,921	129,850	239,771	-61,189	178,582	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	581,574	666,433	1,248,007	-408,897	839,110	90.01
90.02	09002	JAY FAMILY MEDICINE	697,161	1,146,132	1,843,293	-370,976	1,472,317	90.02
90.03	09003	WOUND CLINIC	38,398	105,747	144,145	-6,894	137,251	90.03
90.04	09004	OP ORTHO CLINIC	0	102,210	102,210	3	102,213	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	307,734	310,712	618,446	-136,139	482,307	90.05
90.06	09006	INFUSION CLINIC	85,402	23,824	109,226	-15,406	93,820	90.06
91.00	09100	EMERGENCY	989,001	2,267,602	3,256,603	-345,040	2,911,563	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	23,691	25,294	48,985	-22,330	26,655	93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,588,527	26,620,950	38,209,477	204,671	38,414,148	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	17	17	-17	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	109,150	83,921	193,071	-57,559	135,512	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT	0	0	0	0	0	194.00
194.02	07952	WEST JAY CLINIC	270,464	140,601	411,065	-92,031	319,034	194.02
194.03	07953	JAY MERIDIAN URGENT CARE	183,961	81,589	265,550	-55,064	210,486	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	12,152,102	26,927,078	39,079,180	0	39,079,180	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A | Date/Time Prepared: 6/29/2020 8:10 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-351,355	858,094		1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MOB	-75,227	0		1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT-POB	-35,030	0		1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT-WJ	-24,153	0		1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT-INTEREST	0	0		1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP	194,703	1,810,612		2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB	17,672	24,005		2.01
2.02	00202	CAP REL COSTS-MVBLE EQUIP - POB	0	0		2.02
2.03	00203	CAP REL COSTS-MVBLE EQUIP - WJ	0	0		2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-37,784	2,784,539		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	564,200	8,651,616		5.00
7.00	00700	OPERATION OF PLANT	234,167	2,284,913		7.00
7.01	00701	OPERATION OF PLANT - MOB	0	70,697		7.01
7.02	00702	OPERATION OF PLANT - POB	-24,364	24,465		7.02
7.03	00703	OPERATION OF PLANT - WJ	-18,070	0		7.03
8.00	00800	LAUNDRY & LINEN SERVICE	0	89,911		8.00
9.00	00900	HOUSEKEEPING	0	490,851		9.00
10.00	01000	DIETARY	-6,063	228,213		10.00
11.00	01100	CAFETERIA	-167,054	247,366		11.00
13.00	01300	NURSING ADMINISTRATION	422,626	1,715,903		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-35	658,441		14.00
15.00	01500	PHARMACY	345,630	1,076,159		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0		16.00
17.00	01700	SOCIAL SERVICE	0	0		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-629,471	1,683,231		30.00
40.00	04000	SUBPROVIDER - IPF	-254,614	964,398		40.00
43.00	04300	NURSERY	0	63,467		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-1,516,361	1,489,156		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	24,867		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	178,805	1,132,825		54.00
60.00	06000	LABORATORY	-12,123	1,793,603		60.00
65.00	06500	RESPIRATORY THERAPY	30,242	446,518		65.00
66.00	06600	PHYSICAL THERAPY	38,449	519,172		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	87,548		67.00
68.00	06800	SPEECH PATHOLOGY	0	17,435		68.00
69.00	06900	ELECTROCARDIOLOGY	0	21,753		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	240,803		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	28,318		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,516,241		73.00
76.00	03160	CARDIOPULMONARY	99,686	278,268		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	-175,997	663,113		90.01
90.02	09002	JAY FAMILY MEDICINE	-614,207	858,110		90.02
90.03	09003	WOUND CLINIC	-95,975	41,276		90.03
90.04	09004	OP ORTHO CLINIC	-102,213	0		90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	-138,560	343,747		90.05
90.06	09006	INFUSION CLINIC	0	93,820		90.06
91.00	09100	EMERGENCY	-1,510,152	1,401,411		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
93.00	04950	OUTPATIENT PSYCH	0	26,655		93.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-3,662,628	34,751,520		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	135,512		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
194.00	07950	VACANT	0	0		194.00
194.02	07952	WEST JAY CLINIC	0	319,034		194.02
194.03	07953	JAY MERIDIAN URGENT CARE	0	210,486		194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-3,662,628	35,416,552		200.00

RECLASSIFICATIONS | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-6 | Date/Time Prepared: 6/29/2020 8:10 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA					
1.00	CAFETERIA	11.00	206,347	208,073		1.00
	0		206,347	208,073		
	B - DRUGS RECLASS					
1.00	PHARMACY	15.00	0	41,080		1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,516,241		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
	0		0	1,557,321		
	C - SUPPLIES/IMPLANTS					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	646,687		1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	240,803		2.00
3.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	28,318		3.00
4.00	NURSING ADMINISTRATION	13.00	0	225		4.00
5.00	LABORATORY	60.00	0	1,121		5.00
6.00	OP ORTHO CLINIC	90.04	0	3		6.00
7.00	OUTPATIENT PSYCH	93.00	0	31		7.00
8.00	JAY MERIDIAN URGENT CARE	194.03	0	131		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
	0		0	917,319		
	D - LAUNDRY					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	41,953		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
	0		0	41,953		
	E - DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,154,745		1.00
2.00	CAP REL COSTS-BLDG & FIXT-MOB	1.01	0	75,227		2.00
3.00	CAP REL COSTS-BLDG & FIXT-POB	1.02	0	35,030		3.00
4.00	CAP REL COSTS-BLDG & FIXT-WJ	1.03	0	24,153		4.00
5.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,352,337		5.00
6.00	CAP REL COSTS-MVBLE EQUIP - MOB	2.01	0	6,333		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00

RECLASSIFICATIONS | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-6 | Date/Time Prepared: 6/29/2020 8:10 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
	0		0	2,647,825		
	F - PROPERTY TAXES					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	31,762		1.00
	0		0	31,762		
	G - PROPERTY INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	22,942		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,242		2.00
	0		0	25,184		
	H - HOUSEKEEPING SUPPLIES					
1.00	HOUSEKEEPING	9.00	0	14,380		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
	0		0	14,380		
	J - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,676,657		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
	0		0	2,676,657		
	K - NURSERY AND LABOR AND DELIVERY					
1.00	NURSERY	43.00	57,106	6,361		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	22,375	2,492		2.00
	0		79,481	8,853		
500.00	Grand Total: Increases		285,828	8,129,327		500.00

RECLASSIFICATIONS | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-6 | Date/Time Prepared: 6/29/2020 8:10 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA						
1.00	DIETARY	10.00	206,347	208,073	0		1.00
	0		206,347	208,073			
	B - DRUGS RECLASS						
1.00	PHARMACY	15.00	0	1,087,181	0		1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	19,783	0		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	117	0		3.00
4.00	DIETARY	10.00	0	33	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	10,396	0		5.00
6.00	SUBPROVIDER - IPF	40.00	0	54	0		6.00
7.00	OPERATING ROOM	50.00	0	18,531	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	35,345	0		8.00
9.00	RESPIRATORY THERAPY	65.00	0	126	0		9.00
10.00	PHYSICAL THERAPY	66.00	0	150	0		10.00
11.00	CARDIOPULMONARY	76.00	0	2,376	0		11.00
12.00	FAMILY PRACTICE OF JAY COUNTY	90.01	0	193,423	0		12.00
13.00	JAY FAMILY MEDICINE	90.02	0	148,441	0		13.00
14.00	WOUND CLINIC	90.03	0	290	0		14.00
15.00	JAY FAMILY FIRST HEALTH CARE	90.05	0	27,954	0		15.00
16.00	INFUSION CLINIC	90.06	0	1,669	0		16.00
17.00	EMERGENCY	91.00	0	11,418	0		17.00
18.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	34	0		18.00
	0		0	1,557,321			
	C - SUPPLIES/IMPLANTS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	243	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	1,598	0		2.00
3.00	OPERATION OF PLANT	7.00	0	33,228	0		3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	0	4	0		4.00
5.00	HOUSEKEEPING	9.00	0	397	0		5.00
6.00	DIETARY	10.00	0	1,738	0		6.00
7.00	PHARMACY	15.00	0	16,701	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	132,789	0		8.00
9.00	SUBPROVIDER - IPF	40.00	0	4,178	0		9.00
10.00	OPERATING ROOM	50.00	0	511,586	0		10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	53,230	0		11.00
12.00	RESPIRATORY THERAPY	65.00	0	13,561	0		12.00
13.00	PHYSICAL THERAPY	66.00	0	2,844	0		13.00
14.00	OCCUPATIONAL THERAPY	67.00	0	273	0		14.00
15.00	ELECTROCARDIOLOGY	69.00	0	709	0		15.00
16.00	CARDIOPULMONARY	76.00	0	1,345	0		16.00
17.00	FAMILY PRACTICE OF JAY COUNTY	90.01	0	20,567	0		17.00
18.00	JAY FAMILY MEDICINE	90.02	0	9,985	0		18.00
19.00	WOUND CLINIC	90.03	0	3,732	0		19.00
20.00	JAY FAMILY FIRST HEALTH CARE	90.05	0	7,788	0		20.00
21.00	INFUSION CLINIC	90.06	0	9,489	0		21.00
22.00	EMERGENCY	91.00	0	89,629	0		22.00
23.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	17	0		23.00
24.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	363	0		24.00
25.00	WEST JAY CLINIC	194.02	0	1,325	0		25.00
	0		0	917,319			
	D - LAUNDRY						
1.00	HOUSEKEEPING	9.00	0	34,561	0		1.00
2.00	DIETARY	10.00	0	176	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	1,359	0		3.00
4.00	OPERATING ROOM	50.00	0	5,385	0		4.00
5.00	INFUSION CLINIC	90.06	0	472	0		5.00
	0		0	41,953			
	E - DEPRECIATION						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	51,949	9		1.00
2.00	OPERATION OF PLANT	7.00	0	1,209,379	9		2.00
3.00	OPERATION OF PLANT - MOB	7.01	0	81,560	9		3.00
4.00	OPERATION OF PLANT - POB	7.02	0	35,030	9		4.00
5.00	OPERATION OF PLANT - WJ	7.03	0	14,720	9		5.00
6.00	DIETARY	10.00	0	8,934	9		6.00
7.00	PHARMACY	15.00	0	69,800	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	131,724	0		8.00
9.00	SUBPROVIDER - IPF	40.00	0	4,734	0		9.00
10.00	OPERATING ROOM	50.00	0	210,638	0		10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	644,429	0		11.00
12.00	LABORATORY	60.00	0	32,865	0		12.00
13.00	RESPIRATORY THERAPY	65.00	0	26,753	0		13.00

RECLASSIFICATIONS | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-6 | Date/Time Prepared: 6/29/2020 8:10 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
14.00	PHYSICAL THERAPY	66.00	0	1,415	0		14.00
15.00	CARDIOPULMONARY	76.00	0	29,941	0		15.00
16.00	WOUND CLINIC	90.03	0	1,322	0		16.00
17.00	INFUSION CLINIC	90.06	0	445	0		17.00
18.00	EMERGENCY	91.00	0	73,038	0		18.00
19.00	OUTPATIENT PSYCH	93.00	0	9,716	0		19.00
20.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	9,433	0		20.00
	0		0	2,647,825			
	F - PROPERTY TAXES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	31,762	13		1.00
	0		0	31,762			
	G - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	25,184	12		1.00
2.00		0.00	0	0	12		2.00
	0		0	25,184			
	H - HOUSEKEEPING SUPPLIES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	53	0		1.00
2.00	OPERATION OF PLANT	7.00	0	10,817	0		2.00
3.00	PHARMACY	15.00	0	9	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	218	0		4.00
5.00	SUBPROVIDER - IPF	40.00	0	427	0		5.00
6.00	OPERATING ROOM	50.00	0	1,191	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	545	0		7.00
8.00	RESPIRATORY THERAPY	65.00	0	48	0		8.00
9.00	PHYSICAL THERAPY	66.00	0	27	0		9.00
10.00	CARDIOPULMONARY	76.00	0	162	0		10.00
11.00	FAMILY PRACTICE OF JAY COUNTY	90.01	0	344	0		11.00
12.00	JAY FAMILY MEDICINE	90.02	0	388	0		12.00
13.00	JAY FAMILY FIRST HEALTH CARE	90.05	0	21	0		13.00
14.00	EMERGENCY	91.00	0	62	0		14.00
15.00	OUTPATIENT PSYCH	93.00	0	10	0		15.00
16.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	58	0		16.00
	0		0	14,380			
	J - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	90,136	0		1.00
2.00	OPERATION OF PLANT	7.00	0	71,261	0		2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	10,601	0		3.00
4.00	HOUSEKEEPING	9.00	0	130,218	0		4.00
5.00	DIETARY	10.00	0	127,786	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	211,691	0		6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	7	0		7.00
8.00	PHARMACY	15.00	0	89,579	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	368,657	0		9.00
10.00	SUBPROVIDER - IPF	40.00	0	174,582	0		10.00
11.00	OPERATING ROOM	50.00	0	262,029	0		11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	136,982	0		12.00
13.00	RESPIRATORY THERAPY	65.00	0	86,681	0		13.00
14.00	CARDIOPULMONARY	76.00	0	27,365	0		14.00
15.00	FAMILY PRACTICE OF JAY COUNTY	90.01	0	194,563	0		15.00
16.00	JAY FAMILY MEDICINE	90.02	0	212,162	0		16.00
17.00	WOUND CLINIC	90.03	0	1,550	0		17.00
18.00	JAY FAMILY FIRST HEALTH CARE	90.05	0	100,376	0		18.00
19.00	INFUSION CLINIC	90.06	0	3,331	0		19.00
20.00	EMERGENCY	91.00	0	170,893	0		20.00
21.00	OUTPATIENT PSYCH	93.00	0	12,635	0		21.00
22.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	47,671	0		22.00
23.00	WEST JAY CLINIC	194.02	0	90,706	0		23.00
24.00	JAY MERIDIAN URGENT CARE	194.03	0	55,195	0		24.00
	0		0	2,676,657			
	K - NURSERY AND LABOR AND DELIVERY						
1.00	ADULTS & PEDIATRICS	30.00	79,481	8,853	0		1.00
2.00		0.00	0	0	0		2.00
	0		79,481	8,853			
500.00	Grand Total: Decreases		285,828	8,129,327			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 Part I | Date/Time Prepared: 6/29/2020 8:10 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,006,948	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	19,125,052	0	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	7,974,055	752,827	0	752,827	64,700	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	28,106,055	752,827	0	752,827	64,700	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	28,106,055	752,827	0	752,827	64,700	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,006,948	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	19,125,052	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	8,662,182	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	28,794,182	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	28,794,182	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 Part II | Date/Time Prepared: 6/29/2020 8:10 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT-MOB	0	0	0	0	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT-POB	0	0	0	0	0	1.02
1.03	CAP REL COSTS-BLDG & FIXT-WJ	0	0	0	0	0	1.03
1.04	CAP REL COSTS-BLDG & FIXT-INTEREST	0	0	0	0	0	1.04
2.00	CAP REL COSTS-MVBLE EQUIP	261,330	0	0	0	0	2.00
2.01	CAP REL COSTS-MVBLE EQUIP - MOB	0	0	0	0	0	2.01
2.02	CAP REL COSTS-MVBLE EQUIP - POB	0	0	0	0	0	2.02
2.03	CAP REL COSTS-MVBLE EQUIP - WJ	0	0	0	0	0	2.03
3.00	Total (sum of lines 1-2)	261,330	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT-MOB	0	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT-POB	0	0	1.02
1.03	CAP REL COSTS-BLDG & FIXT-WJ	0	0	1.03
1.04	CAP REL COSTS-BLDG & FIXT-INTEREST	0	0	1.04
2.00	CAP REL COSTS-MVBLE EQUIP	0	261,330	2.00
2.01	CAP REL COSTS-MVBLE EQUIP - MOB	0	0	2.01
2.02	CAP REL COSTS-MVBLE EQUIP - POB	0	0	2.02
2.03	CAP REL COSTS-MVBLE EQUIP - WJ	0	0	2.03
3.00	Total (sum of lines 1-2)	0	261,330	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 Part III | Date/Time Prepared: 6/29/2020 8:10 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	28,794,182	0	28,794,182	1.000000	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT-MOB	0	0	0	0.000000	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT-POB	0	0	0	0.000000	0	1.02
1.03	CAP REL COSTS-BLDG & FIXT-WJ	0	0	0	0.000000	0	1.03
1.04	CAP REL COSTS-BLDG & FIXT-INTEREST	0	0	0	0.000000	0	1.04
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
2.01	CAP REL COSTS-MVBLE EQUIP - MOB	0	0	0	0.000000	0	2.01
2.02	CAP REL COSTS-MVBLE EQUIP - POB	0	0	0	0.000000	0	2.02
2.03	CAP REL COSTS-MVBLE EQUIP - WJ	0	0	0	0.000000	0	2.03
3.00	Total (sum of lines 1-2)	28,794,182	0	28,794,182	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	803,390	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT-MOB	0	0	0	0	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT-POB	0	0	0	0	0	1.02
1.03	CAP REL COSTS-BLDG & FIXT-WJ	0	0	0	0	0	1.03
1.04	CAP REL COSTS-BLDG & FIXT-INTEREST	0	0	0	0	0	1.04
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,808,370	0	2.00
2.01	CAP REL COSTS-MVBLE EQUIP - MOB	0	0	0	24,005	0	2.01
2.02	CAP REL COSTS-MVBLE EQUIP - POB	0	0	0	0	0	2.02
2.03	CAP REL COSTS-MVBLE EQUIP - WJ	0	0	0	0	0	2.03
3.00	Total (sum of lines 1-2)	0	0	0	2,635,765	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	22,942	31,762	0	858,094	1.00
1.01	CAP REL COSTS-BLDG & FIXT-MOB	0	0	0	0	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT-POB	0	0	0	0	0	1.02
1.03	CAP REL COSTS-BLDG & FIXT-WJ	0	0	0	0	0	1.03
1.04	CAP REL COSTS-BLDG & FIXT-INTEREST	0	0	0	0	0	1.04
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,242	0	0	1,810,612	2.00
2.01	CAP REL COSTS-MVBLE EQUIP - MOB	0	0	0	0	24,005	2.01
2.02	CAP REL COSTS-MVBLE EQUIP - POB	0	0	0	0	0	2.02
2.03	CAP REL COSTS-MVBLE EQUIP - WJ	0	0	0	0	0	2.03
3.00	Total (sum of lines 1-2)	0	25,184	31,762	0	2,692,711	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8 | Date/Time Prepared: 6/29/2020 8:10 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	288,997	CAP REL COSTS-BLDG & FIXT	1.00	9	1.00
1.01	Investment income - CAP REL COSTS-BLDG & FIXT-MOB (chapter 2)		0	CAP REL COSTS-BLDG & FIXT-MOB	1.01	0	1.01
1.02	Investment income - CAP REL COSTS-BLDG & FIXT-POB (chapter 2)		0	CAP REL COSTS-BLDG & FIXT-POB	1.02	0	1.02
1.03	Investment income - CAP REL COSTS-BLDG & FIXT-WJ (chapter 2)		0	CAP REL COSTS-BLDG & FIXT-WJ	1.03	0	1.03
1.04	Investment income - CAP REL COSTS-BLDG & FIXT-INTEREST (chapter 2)		0	CAP REL COSTS-BLDG & FIXT-INTEREST	1.04	0	1.04
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
2.01	Investment income - CAP REL COSTS-MVBLE EQUIP - MOB (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP - MOB	2.01	0	2.01
2.02	Investment income - CAP REL COSTS-MVBLE EQUIP - POB (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP - POB	2.02	0	2.02
2.03	Investment income - CAP REL COSTS-MVBLE EQUIP - WJ (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP - WJ	2.03	0	2.03
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	B	-105,661	CAP REL COSTS-BLDG & FIXT	1.00	9	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-3,875,945			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	6,368,007			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-167,054	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8 | Date/Time Prepared: 6/29/2020 8:10 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - CAP REL COSTS-BLDG & FIXT-MOB		0	CAP REL COSTS-BLDG & FIXT-MOB	1.01	0	26.01
26.02	Depreciation - CAP REL COSTS-BLDG & FIXT-POB		0	CAP REL COSTS-BLDG & FIXT-POB	1.02	0	26.02
26.03	Depreciation - CAP REL COSTS-BLDG & FIXT-WJ		0	CAP REL COSTS-BLDG & FIXT-WJ	1.03	0	26.03
26.04	Depreciation - CAP REL COSTS-BLDG & FIXT-INTEREST		0	CAP REL COSTS-BLDG & FIXT-INTEREST	1.04	0	26.04
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
27.01	Depreciation - CAP REL COSTS-MVBLE EQUIP - MOB		0	CAP REL COSTS-MVBLE EQUIP - MOB	2.01	0	27.01
27.02	Depreciation - CAP REL COSTS-MVBLE EQUIP - POB		0	CAP REL COSTS-MVBLE EQUIP - POB	2.02	0	27.02
27.03	Depreciation - CAP REL COSTS-MVBLE EQUIP - WJ		0	CAP REL COSTS-MVBLE EQUIP - WJ	2.03	0	27.03
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	EMPLOYEE BENEFITS	A	-2,674,783	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
33.01	HOSPITAL ASSESSMENT FEES	A	-1,935,476	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	MISCELLANEOUS INCOME	B	-225,811	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	MISCELLANEOUS INCOME	B	-24,364	OPERATION OF PLANT - POB	7.02	9	33.03
33.04	MISCELLANEOUS INCOME	B	-18,070	OPERATION OF PLANT - WJ	7.03	9	33.04
33.05	MISCELLANEOUS INCOME	B	-6,063	DIETARY	10.00	9	33.05
33.06	MISCELLANEOUS INCOME	B	-721	NURSING ADMINISTRATION	13.00	0	33.06
33.07	MISCELLANEOUS INCOME	B	-35	CENTRAL SERVICES & SUPPLY	14.00	0	33.07
33.08	MISCELLANEOUS INCOME	B	-7,141	PHARMACY	15.00	0	33.08
33.09	MISCELLANEOUS INCOME	B	-400	SUBPROVIDER - IPF	40.00	0	33.09
33.10	MISCELLANEOUS INCOME	B	-12,123	LABORATORY	60.00	0	33.10
33.11	MISCELLANEOUS INCOME	B	-2,200	EMERGENCY	91.00	0	33.11
33.12	ACCRUED PTO EXPENSE	A	-120,525	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.12
33.13	MARKETING EXPENSES	A	-37,106	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	CONTRACTED HOSPITALIST	A	-629,471	ADULTS & PEDIATRICS	30.00	0	33.14
33.15	CONTRACTED CRNA	A	-578,344	OPERATING ROOM	50.00	0	33.15
33.16	AMORTIZED START UP COST	A	586,827	ADMINISTRATIVE & GENERAL	5.00	0	33.16
33.17	MEDICARE DEPRECIATION EXPENSE	A	-353,952	CAP REL COSTS-BLDG & FIXT	1.00	9	33.17
33.18	MEDICARE DEPRECIATION EXPENSE	A	-75,227	CAP REL COSTS-BLDG & FIXT-MOB	1.01	9	33.18
33.19	MEDICARE DEPRECIATION EXPENSE	A	-35,030	CAP REL COSTS-BLDG & FIXT-POB	1.02	9	33.19
33.20	MEDICARE DEPRECIATION EXPENSE	A	-24,153	CAP REL COSTS-BLDG & FIXT-WJ	1.03	9	33.20
33.21	MEDICARE DEPRECIATION EXPENSE	A	-14,476	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.21
33.22	MEDICARE DEPRECIATION EXPENSE	A	17,672	CAP REL COSTS-MVBLE EQUIP - MOB	2.01	9	33.22
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,662,628				50.00

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

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8 | Date/Time Prepared: 6/29/2020 8:10 am

			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	

Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8-1 | Date/Time Prepared: 6/29/2020 8:10 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	-180,739	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	209,179	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	2,757,524	0	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	6,471,608	4,857,865	3.01
3.02	5.00	ADMINISTRATIVE & GENERAL	RELATED PARTY	696,239	134,216	3.02
3.03	7.00	OPERATION OF PLANT	RELATED PARTY	234,167	0	3.03
3.04	13.00	NURSING ADMINISTRATION	RELATED PARTY	423,347	0	3.04
3.05	15.00	PHARMACY	RELATED PARTY	352,771	0	3.05
3.06	50.00	OPERATING ROOM	RELATED PARTY	17,186	0	3.06
3.07	54.00	RADIOLOGY-DIAGNOSTIC	RELATED PARTY	178,805	0	3.07
3.08	65.00	RESPIRATORY THERAPY	RELATED PARTY	30,242	0	3.08
3.09	66.00	PHYSICAL THERAPY	RELATED PARTY	38,449	0	3.09
3.10	76.00	CARDIOPULMONARY	RELATED PARTY	131,310	0	3.10
3.11	4.00	EMPLOYEE BENEFITS DEPARTMENT	RELATED PARTY	9,578	9,578	3.11
3.12	5.00	ADMINISTRATIVE & GENERAL	RELATED PARTY	87,678	87,678	3.12
3.13	7.00	OPERATION OF PLANT	RELATED PARTY	125,827	125,827	3.13
3.14	10.00	DIETARY	RELATED PARTY	55,295	55,295	3.14
3.15	15.00	PHARMACY	RELATED PARTY	130,436	130,436	3.15
3.16	30.00	ADULTS & PEDIATRICS	RELATED PARTY	649,428	649,428	3.16
3.17	40.00	SUBPROVIDER - IPF	RELATED PARTY	244,956	244,956	3.17
3.18	50.00	OPERATING ROOM	RELATED PARTY	982,244	982,244	3.18
3.19	54.00	RADIOLOGY-DIAGNOSTIC	RELATED PARTY	523	523	3.19
3.20	60.00	LABORATORY	RELATED PARTY	1,699,931	1,699,931	3.20
3.21	65.00	RESPIRATORY THERAPY	RELATED PARTY	1,438	1,438	3.21
3.22	66.00	PHYSICAL THERAPY	RELATED PARTY	477,449	477,449	3.22
3.23	67.00	OCCUPATIONAL THERAPY	RELATED PARTY	87,548	87,548	3.23
3.24	68.00	SPEECH PATHOLOGY	RELATED PARTY	17,435	17,435	3.24
3.25	69.00	ELECTROCARDIOLOGY	RELATED PARTY	20,564	20,564	3.25
3.26	76.00	CARDIOPULMONARY	RELATED PARTY	58,825	58,825	3.26
3.27	90.01	FAMILY PRACTICE OF JAY COUNT	RELATED PARTY	185,837	185,837	3.27
3.28	90.02	JAY FAMILY MEDICINE	RELATED PARTY	712,741	712,741	3.28
3.29	90.03	WOUND CLINIC	RELATED PARTY	95,975	95,975	3.29
3.30	90.05	JAY FAMILY FIRST HEALTH CARE	RELATED PARTY	144,457	144,457	3.30
3.31	91.00	EMERGENCY	RELATED PARTY	1,824,308	1,824,308	3.31
3.32	93.00	OUTPATIENT PSYCH	RELATED PARTY	333	333	3.32
3.33	192.00	PHYSICIANS' PRIVATE OFFICES	RELATED PARTY	1,429	1,429	3.33
3.34	194.02	WEST JAY CLINIC	RELATED PARTY	23,500	23,500	3.34
3.35	194.03	JAY MERIDIAN URGENT CARE	RELATED PARTY	9,560	9,560	3.35
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.			19,007,383	12,639,376	5.00

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

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-1320	Period: From 01/01/2019 To 12/31/2019	Worksheet A-8-1 Date/Time Prepared: 6/29/2020 8:10 am

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8-1 | Date/Time Prepared: 6/29/2020 8:10 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	-180,739	9		1.00
2.00	209,179	9		2.00
3.00	2,757,524	0		3.00
3.01	1,613,743	0		3.01
3.02	562,023	0		3.02
3.03	234,167	0		3.03
3.04	423,347	0		3.04
3.05	352,771	0		3.05
3.06	17,186	0		3.06
3.07	178,805	0		3.07
3.08	30,242	0		3.08
3.09	38,449	0		3.09
3.10	131,310	0		3.10
3.11	0	0		3.11
3.12	0	0		3.12
3.13	0	0		3.13
3.14	0	0		3.14
3.15	0	0		3.15
3.16	0	0		3.16
3.17	0	9		3.17
3.18	0	0		3.18
3.19	0	0		3.19
3.20	0	0		3.20
3.21	0	0		3.21
3.22	0	0		3.22
3.23	0	0		3.23
3.24	0	0		3.24
3.25	0	9		3.25
3.26	0	0		3.26
3.27	0	0		3.27
3.28	0	0		3.28
3.29	0	0		3.29
3.30	0	0		3.30
3.31	0	0		3.31
3.32	0	0		3.32
3.33	0	0		3.33
3.34	0	0		3.34
3.35	0	0		3.35
4.00	0	0		4.00
5.00	6,368,007			5.00

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

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:		

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

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

6.00	HOSPITAL		6.00
7.00	HOME OFFICE		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-1320	Period: From 01/01/2019 To 12/31/2019	Worksheet A-8-1 Date/Time Prepared: 6/29/2020 8:10 am

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8-2 | Date/Time Prepared: 6/29/2020 8:10 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	40.00	SUBPROVIDER - IPF	254,214	254,214	0	0	0	1.00
2.00	50.00	OPERATING ROOM	955,203	955,203	0	0	0	2.00
3.00	60.00	LABORATORY	40,000	0	40,000	0	0	3.00
4.00	76.00	CARDIOPULMONARY	31,624	31,624	0	0	0	4.00
5.00	90.01	FAMILY PRACTICE OF JAY COUNTY	175,997	175,997	0	0	0	5.00
6.00	90.02	JAY FAMILY MEDICINE	614,207	614,207	0	0	0	6.00
7.00	90.03	WOUND CLINIC	95,975	95,975	0	0	0	7.00
8.00	90.04	OP ORTHO CLINIC	102,213	102,213	0	0	0	8.00
9.00	90.05	JAY FAMILY FIRST HEALTH CARE	138,560	138,560	0	0	0	9.00
10.00	91.00	EMERGENCY	1,788,368	1,507,952	280,416	0	0	10.00
200.00			4,196,361	3,875,945	320,416		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	40.00	SUBPROVIDER - IPF	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	76.00	CARDIOPULMONARY	0	0	0	0	0	4.00
5.00	90.01	FAMILY PRACTICE OF JAY COUNTY	0	0	0	0	0	5.00
6.00	90.02	JAY FAMILY MEDICINE	0	0	0	0	0	6.00
7.00	90.03	WOUND CLINIC	0	0	0	0	0	7.00
8.00	90.04	OP ORTHO CLINIC	0	0	0	0	0	8.00
9.00	90.05	JAY FAMILY FIRST HEALTH CARE	0	0	0	0	0	9.00
10.00	91.00	EMERGENCY	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	40.00	SUBPROVIDER - IPF	0	0	0	254,214		1.00
2.00	50.00	OPERATING ROOM	0	0	0	955,203		2.00
3.00	60.00	LABORATORY	0	0	0	0		3.00
4.00	76.00	CARDIOPULMONARY	0	0	0	31,624		4.00
5.00	90.01	FAMILY PRACTICE OF JAY COUNTY	0	0	0	175,997		5.00
6.00	90.02	JAY FAMILY MEDICINE	0	0	0	614,207		6.00
7.00	90.03	WOUND CLINIC	0	0	0	95,975		7.00
8.00	90.04	OP ORTHO CLINIC	0	0	0	102,213		8.00
9.00	90.05	JAY FAMILY FIRST HEALTH CARE	0	0	0	138,560		9.00
10.00	91.00	EMERGENCY	0	0	0	1,507,952		10.00
200.00			0	0	0	3,875,945		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I Date/Time Prepared: 6/29/2020 8:10 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	BLDG & FIXT-MOB	BLDG & FIXT-POB	BLDG & FIXT-WJ	
			0	1.00	1.01	1.02	1.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	858,094	858,094				1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MOB	0	0	0			1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT-POB	0	0	0	0		1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT-WJ	0	0	0	0	0	1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT-INTEREST	0	0	0	0	0	1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,810,612					2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB	24,005					2.01
2.02	00202	CAP REL COSTS-MVBLE EQUIP - POB	0					2.02
2.03	00203	CAP REL COSTS-MVBLE EQUIP - WJ	0					2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,784,539	1,182	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,651,616	112,510	0	0	0	5.00
7.00	00700	OPERATION OF PLANT	2,284,913	156,329	0	0	0	7.00
7.01	00701	OPERATION OF PLANT - MOB	70,697	0	0	0	0	7.01
7.02	00702	OPERATION OF PLANT - POB	24,465	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	89,911	6,215	0	0	0	8.00
9.00	00900	HOUSEKEEPING	490,851	6,278	0	0	0	9.00
10.00	01000	DIETARY	228,213	16,145	0	0	0	10.00
11.00	01100	CAFETERIA	247,366	28,554	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,715,903	11,604	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	658,441	0	0	0	0	14.00
15.00	01500	PHARMACY	1,076,159	10,463	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,683,231	124,219	0	0	0	30.00
40.00	04000	SUBPROVIDER - IPF	964,398	38,201	0	0	0	40.00
43.00	04300	NURSERY	63,467	5,891	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,489,156	41,769	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	24,867	2,302	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,132,825	52,253	0	0	0	54.00
60.00	06000	LABORATORY	1,793,603	27,361	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	446,518	7,649	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	519,172	34,068	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	87,548	6,027	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	17,435	105	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	21,753	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	240,803	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	28,318	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,516,241	0	0	0	0	73.00
76.00	03160	CARDIOPULMONARY	278,268	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	663,113	0	0	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	858,110	0	0	0	0	90.02
90.03	09003	WOUND CLINIC	41,276	3,568	0	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0	0	0	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	343,747	40,471	0	0	0	90.05
90.06	09006	INFUSION CLINIC	93,820	6,466	0	0	0	90.06
91.00	09100	EMERGENCY	1,401,411	49,909	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	26,655	16,438	0	0	0	93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	34,751,520	805,977	0	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,067	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	135,512	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT	0	27,257	0	0	0	194.00
194.02	07952	WEST JAY CLINIC	319,034	0	0	0	0	194.02
194.03	07953	JAY MERIDIAN URGENT CARE	210,486	16,793	0	0	0	194.03
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)	35,416,552	858,094	0	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I Date/Time Prepared: 6/29/2020 8:10 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT-INTEREST	MVBLE EQUIP	MVBLE EQUIP - MOB	MVBLE EQUIP - POB	MVBLE EQUIP - WJ	
			1.04	2.00	2.01	2.02	2.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MOB						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT-POB						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT-WJ						1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT-INTEREST	0					1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,810,612				2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB		0	24,005			2.01
2.02	00202	CAP REL COSTS-MVBLE EQUIP - POB		0	0	0		2.02
2.03	00203	CAP REL COSTS-MVBLE EQUIP - WJ		0	0	0	0	2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,495	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	237,401	1,781	0	0	5.00
7.00	00700	OPERATION OF PLANT	0	329,861	623	0	0	7.00
7.01	00701	OPERATION OF PLANT - MOB	0	0	0	0	0	7.01
7.02	00702	OPERATION OF PLANT - POB	0	0	0	0	0	7.02
7.03	00703	OPERATION OF PLANT - WJ	0	0	0	0	0	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	0	13,114	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	13,247	0	0	0	9.00
10.00	01000	DIETARY	0	34,066	0	0	0	10.00
11.00	01100	CAFETERIA	0	60,250	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	24,484	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	22,078	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	262,106	0	0	0	30.00
40.00	04000	SUBPROVIDER - IPF	0	80,606	0	0	0	40.00
43.00	04300	NURSERY	0	12,430	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	88,134	1,148	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,857	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	110,256	0	0	0	54.00
60.00	06000	LABORATORY	0	57,733	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	16,139	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	71,885	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	12,717	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	221	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03160	CARDIOPULMONARY	0	0	1,903	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	0	7,661	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	10,713	0	0	90.02
90.03	09003	WOUND CLINIC	0	7,528	0	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0	0	0	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0	85,396	176	0	0	90.05
90.06	09006	INFUSION CLINIC	0	13,644	0	0	0	90.06
91.00	09100	EMERGENCY	0	105,311	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	0	34,684	0	0	0	93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,700,643	24,005	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	17,022	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT	0	57,512	0	0	0	194.00
194.02	07952	WEST JAY CLINIC	0	0	0	0	0	194.02
194.03	07953	JAY MERIDIAN URGENT CARE	0	35,435	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,810,612	24,005	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I Date/Time Prepared: 6/29/2020 8:10 am

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT - MOB	
			4.00	4A	5.00	7.00	7.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MOB						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT-POB						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT-WJ						1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT-INTEREST						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB						2.01
2.02	00202	CAP REL COSTS-MVBLE EQUIP - POB						2.02
2.03	00203	CAP REL COSTS-MVBLE EQUIP - WJ						2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,788,216					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	98,723	9,102,031	9,102,031			5.00
7.00	00700	OPERATION OF PLANT	72,158	2,843,884	983,680	3,827,564		7.00
7.01	00701	OPERATION OF PLANT - MOB	0	70,697	24,454	0	95,151	7.01
7.02	00702	OPERATION OF PLANT - POB	0	24,465	8,462	0	0	7.02
7.03	00703	OPERATION OF PLANT - WJ	0	0	0	0	0	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	10,357	119,597	41,368	25,463	0	8.00
9.00	00900	HOUSEKEEPING	89,343	599,719	207,439	25,720	0	9.00
10.00	01000	DIETARY	27,071	305,495	105,669	66,143	0	10.00
11.00	01100	CAFETERIA	47,886	384,056	132,843	116,982	0	11.00
13.00	01300	NURSING ADMINISTRATION	275,886	2,027,877	701,430	47,539	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	37	658,478	227,764	0	0	14.00
15.00	01500	PHARMACY	111,397	1,220,097	422,024	42,866	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	354,338	2,423,894	838,410	508,905	0	30.00
40.00	04000	SUBPROVIDER - IPF	208,413	1,291,618	446,763	156,504	0	40.00
43.00	04300	NURSERY	13,252	95,040	32,874	24,134	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	291,509	1,911,716	661,251	484,774	5,059	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,192	37,218	12,873	9,431	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	170,530	1,465,864	507,034	214,074	0	54.00
60.00	06000	LABORATORY	0	1,878,697	649,830	112,095	0	60.00
65.00	06500	RESPIRATORY THERAPY	89,050	559,356	193,478	31,335	0	65.00
66.00	06600	PHYSICAL THERAPY	110,593	735,718	254,480	139,572	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	20,230	126,522	43,763	24,691	0	67.00
68.00	06800	SPEECH PATHOLOGY	4,046	21,807	7,543	429	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	21,753	7,524	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	240,803	83,292	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	28,318	9,795	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,516,241	524,459	0	0	73.00
76.00	03160	CARDIOPULMONARY	25,509	305,680	105,733	64,985	8,381	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	134,964	805,738	278,700	261,655	33,746	90.01
90.02	09002	JAY FAMILY MEDICINE	161,788	1,030,611	356,482	365,906	47,191	90.02
90.03	09003	WOUND CLINIC	8,911	61,283	21,197	14,617	0	90.03
90.04	09004	OP ORTHO CLINIC	0	0	0	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	71,415	541,205	187,200	171,808	774	90.05
90.06	09006	INFUSION CLINIC	19,819	133,749	46,263	26,491	0	90.06
91.00	09100	EMERGENCY	229,514	1,786,145	617,817	204,472	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0				92.00
93.00	04950	OUTPATIENT PSYCH	5,498	83,275	28,804	67,343	0	93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,657,429	34,458,647	8,770,698	3,207,934	95,151	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	25,089	8,678	33,050	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	25,330	160,842	55,634	267,871	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT	0	84,769	29,321	111,666	0	194.00
194.02	07952	WEST JAY CLINIC	62,766	381,800	132,062	138,243	0	194.02
194.03	07953	JAY MERIDIAN URGENT CARE	42,691	305,405	105,638	68,800	0	194.03
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)	2,788,216	35,416,552	9,102,031	3,827,564	95,151	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 6/29/2020 8:10 am

		Cost Center Description	OPERATION OF PLANT - POB	OPERATION OF PLANT - WJ	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			7.02	7.03	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MOB						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT-POB						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT-WJ						1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT-INTEREST						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB						2.01
2.02	00202	CAP REL COSTS-MVBLE EQUIP - POB						2.02
2.03	00203	CAP REL COSTS-MVBLE EQUIP - WJ						2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT - MOB						7.01
7.02	00702	OPERATION OF PLANT - POB	32,927					7.02
7.03	00703	OPERATION OF PLANT - WJ	0	0				7.03
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	186,428			8.00
9.00	00900	HOUSEKEEPING	0	0	22,575	855,453		9.00
10.00	01000	DIETARY	0	0	5,826	15,552	498,685	10.00
11.00	01100	CAFETERIA	0	0	0	27,506	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	11,178	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	10,079	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	85,467	119,664	354,423	30.00
40.00	04000	SUBPROVIDER - IPF	0	0	4,612	36,800	144,262	40.00
43.00	04300	NURSERY	0	0	3,378	5,675	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	23,624	0	19,420	113,987	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	2,217	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	14,807	50,336	0	54.00
60.00	06000	LABORATORY	0	0	0	26,357	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	7,368	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,214	32,818	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	5,806	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	101	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	3,884	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03160	CARDIOPULMONARY	0	0	0	15,280	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	0	0	61,524	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	0	86,037	0	90.02
90.03	09003	WOUND CLINIC	0	0	0	3,437	0	90.03
90.04	09004	OP ORTHO CLINIC	0	0	0	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0	0	0	40,398	0	90.05
90.06	09006	INFUSION CLINIC	0	0	0	6,229	0	90.06
91.00	09100	EMERGENCY	0	0	25,245	48,078	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	0	0	0	15,835	0	93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	23,624	0	186,428	742,262	498,685	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	7,771	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	9,303	0	0	62,986	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT	0	0	0	26,257	0	194.00
194.02	07952	WEST JAY CLINIC	0	0	0	0	0	194.02
194.03	07953	JAY MERIDIAN URGENT CARE	0	0	0	16,177	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	32,927	0	186,428	855,453	498,685	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 6/29/2020 8:10 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MOB						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT-POB						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT-WJ						1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT-INTEREST						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB						2.01
2.02	00202	CAP REL COSTS-MVBLE EQUIP - POB						2.02
2.03	00203	CAP REL COSTS-MVBLE EQUIP - WJ						2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT - MOB						7.01
7.02	00702	OPERATION OF PLANT - POB						7.02
7.03	00703	OPERATION OF PLANT - WJ						7.03
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	661,387					11.00
13.00	01300	NURSING ADMINISTRATION	53,118	2,841,142				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	886,242			14.00
15.00	01500	PHARMACY	21,775	0	6,577	1,723,418		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	89,331	607,049	94,757	11,323	0	30.00
40.00	04000	SUBPROVIDER - IPF	48,900	357,995	4,303	10	0	40.00
43.00	04300	NURSERY	2,743	18,639	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	72,699	469,185	324,623	6,655	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,063	7,391	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	35,904	0	35,697	4,128	0	54.00
60.00	06000	LABORATORY	40,224	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	21,021	0	14,169	90	0	65.00
66.00	06600	PHYSICAL THERAPY	18,175	0	2,893	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,252	0	273	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	617	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	697	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	236,068	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	27,761	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,678,033	0	73.00
76.00	03160	CARDIOPULMONARY	6,413	1,607	1,392	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	59,325	351,889	19,932	9,015	0	90.01
90.02	09002	JAY FAMILY MEDICINE	70,127	448,297	10,626	227	0	90.02
90.03	09003	WOUND CLINIC	2,366	22,174	3,528	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0	0	0	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	28,359	150,396	7,458	0	0	90.05
90.06	09006	INFUSION CLINIC	3,429	32,136	9,187	1,847	0	90.06
91.00	09100	EMERGENCY	50,203	374,384	84,569	12,052	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	3,361	0	12	0	0	93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	633,405	2,841,142	884,522	1,723,380	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	17	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	10,596	0	394	38	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT	0	0	0	0	0	194.00
194.02	07952	WEST JAY CLINIC	0	0	1,309	0	0	194.02
194.03	07953	JAY MERIDIAN URGENT CARE	17,386	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	661,387	2,841,142	886,242	1,723,418	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 6/29/2020 8:10 am

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MOB						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT-POB						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT-WJ						1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT-INTEREST						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB						2.01
2.02	00202	CAP REL COSTS-MVBLE EQUIP - POB						2.02
2.03	00203	CAP REL COSTS-MVBLE EQUIP - WJ						2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT - MOB						7.01
7.02	00702	OPERATION OF PLANT - POB						7.02
7.03	00703	OPERATION OF PLANT - WJ						7.03
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	0					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	5,133,223	0	5,133,223		30.00
40.00	04000	SUBPROVIDER - IPF	0	2,491,767	0	2,491,767		40.00
43.00	04300	NURSERY	0	182,483	0	182,483		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,092,993	0	4,092,993		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	70,193	0	70,193		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,327,844	0	2,327,844		54.00
60.00	06000	LABORATORY	0	2,707,203	0	2,707,203		60.00
65.00	06500	RESPIRATORY THERAPY	0	826,817	0	826,817		65.00
66.00	06600	PHYSICAL THERAPY	0	1,184,870	0	1,184,870		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	205,307	0	205,307		67.00
68.00	06800	SPEECH PATHOLOGY	0	30,497	0	30,497		68.00
69.00	06900	ELECTROCARDIOLOGY	0	33,858	0	33,858		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	560,163	0	560,163		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	65,874	0	65,874		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,718,733	0	3,718,733		73.00
76.00	03160	CARDIOPULMONARY	0	509,471	0	509,471		76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0		90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	1,881,524	0	1,881,524		90.01
90.02	09002	JAY FAMILY MEDICINE	0	2,415,504	0	2,415,504		90.02
90.03	09003	WOUND CLINIC	0	128,602	0	128,602		90.03
90.04	09004	OP ORTHO CLINIC	0	0	0	0		90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0	1,127,598	0	1,127,598		90.05
90.06	09006	INFUSION CLINIC	0	259,331	0	259,331		90.06
91.00	09100	EMERGENCY	0	3,202,965	0	3,202,965		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
93.00	04950	OUTPATIENT PSYCH	0	198,630	0	198,630		93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	33,355,450	0	33,355,450		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	74,605	0	74,605		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	567,664	0	567,664		192.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
194.00	07950	VACANT	0	252,013	0	252,013		194.00
194.02	07952	WEST JAY CLINIC	0	653,414	0	653,414		194.02
194.03	07953	JAY MERIDIAN URGENT CARE	0	513,406	0	513,406		194.03
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	35,416,552	0	35,416,552		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 6/29/2020 8:10 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	BLDG & FIXT-MOB	BLDG & FIXT-POB	BLDG & FIXT-WJ	
			0	1.00	1.01	1.02	1.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MOB						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT-POB						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT-WJ						1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT-INTEREST						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB						2.01
2.02	00202	CAP REL COSTS-MVBLE EQUIP - POB						2.02
2.03	00203	CAP REL COSTS-MVBLE EQUIP - WJ						2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,182	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	112,510	0	0	0	5.00
7.00	00700	OPERATION OF PLANT	0	156,329	0	0	0	7.00
7.01	00701	OPERATION OF PLANT - MOB	0	0	0	0	0	7.01
7.02	00702	OPERATION OF PLANT - POB	0	0	0	0	0	7.02
7.03	00703	OPERATION OF PLANT - WJ	0	0	0	0	0	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	0	6,215	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	6,278	0	0	0	9.00
10.00	01000	DIETARY	0	16,145	0	0	0	10.00
11.00	01100	CAFETERIA	0	28,554	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	11,604	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	10,463	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	124,219	0	0	0	30.00
40.00	04000	SUBPROVIDER - IPF	0	38,201	0	0	0	40.00
43.00	04300	NURSERY	0	5,891	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	41,769	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,302	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	52,253	0	0	0	54.00
60.00	06000	LABORATORY	0	27,361	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	7,649	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	34,068	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	6,027	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	105	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	0	0	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	0	0	0	90.02
90.03	09003	WOUND CLINIC	0	3,568	0	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0	0	0	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0	40,471	0	0	0	90.05
90.06	09006	INFUSION CLINIC	0	6,466	0	0	0	90.06
91.00	09100	EMERGENCY	0	49,909	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	0	16,438	0	0	0	93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	805,977	0	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,067	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT	0	27,257	0	0	0	194.00
194.02	07952	WEST JAY CLINIC	0	0	0	0	0	194.02
194.03	07953	JAY MERIDIAN URGENT CARE	0	16,793	0	0	0	194.03
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	858,094	0	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II | Date/Time Prepared: 6/29/2020 8:10 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT-INTEREST	MVBLE EQUIP	MVBLE EQUIP - MOB	MVBLE EQUIP - POB	MVBLE EQUIP - WJ	
			1.04	2.00	2.01	2.02	2.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MOB						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT-POB						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT-WJ						1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT-INTEREST						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB						2.01
2.02	00202	CAP REL COSTS-MVBLE EQUIP - POB						2.02
2.03	00203	CAP REL COSTS-MVBLE EQUIP - WJ						2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,495	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	237,401	1,781	0	0	5.00
7.00	00700	OPERATION OF PLANT	0	329,861	623	0	0	7.00
7.01	00701	OPERATION OF PLANT - MOB	0	0	0	0	0	7.01
7.02	00702	OPERATION OF PLANT - POB	0	0	0	0	0	7.02
7.03	00703	OPERATION OF PLANT - WJ	0	0	0	0	0	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	0	13,114	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	13,247	0	0	0	9.00
10.00	01000	DIETARY	0	34,066	0	0	0	10.00
11.00	01100	CAFETERIA	0	60,250	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	24,484	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	22,078	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	262,106	0	0	0	30.00
40.00	04000	SUBPROVIDER - IPF	0	80,606	0	0	0	40.00
43.00	04300	NURSERY	0	12,430	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	88,134	1,148	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,857	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	110,256	0	0	0	54.00
60.00	06000	LABORATORY	0	57,733	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	16,139	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	71,885	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	12,717	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	221	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03160	CARDIOPULMONARY	0	0	1,903	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	0	7,661	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	10,713	0	0	90.02
90.03	09003	WOUND CLINIC	0	7,528	0	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0	0	0	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0	85,396	176	0	0	90.05
90.06	09006	INFUSION CLINIC	0	13,644	0	0	0	90.06
91.00	09100	EMERGENCY	0	105,311	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	0	34,684	0	0	0	93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,700,643	24,005	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	17,022	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT	0	57,512	0	0	0	194.00
194.02	07952	WEST JAY CLINIC	0	0	0	0	0	194.02
194.03	07953	JAY MERIDIAN URGENT CARE	0	35,435	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,810,612	24,005	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 6/29/2020 8:10 am

		Cost Center Description	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT - MOB	
			2A	4.00	5.00	7.00	7.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MOB						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT-POB						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT-WJ						1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT-INTEREST						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB						2.01
2.02	00202	CAP REL COSTS-MVBLE EQUIP - POB						2.02
2.03	00203	CAP REL COSTS-MVBLE EQUIP - WJ						2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,677	3,677				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	351,692	130	351,822			5.00
7.00	00700	OPERATION OF PLANT	486,813	95	38,018	524,926		7.00
7.01	00701	OPERATION OF PLANT - MOB	0	0	945	0	945	7.01
7.02	00702	OPERATION OF PLANT - POB	0	0	327	0	0	7.02
7.03	00703	OPERATION OF PLANT - WJ	0	0	0	0	0	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	19,329	14	1,599	3,492	0	8.00
9.00	00900	HOUSEKEEPING	19,525	118	8,018	3,527	0	9.00
10.00	01000	DIETARY	50,211	36	4,084	9,071	0	10.00
11.00	01100	CAFETERIA	88,804	63	5,135	16,043	0	11.00
13.00	01300	NURSING ADMINISTRATION	36,088	364	27,113	6,520	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	8,804	0	0	14.00
15.00	01500	PHARMACY	32,541	147	16,313	5,879	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	386,325	468	32,407	69,793	0	30.00
40.00	04000	SUBPROVIDER - IPF	118,807	275	17,269	21,464	0	40.00
43.00	04300	NURSERY	18,321	17	1,271	3,310	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	131,051	384	25,560	66,484	50	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,159	7	498	1,293	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	162,509	225	19,599	29,359	0	54.00
60.00	06000	LABORATORY	85,094	0	25,118	15,373	0	60.00
65.00	06500	RESPIRATORY THERAPY	23,788	117	7,479	4,297	0	65.00
66.00	06600	PHYSICAL THERAPY	105,953	146	9,837	19,141	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	18,744	27	1,692	3,386	0	67.00
68.00	06800	SPEECH PATHOLOGY	326	5	292	59	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	291	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	3,220	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	379	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	20,272	0	0	73.00
76.00	03160	CARDIOPULMONARY	1,903	34	4,087	8,912	83	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	7,661	178	10,773	35,884	335	90.01
90.02	09002	JAY FAMILY MEDICINE	10,713	213	13,779	50,182	469	90.02
90.03	09003	WOUND CLINIC	11,096	12	819	2,005	0	90.03
90.04	09004	OP ORTHO CLINIC	0	0	0	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	126,043	94	7,236	23,562	8	90.05
90.06	09006	INFUSION CLINIC	20,110	26	1,788	3,633	0	90.06
91.00	09100	EMERGENCY	155,220	303	23,881	28,042	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
93.00	04950	OUTPATIENT PSYCH	51,122	7	1,113	9,236	0	93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,530,625	3,505	339,016	439,947	945	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	25,089	0	335	4,533	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	33	2,150	36,737	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT	84,769	0	1,133	15,314	0	194.00
194.02	07952	WEST JAY CLINIC	0	83	5,105	18,959	0	194.02
194.03	07953	JAY MERIDIAN URGENT CARE	52,228	56	4,083	9,436	0	194.03
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)	2,692,711	3,677	351,822	524,926	945	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 6/29/2020 8:10 am

		Cost Center Description	OPERATION OF PLANT - POB	OPERATION OF PLANT - WJ	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			7.02	7.03	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MOB						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT-POB						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT-WJ						1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT-INTEREST						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB						2.01
2.02	00202	CAP REL COSTS-MVBLE EQUIP - POB						2.02
2.03	00203	CAP REL COSTS-MVBLE EQUIP - WJ						2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT - MOB						7.01
7.02	00702	OPERATION OF PLANT - POB	327					7.02
7.03	00703	OPERATION OF PLANT - WJ	0	0				7.03
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	24,434			8.00
9.00	00900	HOUSEKEEPING	0	0	2,959	34,147		9.00
10.00	01000	DIETARY	0	0	764	621	64,787	10.00
11.00	01100	CAFETERIA	0	0	0	1,098	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	446	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	402	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	11,201	4,776	46,045	30.00
40.00	04000	SUBPROVIDER - IPF	0	0	604	1,469	18,742	40.00
43.00	04300	NURSERY	0	0	443	227	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	235	0	2,545	4,550	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	89	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	1,941	2,009	0	54.00
60.00	06000	LABORATORY	0	0	0	1,052	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	294	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	159	1,310	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	232	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	4	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	509	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03160	CARDIOPULMONARY	0	0	0	610	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	0	0	2,456	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	0	3,434	0	90.02
90.03	09003	WOUND CLINIC	0	0	0	137	0	90.03
90.04	09004	OP ORTHO CLINIC	0	0	0	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0	0	0	1,613	0	90.05
90.06	09006	INFUSION CLINIC	0	0	0	249	0	90.06
91.00	09100	EMERGENCY	0	0	3,309	1,919	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	0	0	0	632	0	93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	235	0	24,434	29,629	64,787	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	310	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	92	0	0	2,514	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT	0	0	0	1,048	0	194.00
194.02	07952	WEST JAY CLINIC	0	0	0	0	0	194.02
194.03	07953	JAY MERIDIAN URGENT CARE	0	0	0	646	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	327	0	24,434	34,147	64,787	202.00

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		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MOB						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT-POB						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT-WJ						1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT-INTEREST						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB						2.01
2.02	00202	CAP REL COSTS-MVBLE EQUIP - POB						2.02
2.03	00203	CAP REL COSTS-MVBLE EQUIP - WJ						2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT - MOB						7.01
7.02	00702	OPERATION OF PLANT - POB						7.02
7.03	00703	OPERATION OF PLANT - WJ						7.03
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	111,143					11.00
13.00	01300	NURSING ADMINISTRATION	8,926	79,457				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	8,804			14.00
15.00	01500	PHARMACY	3,659	0	65	59,006		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,011	16,977	941	388	0	30.00
40.00	04000	SUBPROVIDER - IPF	8,217	10,012	43	0	0	40.00
43.00	04300	NURSERY	461	521	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,217	13,122	3,224	228	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	179	207	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,033	0	355	141	0	54.00
60.00	06000	LABORATORY	6,760	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,532	0	141	3	0	65.00
66.00	06600	PHYSICAL THERAPY	3,054	0	29	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	715	0	3	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	104	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	7	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	2,345	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	276	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	57,452	0	73.00
76.00	03160	CARDIOPULMONARY	1,078	45	14	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	9,969	9,841	198	309	0	90.01
90.02	09002	JAY FAMILY MEDICINE	11,784	12,537	106	8	0	90.02
90.03	09003	WOUND CLINIC	398	620	35	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0	0	0	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	4,766	4,206	74	0	0	90.05
90.06	09006	INFUSION CLINIC	576	899	91	63	0	90.06
91.00	09100	EMERGENCY	8,436	10,470	840	413	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	565	0	0	0	0	93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	106,440	79,457	8,787	59,005	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,781	0	4	1	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT	0	0	0	0	0	194.00
194.02	07952	WEST JAY CLINIC	0	0	13	0	0	194.02
194.03	07953	JAY MERIDIAN URGENT CARE	2,922	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	111,143	79,457	8,804	59,006	0	202.00

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		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MOB						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT-POB						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT-WJ						1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT-INTEREST						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB						2.01
2.02	00202	CAP REL COSTS-MVBLE EQUIP - POB						2.02
2.03	00203	CAP REL COSTS-MVBLE EQUIP - WJ						2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT - MOB						7.01
7.02	00702	OPERATION OF PLANT - POB						7.02
7.03	00703	OPERATION OF PLANT - WJ						7.03
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	0					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	584,332	0	584,332		30.00
40.00	04000	SUBPROVIDER - IPF	0	196,902	0	196,902		40.00
43.00	04300	NURSERY	0	24,571	0	24,571		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	259,650	0	259,650		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	9,432	0	9,432		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	222,171	0	222,171		54.00
60.00	06000	LABORATORY	0	133,397	0	133,397		60.00
65.00	06500	RESPIRATORY THERAPY	0	39,651	0	39,651		65.00
66.00	06600	PHYSICAL THERAPY	0	139,629	0	139,629		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	24,799	0	24,799		67.00
68.00	06800	SPEECH PATHOLOGY	0	790	0	790		68.00
69.00	06900	ELECTROCARDIOLOGY	0	807	0	807		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,565	0	5,565		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	655	0	655		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	77,724	0	77,724		73.00
76.00	03160	CARDIOPULMONARY	0	16,766	0	16,766		76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0		90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	77,604	0	77,604		90.01
90.02	09002	JAY FAMILY MEDICINE	0	103,225	0	103,225		90.02
90.03	09003	WOUND CLINIC	0	15,122	0	15,122		90.03
90.04	09004	OP ORTHO CLINIC	0	0	0	0		90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0	167,602	0	167,602		90.05
90.06	09006	INFUSION CLINIC	0	27,435	0	27,435		90.06
91.00	09100	EMERGENCY	0	232,833	0	232,833		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
93.00	04950	OUTPATIENT PSYCH	0	62,675	0	62,675		93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,423,337	0	2,423,337		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	30,267	0	30,267		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	43,312	0	43,312		192.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
194.00	07950	VACANT	0	102,264	0	102,264		194.00
194.02	07952	WEST JAY CLINIC	0	24,160	0	24,160		194.02
194.03	07953	JAY MERIDIAN URGENT CARE	0	69,371	0	69,371		194.03
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,692,711	0	2,692,711		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 6/29/2020 8:10 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	BLDG & FIXT-MOB (SQUARE FEET-MOB)	BLDG & FIXT-POB (SQUARE FEET-POB)	BLDG & FIXT-WJ (SQUARE FEET-WJ)	BLDG & FIXT-INTEREST (SQUARE FEET)	
			1.00	1.01	1.02	1.03	1.04	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	82,011					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MOB	0	19,126				1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT-POB	0	0	9,538			1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT-WJ	0	0	0	6,953		1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT-INTEREST	0	0	0	0	82,011	1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB						2.01
2.02	00202	CAP REL COSTS-MVBLE EQUIP - POB						2.02
2.03	00203	CAP REL COSTS-MVBLE EQUIP - WJ						2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	113	0	0	0	113	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,753	1,419	0	0	10,753	5.00
7.00	00700	OPERATION OF PLANT	14,941	496	615	0	14,941	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	594	0	0	0	594	8.00
9.00	00900	HOUSEKEEPING	600	0	0	0	600	9.00
10.00	01000	DIETARY	1,543	0	0	0	1,543	10.00
11.00	01100	CAFETERIA	2,729	0	0	0	2,729	11.00
13.00	01300	NURSING ADMINISTRATION	1,109	0	0	0	1,109	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	1,000	0	0	0	1,000	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,872	0	0	0	11,872	30.00
40.00	04000	SUBPROVIDER - IPF	3,651	0	0	0	3,651	40.00
43.00	04300	NURSERY	563	0	0	0	563	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,992	915	6,402	0	3,992	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	220	0	0	0	220	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,994	0	0	0	4,994	54.00
60.00	06000	LABORATORY	2,615	0	0	0	2,615	60.00
65.00	06500	RESPIRATORY THERAPY	731	0	0	0	731	65.00
66.00	06600	PHYSICAL THERAPY	3,256	0	0	0	3,256	66.00
67.00	06700	OCCUPATIONAL THERAPY	576	0	0	0	576	67.00
68.00	06800	SPEECH PATHOLOGY	10	0	0	0	10	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03160	CARDIOPULMONARY	0	1,516	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	6,104	0	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0	8,536	0	0	0	90.02
90.03	09003	WOUND CLINIC	341	0	0	0	341	90.03
90.04	09004	OP ORTHO CLINIC	0	0	0	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	3,868	140	0	0	3,868	90.05
90.06	09006	INFUSION CLINIC	618	0	0	0	618	90.06
91.00	09100	EMERGENCY	4,770	0	0	0	4,770	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	1,571	0	0	0	1,571	93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	77,030	19,126	7,017	0	77,030	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	771	0	0	0	771	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	2,521	3,728	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT	2,605	0	0	0	2,605	194.00
194.02	07952	WEST JAY CLINIC	0	0	0	3,225	0	194.02
194.03	07953	JAY MERIDIAN URGENT CARE	1,605	0	0	0	1,605	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	858,094	0	0	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	10.463157	0.000000	0.000000	0.000000	0.000000	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 6/29/2020 8:10 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	BLDG & FIXT-MOB (SQUARE FEET-MOB)	BLDG & FIXT-POB (SQUARE FEET-POB)	BLDG & FIXT-WJ (SQUARE FEET-WJ)	BLDG & FIXT-INTEREST (SQUARE FEET)	
			1.00	1.01	1.02	1.03	1.04	
204.00		Cost to be allocated (per Wkst. B, Part II)						204.00
205.00		Unit cost multiplier (Wkst. B, Part II)						205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 6/29/2020 8:10 am

		Cost Center Description	CAPITAL RELATED COSTS					
			MVBLE EQUIP (SQUARE FEET)	MVBLE EQUIP - MOB (SQUARE FEET-MOB)	MVBLE EQUIP - POB (SQUARE FEET-POB)	MVBLE EQUIP - WJ (SQUARE FEET-WJ)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
			2.00	2.01	2.02	2.03	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MOB						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT-POB						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT-WJ						1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT-INTEREST						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP	82,011					2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB	0	19,126				2.01
2.02	00202	CAP REL COSTS-MVBLE EQUIP - POB	0	0	9,538			2.02
2.03	00203	CAP REL COSTS-MVBLE EQUIP - WJ	0	0	0	6,953		2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	113	0	0	0	12,014,727	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,753	1,419	0	0	425,408	5.00
7.00	00700	OPERATION OF PLANT	14,941	496	615	0	310,937	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	594	0	0	0	44,630	8.00
9.00	00900	HOUSEKEEPING	600	0	0	0	384,987	9.00
10.00	01000	DIETARY	1,543	0	0	0	116,650	10.00
11.00	01100	CAFETERIA	2,729	0	0	0	206,347	11.00
13.00	01300	NURSING ADMINISTRATION	1,109	0	0	0	1,188,820	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	160	14.00
15.00	01500	PHARMACY	1,000	0	0	0	480,020	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,872	0	0	0	1,526,891	30.00
40.00	04000	SUBPROVIDER - IPF	3,651	0	0	0	898,072	40.00
43.00	04300	NURSERY	563	0	0	0	57,106	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,992	915	6,402	0	1,256,143	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	220	0	0	0	22,375	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,994	0	0	0	734,829	54.00
60.00	06000	LABORATORY	2,615	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	731	0	0	0	383,727	65.00
66.00	06600	PHYSICAL THERAPY	3,256	0	0	0	476,558	66.00
67.00	06700	OCCUPATIONAL THERAPY	576	0	0	0	87,175	67.00
68.00	06800	SPEECH PATHOLOGY	10	0	0	0	17,435	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03160	CARDIOPULMONARY	0	1,516	0	0	109,921	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	6,104	0	0	581,574	90.01
90.02	09002	JAY FAMILY MEDICINE	0	8,536	0	0	697,161	90.02
90.03	09003	WOUND CLINIC	341	0	0	0	38,398	90.03
90.04	09004	OP ORTHO CLINIC	0	0	0	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	3,868	140	0	0	307,734	90.05
90.06	09006	INFUSION CLINIC	618	0	0	0	85,402	90.06
91.00	09100	EMERGENCY	4,770	0	0	0	989,001	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	1,571	0	0	0	23,691	93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	77,030	19,126	7,017	0	11,451,152	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	771	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	2,521	3,728	109,150	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT	2,605	0	0	0	0	194.00
194.02	07952	WEST JAY CLINIC	0	0	0	3,225	270,464	194.02
194.03	07953	JAY MERIDIAN URGENT CARE	1,605	0	0	0	183,961	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,810,612	24,005	0	0	2,788,216	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	22.077673	1.255098	0.000000	0.000000	0.232067	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 6/29/2020 8:10 am

		Cost Center Description	CAPITAL RELATED COSTS					
			MVBLE EQUIP (SQUARE FEET)	MVBLE EQUIP - MOB (SQUARE FEET-MOB)	MVBLE EQUIP - POB (SQUARE FEET-POB)	MVBLE EQUIP - WJ (SQUARE FEET-WJ)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
			2.00	2.01	2.02	2.03	4.00	
204.00		Cost to be allocated (per Wkst. B, Part II)					3,677	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)					0.000306	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 6/29/2020 8:10 am

		Cost Center Description	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT - MOB (SQUARE FEET-MOB)	OPERATION OF PLANT - POB (SQUARE FEET-POB)	
			5A	5.00	7.00	7.01	7.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MOB						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT-POB						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT-WJ						1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT-INTEREST						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB						2.01
2.02	00202	CAP REL COSTS-MVBLE EQUIP - POB						2.02
2.03	00203	CAP REL COSTS-MVBLE EQUIP - WJ						2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-9,102,031	26,314,521				5.00
7.00	00700	OPERATION OF PLANT	0	2,843,884	89,291			7.00
7.01	00701	OPERATION OF PLANT - MOB	0	70,697	0	17,211		7.01
7.02	00702	OPERATION OF PLANT - POB	0	24,465	0	0	8,923	7.02
7.03	00703	OPERATION OF PLANT - WJ	0	0	0	0	0	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	0	119,597	594	0	0	8.00
9.00	00900	HOUSEKEEPING	0	599,719	600	0	0	9.00
10.00	01000	DIETARY	0	305,495	1,543	0	0	10.00
11.00	01100	CAFETERIA	0	384,056	2,729	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,027,877	1,109	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	658,478	0	0	0	14.00
15.00	01500	PHARMACY	0	1,220,097	1,000	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,423,894	11,872	0	0	30.00
40.00	04000	SUBPROVIDER - IPF	0	1,291,618	3,651	0	0	40.00
43.00	04300	NURSERY	0	95,040	563	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,911,716	11,309	915	6,402	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	37,218	220	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,465,864	4,994	0	0	54.00
60.00	06000	LABORATORY	0	1,878,697	2,615	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	559,356	731	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	735,718	3,256	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	126,522	576	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	21,807	10	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	21,753	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	240,803	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	28,318	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,516,241	0	0	0	73.00
76.00	03160	CARDIOPULMONARY	0	305,680	1,516	1,516	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	805,738	6,104	6,104	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0	1,030,611	8,536	8,536	0	90.02
90.03	09003	WOUND CLINIC	0	61,283	341	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0	0	0	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0	541,205	4,008	140	0	90.05
90.06	09006	INFUSION CLINIC	0	133,749	618	0	0	90.06
91.00	09100	EMERGENCY	0	1,786,145	4,770	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	0	83,275	1,571	0	0	93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-9,102,031	25,356,616	74,836	17,211	6,402	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	25,089	771	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	160,842	6,249	0	2,521	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT	0	84,769	2,605	0	0	194.00
194.02	07952	WEST JAY CLINIC	0	381,800	3,225	0	0	194.02
194.03	07953	JAY MERIDIAN URGENT CARE	0	305,405	1,605	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)		9,102,031	3,827,564	95,151	32,927	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.345894	42.866179	5.528499	3.690127	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		351,822	524,926	945	327	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 6/29/2020 8:10 am

		Cost Center Description	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT - MOB (SQUARE FEET-MOB)	OPERATION OF PLANT - POB (SQUARE FEET-POB)	
			5A	5.00	7.00	7.01	7.02	
205.00		Unit cost multiplier (Wkst. B, Part II)		0.013370	5.878823	0.054907	0.036647	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 6/29/2020 8:10 am

		Cost Center Description	OPERATION OF PLANT - WJ (SQUARE FEET-WJ)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	
			7.03	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MOB						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT-POB						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT-WJ						1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT-INTEREST						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB						2.01
2.02	00202	CAP REL COSTS-MVBLE EQUIP - POB						2.02
2.03	00203	CAP REL COSTS-MVBLE EQUIP - WJ						2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT - MOB						7.01
7.02	00702	OPERATION OF PLANT - POB						7.02
7.03	00703	OPERATION OF PLANT - WJ	6,953					7.03
8.00	00800	LAUNDRY & LINEN SERVICE	0	46,080				8.00
9.00	00900	HOUSEKEEPING	0	5,580	84,872			9.00
10.00	01000	DIETARY	0	1,440	1,543	12,963		10.00
11.00	01100	CAFETERIA	0	0	2,729	0	19,287	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	1,109	0	1,549	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	1,000	0	635	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	21,125	11,872	9,213	2,605	30.00
40.00	04000	SUBPROVIDER - IPF	0	1,140	3,651	3,750	1,426	40.00
43.00	04300	NURSERY	0	835	563	0	80	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,800	11,309	0	2,120	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	220	0	31	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,660	4,994	0	1,047	54.00
60.00	06000	LABORATORY	0	0	2,615	0	1,173	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	731	0	613	65.00
66.00	06600	PHYSICAL THERAPY	0	300	3,256	0	530	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	576	0	124	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	10	0	18	68.00
69.00	06900	ELECTROCARDIOLOGY	0	960	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03160	CARDIOPULMONARY	0	0	1,516	0	187	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	0	6,104	0	1,730	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	8,536	0	2,045	90.02
90.03	09003	WOUND CLINIC	0	0	341	0	69	90.03
90.04	09004	OP ORTHO CLINIC	0	0	0	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0	0	4,008	0	827	90.05
90.06	09006	INFUSION CLINIC	0	0	618	0	100	90.06
91.00	09100	EMERGENCY	0	6,240	4,770	0	1,464	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	0	0	1,571	0	98	93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	46,080	73,642	12,963	18,471	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	771	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,728	0	6,249	0	309	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT	0	0	2,605	0	0	194.00
194.02	07952	WEST JAY CLINIC	3,225	0	0	0	0	194.02
194.03	07953	JAY MERIDIAN URGENT CARE	0	0	1,605	0	507	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	186,428	855,453	498,685	661,387	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	4.045747	10.079331	38.469876	34.291855	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	24,434	34,147	64,787	111,143	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 6/29/2020 8:10 am

		Cost Center Description	OPERATION OF PLANT - WJ (SQUARE FEET-WJ)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	
			7.03	8.00	9.00	10.00	11.00	
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.530252	0.402335	4.997840	5.762586	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 6/29/2020 8:10 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MOB						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT-POB						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT-WJ						1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT-INTEREST						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB						2.01
2.02	00202	CAP REL COSTS-MVBLE EQUIP - POB						2.02
2.03	00203	CAP REL COSTS-MVBLE EQUIP - WJ						2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT - MOB						7.01
7.02	00702	OPERATION OF PLANT - POB						7.02
7.03	00703	OPERATION OF PLANT - WJ						7.03
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	8,841					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	904,019				14.00
15.00	01500	PHARMACY	0	6,709	1,557,249			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	94,763,214		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,889	96,658	10,231	8,907,287	0	30.00
40.00	04000	SUBPROVIDER - IPF	1,114	4,389	9	2,212,200	0	40.00
43.00	04300	NURSERY	58	0	0	207,215	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,460	331,136	6,013	20,769,132	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	23	0	0	1,339,572	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	36,413	3,730	11,346,101	0	54.00
60.00	06000	LABORATORY	0	0	0	8,927,999	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	14,453	81	1,178,512	0	65.00
66.00	06600	PHYSICAL THERAPY	0	2,951	0	1,417,082	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	278	0	300,745	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	14,646	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	711	0	880,483	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	240,803	0	1,208,669	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	28,318	0	437,550	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,516,241	10,726,684	0	73.00
76.00	03160	CARDIOPULMONARY	5	1,420	0	2,253,308	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1,095	20,332	8,146	1,258,334	0	90.01
90.02	09002	JAY FAMILY MEDICINE	1,395	10,839	205	1,068,471	0	90.02
90.03	09003	WOUND CLINIC	69	3,599	0	115,619	0	90.03
90.04	09004	OP ORTHO CLINIC	0	0	0	50,563	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	468	7,608	0	243,853	0	90.05
90.06	09006	INFUSION CLINIC	100	9,371	1,669	1,951,392	0	90.06
91.00	09100	EMERGENCY	1,165	86,265	10,890	17,740,970	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	0	12	0	206,827	0	93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,841	902,265	1,557,215	94,763,214	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	17	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	402	34	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT	0	0	0	0	0	194.00
194.02	07952	WEST JAY CLINIC	0	1,335	0	0	0	194.02
194.03	07953	JAY MERIDIAN URGENT CARE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,841,142	886,242	1,723,418	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	321.359801	0.980336	1.106707	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	79,457	8,804	59,006	0	0	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 6/29/2020 8:10 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	
			13.00	14.00	15.00	16.00	17.00	
205.00		Unit cost multiplier (Wkst. B, Part II)	8.987332	0.009739	0.037891	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 6/29/2020 8:10 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,133,223		5,133,223	0	5,133,223	30.00
40.00	04000	SUBPROVIDER - IPF	2,491,767		2,491,767	0	2,491,767	40.00
43.00	04300	NURSERY	182,483		182,483	0	182,483	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,092,993		4,092,993	0	4,092,993	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	70,193		70,193	0	70,193	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,327,844		2,327,844	0	2,327,844	54.00
60.00	06000	LABORATORY	2,707,203		2,707,203	0	2,707,203	60.00
65.00	06500	RESPIRATORY THERAPY	826,817	0	826,817	0	826,817	65.00
66.00	06600	PHYSICAL THERAPY	1,184,870	0	1,184,870	0	1,184,870	66.00
67.00	06700	OCCUPATIONAL THERAPY	205,307	0	205,307	0	205,307	67.00
68.00	06800	SPEECH PATHOLOGY	30,497	0	30,497	0	30,497	68.00
69.00	06900	ELECTROCARDIOLOGY	33,858		33,858	0	33,858	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	560,163		560,163	0	560,163	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	65,874		65,874	0	65,874	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,718,733		3,718,733	0	3,718,733	73.00
76.00	03160	CARDIOPULMONARY	509,471		509,471	0	509,471	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1,881,524		1,881,524	0	1,881,524	90.01
90.02	09002	JAY FAMILY MEDICINE	2,415,504		2,415,504	0	2,415,504	90.02
90.03	09003	WOUND CLINIC	128,602		128,602	0	128,602	90.03
90.04	09004	OP ORTHO CLINIC	0		0	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	1,127,598		1,127,598	0	1,127,598	90.05
90.06	09006	INFUSION CLINIC	259,331		259,331	0	259,331	90.06
91.00	09100	EMERGENCY	3,202,965		3,202,965	0	3,202,965	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,433,909		1,433,909		1,433,909	92.00
93.00	04950	OUTPATIENT PSYCH	198,630		198,630	0	198,630	93.00
200.00		Subtotal (see instructions)	34,789,359	0	34,789,359	0	34,789,359	200.00
201.00		Less Observation Beds	1,433,909		1,433,909		1,433,909	201.00
202.00		Total (see instructions)	33,355,450	0	33,355,450	0	33,355,450	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 6/29/2020 8:10 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,970,129		3,970,129			30.00
40.00	04000	SUBPROVIDER - IPF	2,212,200		2,212,200			40.00
43.00	04300	NURSERY	207,215		207,215			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,415,696	16,353,436	20,769,132	0.197071	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	910,635	428,937	1,339,572	0.052400	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	660,056	10,686,045	11,346,101	0.205167	0.000000	54.00
60.00	06000	LABORATORY	1,632,941	7,295,058	8,927,999	0.303226	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	641,167	537,345	1,178,512	0.701577	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	195,861	1,221,221	1,417,082	0.836134	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	128,434	172,311	300,745	0.682661	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	2,936	11,710	14,646	2.082275	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	91,892	788,591	880,483	0.038454	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	600,234	608,435	1,208,669	0.463454	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	47,846	389,704	437,550	0.150552	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,407,622	8,319,062	10,726,684	0.346681	0.000000	73.00
76.00	03160	CARDIOPULMONARY	271,015	1,982,293	2,253,308	0.226099	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	590	1,257,744	1,258,334	1.495250	0.000000	90.01
90.02	09002	JAY FAMILY MEDICINE	768	1,067,703	1,068,471	2.260711	0.000000	90.02
90.03	09003	WOUND CLINIC	0	115,619	115,619	1.112291	0.000000	90.03
90.04	09004	OP ORTHO CLINIC	0	50,563	50,563	0.000000	0.000000	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	141	243,712	243,853	4.624089	0.000000	90.05
90.06	09006	INFUSION CLINIC	0	1,951,392	1,951,392	0.132895	0.000000	90.06
91.00	09100	EMERGENCY	875,139	16,865,831	17,740,970	0.180541	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	10,350	4,926,808	4,937,158	0.290432	0.000000	92.00
93.00	04950	OUTPATIENT PSYCH	250	206,577	206,827	0.960368	0.000000	93.00
200.00		Subtotal (see instructions)	19,283,117	75,480,097	94,763,214			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	19,283,117	75,480,097	94,763,214			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 6/29/2020 8:10 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.197071		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.052400		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.205167		54.00
60.00	06000	LABORATORY	0.303226		60.00
65.00	06500	RESPIRATORY THERAPY	0.701577		65.00
66.00	06600	PHYSICAL THERAPY	0.836134		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.682661		67.00
68.00	06800	SPEECH PATHOLOGY	2.082275		68.00
69.00	06900	ELECTROCARDIOLOGY	0.038454		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.463454		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.150552		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.346681		73.00
76.00	03160	CARDIOPULMONARY	0.226099		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1.495250		90.01
90.02	09002	JAY FAMILY MEDICINE	2.260711		90.02
90.03	09003	WOUND CLINIC	1.112291		90.03
90.04	09004	OP ORTHO CLINIC	0.000000		90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	4.624089		90.05
90.06	09006	INFUSION CLINIC	0.132895		90.06
91.00	09100	EMERGENCY	0.180541		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.290432		92.00
93.00	04950	OUTPATIENT PSYCH	0.960368		93.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 6/29/2020 8:10 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,133,223		5,133,223	0	5,133,223	30.00
40.00	04000	SUBPROVIDER - IPF	2,491,767		2,491,767	0	2,491,767	40.00
43.00	04300	NURSERY	182,483		182,483	0	182,483	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,092,993		4,092,993	0	4,092,993	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	70,193		70,193	0	70,193	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,327,844		2,327,844	0	2,327,844	54.00
60.00	06000	LABORATORY	2,707,203		2,707,203	0	2,707,203	60.00
65.00	06500	RESPIRATORY THERAPY	826,817	0	826,817	0	826,817	65.00
66.00	06600	PHYSICAL THERAPY	1,184,870	0	1,184,870	0	1,184,870	66.00
67.00	06700	OCCUPATIONAL THERAPY	205,307	0	205,307	0	205,307	67.00
68.00	06800	SPEECH PATHOLOGY	30,497	0	30,497	0	30,497	68.00
69.00	06900	ELECTROCARDIOLOGY	33,858		33,858	0	33,858	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	560,163		560,163	0	560,163	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	65,874		65,874	0	65,874	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,718,733		3,718,733	0	3,718,733	73.00
76.00	03160	CARDIOPULMONARY	509,471		509,471	0	509,471	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1,881,524		1,881,524	0	1,881,524	90.01
90.02	09002	JAY FAMILY MEDICINE	2,415,504		2,415,504	0	2,415,504	90.02
90.03	09003	WOUND CLINIC	128,602		128,602	0	128,602	90.03
90.04	09004	OP ORTHO CLINIC	0		0	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	1,127,598		1,127,598	0	1,127,598	90.05
90.06	09006	INFUSION CLINIC	259,331		259,331	0	259,331	90.06
91.00	09100	EMERGENCY	3,202,965		3,202,965	0	3,202,965	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,433,909		1,433,909		1,433,909	92.00
93.00	04950	OUTPATIENT PSYCH	198,630		198,630	0	198,630	93.00
200.00		Subtotal (see instructions)	34,789,359	0	34,789,359	0	34,789,359	200.00
201.00		Less Observation Beds	1,433,909		1,433,909		1,433,909	201.00
202.00		Total (see instructions)	33,355,450	0	33,355,450	0	33,355,450	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 6/29/2020 8:10 am

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,970,129		3,970,129			30.00
40.00	04000	SUBPROVIDER - IPF	2,212,200		2,212,200			40.00
43.00	04300	NURSERY	207,215		207,215			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,415,696	16,353,436	20,769,132	0.197071	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	910,635	428,937	1,339,572	0.052400	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	660,056	10,686,045	11,346,101	0.205167	0.000000	54.00
60.00	06000	LABORATORY	1,632,941	7,295,058	8,927,999	0.303226	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	641,167	537,345	1,178,512	0.701577	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	195,861	1,221,221	1,417,082	0.836134	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	128,434	172,311	300,745	0.682661	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	2,936	11,710	14,646	2.082275	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	91,892	788,591	880,483	0.038454	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	600,234	608,435	1,208,669	0.463454	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	47,846	389,704	437,550	0.150552	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,407,622	8,319,062	10,726,684	0.346681	0.000000	73.00
76.00	03160	CARDIOPULMONARY	271,015	1,982,293	2,253,308	0.226099	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	590	1,257,744	1,258,334	1.495250	0.000000	90.01
90.02	09002	JAY FAMILY MEDICINE	768	1,067,703	1,068,471	2.260711	0.000000	90.02
90.03	09003	WOUND CLINIC	0	115,619	115,619	1.112291	0.000000	90.03
90.04	09004	OP ORTHO CLINIC	0	50,563	50,563	0.000000	0.000000	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	141	243,712	243,853	4.624089	0.000000	90.05
90.06	09006	INFUSION CLINIC	0	1,951,392	1,951,392	0.132895	0.000000	90.06
91.00	09100	EMERGENCY	875,139	16,865,831	17,740,970	0.180541	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	10,350	4,926,808	4,937,158	0.290432	0.000000	92.00
93.00	04950	OUTPATIENT PSYCH	250	206,577	206,827	0.960368	0.000000	93.00
200.00		Subtotal (see instructions)	19,283,117	75,480,097	94,763,214			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	19,283,117	75,480,097	94,763,214			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 6/29/2020 8:10 am

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.197071		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.052400		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.205167		54.00
60.00	06000	LABORATORY	0.303226		60.00
65.00	06500	RESPIRATORY THERAPY	0.701577		65.00
66.00	06600	PHYSICAL THERAPY	0.836134		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.682661		67.00
68.00	06800	SPEECH PATHOLOGY	2.082275		68.00
69.00	06900	ELECTROCARDIOLOGY	0.038454		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.463454		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.150552		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.346681		73.00
76.00	03160	CARDIOPULMONARY	0.226099		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1.495250		90.01
90.02	09002	JAY FAMILY MEDICINE	2.260711		90.02
90.03	09003	WOUND CLINIC	1.112291		90.03
90.04	09004	OP ORTHO CLINIC	0.000000		90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	4.624089		90.05
90.06	09006	INFUSION CLINIC	0.132895		90.06
91.00	09100	EMERGENCY	0.180541		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.290432		92.00
93.00	04950	OUTPATIENT PSYCH	0.960368		93.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

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

Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part II | Date/Time Prepared: 6/29/2020 8:10 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,092,993	259,650	3,833,343	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	70,193	9,432	60,761	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,327,844	222,171	2,105,673	0	0	54.00
60.00	06000	LABORATORY	2,707,203	133,397	2,573,806	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	826,817	39,651	787,166	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,184,870	139,629	1,045,241	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	205,307	24,799	180,508	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	30,497	790	29,707	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	33,858	807	33,051	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	560,163	5,565	554,598	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	65,874	655	65,219	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,718,733	77,724	3,641,009	0	0	73.00
76.00	03160	CARDIOPULMONARY	509,471	16,766	492,705	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1,881,524	77,604	1,803,920	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	2,415,504	103,225	2,312,279	0	0	90.02
90.03	09003	WOUND CLINIC	128,602	15,122	113,480	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0	0	0	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	1,127,598	167,602	959,996	0	0	90.05
90.06	09006	INFUSION CLINIC	259,331	27,435	231,896	0	0	90.06
91.00	09100	EMERGENCY	3,202,965	232,833	2,970,132	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,433,909	163,226	1,270,683	0	0	92.00
93.00	04950	OUTPATIENT PSYCH	198,630	62,675	135,955	0	0	93.00
200.00		Subtotal (sum of lines 50 thru 199)	26,981,886	1,780,758	25,201,128	0	0	200.00
201.00		Less Observation Beds	1,433,909	163,226	1,270,683	0	0	201.00
202.00		Total (line 200 minus line 201)	25,547,977	1,617,532	23,930,445	0	0	202.00

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

Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part II Date/Time Prepared: 6/29/2020 8:10 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	4,092,993	20,769,132	0.197071		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	70,193	1,339,572	0.052400		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,327,844	11,346,101	0.205167		54.00
60.00	06000	LABORATORY	2,707,203	8,927,999	0.303226		60.00
65.00	06500	RESPIRATORY THERAPY	826,817	1,178,512	0.701577		65.00
66.00	06600	PHYSICAL THERAPY	1,184,870	1,417,082	0.836134		66.00
67.00	06700	OCCUPATIONAL THERAPY	205,307	300,745	0.682661		67.00
68.00	06800	SPEECH PATHOLOGY	30,497	14,646	2.082275		68.00
69.00	06900	ELECTROCARDIOLOGY	33,858	880,483	0.038454		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	560,163	1,208,669	0.463454		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	65,874	437,550	0.150552		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,718,733	10,726,684	0.346681		73.00
76.00	03160	CARDIOPULMONARY	509,471	2,253,308	0.226099		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0.000000		90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1,881,524	1,258,334	1.495250		90.01
90.02	09002	JAY FAMILY MEDICINE	2,415,504	1,068,471	2.260711		90.02
90.03	09003	WOUND CLINIC	128,602	115,619	1.112291		90.03
90.04	09004	OP ORTHO CLINIC	0	50,563	0.000000		90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	1,127,598	243,853	4.624089		90.05
90.06	09006	INFUSION CLINIC	259,331	1,951,392	0.132895		90.06
91.00	09100	EMERGENCY	3,202,965	17,740,970	0.180541		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,433,909	4,937,158	0.290432		92.00
93.00	04950	OUTPATIENT PSYCH	198,630	206,827	0.960368		93.00
200.00		Subtotal (sum of lines 50 thru 199)	26,981,886	88,373,670			200.00
201.00		Less Observation Beds	1,433,909	0			201.00
202.00		Total (line 200 minus line 201)	25,547,977	88,373,670			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part II Date/Time Prepared: 6/29/2020 8:10 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	259,650	20,769,132	0.012502	750,493	9,383	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,432	1,339,572	0.007041	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	222,171	11,346,101	0.019581	189,265	3,706	54.00
60.00	06000	LABORATORY	133,397	8,927,999	0.014941	458,941	6,857	60.00
65.00	06500	RESPIRATORY THERAPY	39,651	1,178,512	0.033645	254,893	8,576	65.00
66.00	06600	PHYSICAL THERAPY	139,629	1,417,082	0.098533	83,635	8,241	66.00
67.00	06700	OCCUPATIONAL THERAPY	24,799	300,745	0.082459	53,410	4,404	67.00
68.00	06800	SPEECH PATHOLOGY	790	14,646	0.053940	2,028	109	68.00
69.00	06900	ELECTROCARDIOLOGY	807	880,483	0.000917	18,396	17	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,565	1,208,669	0.004604	100,883	464	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	655	437,550	0.001497	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	77,724	10,726,684	0.007246	591,932	4,289	73.00
76.00	03160	CARDIOPULMONARY	16,766	2,253,308	0.007441	157,240	1,170	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	77,604	1,258,334	0.061672	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	103,225	1,068,471	0.096610	0	0	90.02
90.03	09003	WOUND CLINIC	15,122	115,619	0.130792	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0	50,563	0.000000	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	167,602	243,853	0.687308	0	0	90.05
90.06	09006	INFUSION CLINIC	27,435	1,951,392	0.014059	0	0	90.06
91.00	09100	EMERGENCY	232,833	17,740,970	0.013124	10,582	139	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	163,226	4,937,158	0.033061	0	0	92.00
93.00	04950	OUTPATIENT PSYCH	62,675	206,827	0.303031	0	0	93.00
200.00		Total (lines 50 through 199)	1,780,758	88,373,670		2,671,698	47,355	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV Date/Time Prepared: 6/29/2020 8:10 am

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
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	0	0	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	0	0	0	90.02
90.03	09003	WOUND CLINIC	0	0	0	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0	0	0	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0	0	0	0	0	90.05
90.06	09006	INFUSION CLINIC	0	0	0	0	0	90.06
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
93.00	04950	OUTPATIENT PSYCH	0	0	0	0	0	93.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 6/29/2020 8:10 am

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	20,769,132	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,339,572	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	11,346,101	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	8,927,999	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,178,512	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,417,082	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	300,745	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	14,646	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	880,483	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,208,669	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	437,550	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,726,684	0.000000	73.00
76.00	03160	CARDIOPULMONARY	0	0	0	2,253,308	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	0	0	1,258,334	0.000000	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	0	1,068,471	0.000000	90.02
90.03	09003	WOUND CLINIC	0	0	0	115,619	0.000000	90.03
90.04	09004	OP ORTHO CLINIC	0	0	0	50,563	0.000000	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0	0	0	243,853	0.000000	90.05
90.06	09006	INFUSION CLINIC	0	0	0	1,951,392	0.000000	90.06
91.00	09100	EMERGENCY	0	0	0	17,740,970	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	4,937,158	0.000000	92.00
93.00	04950	OUTPATIENT PSYCH	0	0	0	206,827	0.000000	93.00
200.00		Total (lines 50 through 199)	0	0	0	88,373,670		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV Date/Time Prepared: 6/29/2020 8:10 am

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	750,493	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	189,265	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	458,941	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	254,893	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	83,635	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	53,410	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	2,028	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	18,396	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	100,883	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	591,932	0	0	0	73.00
76.00	03160	CARDIOPULMONARY	0.000000	157,240	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0.000000	0	0	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0.000000	0	0	0	0	90.02
90.03	09003	WOUND CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0.000000	0	0	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0.000000	0	0	0	0	90.05
90.06	09006	INFUSION CLINIC	0.000000	0	0	0	0	90.06
91.00	09100	EMERGENCY	0.000000	10,582	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
93.00	04950	OUTPATIENT PSYCH	0.000000	0	0	0	0	93.00
200.00		Total (lines 50 through 199)		2,671,698	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepared: 6/29/2020 8:10 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.197071	0	4,453,906	78	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.052400	0	5,652	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.205167	0	2,849,218	0	0	54.00
60.00	06000	LABORATORY	0.303226	0	1,945,973	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.701577	0	162,388	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.836134	0	446,590	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.682661	0	41,345	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	2.082275	0	6,404	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.038454	0	229,329	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.463454	0	99,405	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.150552	0	99,707	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.346681	0	2,042,960	240,100	0	73.00
76.00	03160	CARDIOPULMONARY	0.226099	0	860,700	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1.495250	0	308,824	32,277	0	90.01
90.02	09002	JAY FAMILY MEDICINE	2.260711	0	472,170	42,936	0	90.02
90.03	09003	WOUND CLINIC	1.112291	0	39,936	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0.000000	0	25,988	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	4.624089	0	87,049	5,098	0	90.05
90.06	09006	INFUSION CLINIC	0.132895	0	855,913	235	0	90.06
91.00	09100	EMERGENCY	0.180541	0	3,371,782	3,670	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.290432	0	1,664,449	1,471	0	92.00
93.00	04950	OUTPATIENT PSYCH	0.960368	0	18,706	0	0	93.00
200.00		Subtotal (see instructions)		0	20,088,394	325,865	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	20,088,394	325,865	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepared: 6/29/2020 8:10 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	877,736	15		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	296	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	584,566	0		54.00
60.00	06000	LABORATORY	590,070	0		60.00
65.00	06500	RESPIRATORY THERAPY	113,928	0		65.00
66.00	06600	PHYSICAL THERAPY	373,409	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	28,225	0		67.00
68.00	06800	SPEECH PATHOLOGY	13,335	0		68.00
69.00	06900	ELECTROCARDIOLOGY	8,819	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	46,070	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,011	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	708,255	83,238		73.00
76.00	03160	CARDIOPULMONARY	194,603	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	461,769	48,262		90.01
90.02	09002	JAY FAMILY MEDICINE	1,067,440	97,066		90.02
90.03	09003	WOUND CLINIC	44,420	0		90.03
90.04	09004	OP ORTHO CLINIC	0	0		90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	402,522	23,574		90.05
90.06	09006	INFUSION CLINIC	113,747	31		90.06
91.00	09100	EMERGENCY	608,745	663		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	483,409	427		92.00
93.00	04950	OUTPATIENT PSYCH	17,965	0		93.00
200.00		Subtotal (see instructions)	6,754,340	253,276		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	6,754,340	253,276		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-1320 | Component CCN: 15-M320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part II Date/Time Prepared: 6/29/2020 8:10 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	259,650	20,769,132	0.012502	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,432	1,339,572	0.007041	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	222,171	11,346,101	0.019581	5,939	116	54.00
60.00	06000	LABORATORY	133,397	8,927,999	0.014941	67,733	1,012	60.00
65.00	06500	RESPIRATORY THERAPY	39,651	1,178,512	0.033645	6,230	210	65.00
66.00	06600	PHYSICAL THERAPY	139,629	1,417,082	0.098533	4,398	433	66.00
67.00	06700	OCCUPATIONAL THERAPY	24,799	300,745	0.082459	5,152	425	67.00
68.00	06800	SPEECH PATHOLOGY	790	14,646	0.053940	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	807	880,483	0.000917	10,731	10	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,565	1,208,669	0.004604	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	655	437,550	0.001497	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	77,724	10,726,684	0.007246	155,369	1,126	73.00
76.00	03160	CARDIOPULMONARY	16,766	2,253,308	0.007441	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	77,604	1,258,334	0.061672	227	14	90.01
90.02	09002	JAY FAMILY MEDICINE	103,225	1,068,471	0.096610	682	66	90.02
90.03	09003	WOUND CLINIC	15,122	115,619	0.130792	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0	50,563	0.000000	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	167,602	243,853	0.687308	0	0	90.05
90.06	09006	INFUSION CLINIC	27,435	1,951,392	0.014059	0	0	90.06
91.00	09100	EMERGENCY	232,833	17,740,970	0.013124	39,867	523	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	4,937,158	0.000000	0	0	92.00
93.00	04950	OUTPATIENT PSYCH	62,675	206,827	0.303031	0	0	93.00
200.00		Total (lines 50 through 199)	1,617,532	88,373,670		296,328	3,935	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1320 | Component CCN: 15-M320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV Date/Time Prepared: 6/29/2020 8:10 am

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
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	0	0	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	0	0	0	90.02
90.03	09003	WOUND CLINIC	0	0	0	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0	0	0	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0	0	0	0	0	90.05
90.06	09006	INFUSION CLINIC	0	0	0	0	0	90.06
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
93.00	04950	OUTPATIENT PSYCH	0	0	0	0	0	93.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1320 | Component CCN: 15-M320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 6/29/2020 8:10 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	20,769,132	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,339,572	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	11,346,101	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	8,927,999	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,178,512	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,417,082	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	300,745	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	14,646	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	880,483	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,208,669	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	437,550	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,726,684	0.000000	73.00
76.00	03160	CARDIOPULMONARY	0	0	0	2,253,308	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	0	0	1,258,334	0.000000	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	0	1,068,471	0.000000	90.02
90.03	09003	WOUND CLINIC	0	0	0	115,619	0.000000	90.03
90.04	09004	OP ORTHO CLINIC	0	0	0	50,563	0.000000	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0	0	0	243,853	0.000000	90.05
90.06	09006	INFUSION CLINIC	0	0	0	1,951,392	0.000000	90.06
91.00	09100	EMERGENCY	0	0	0	17,740,970	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	4,937,158	0.000000	92.00
93.00	04950	OUTPATIENT PSYCH	0	0	0	206,827	0.000000	93.00
200.00		Total (lines 50 through 199)	0	0	0	88,373,670		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1320 | Component CCN: 15-M320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 6/29/2020 8:10 am

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	5,939	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	67,733	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	6,230	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	4,398	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	5,152	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	10,731	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	155,369	0	0	0	73.00
76.00	03160	CARDIOPULMONARY	0.000000	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0.000000	227	0	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0.000000	682	0	0	0	90.02
90.03	09003	WOUND CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0.000000	0	0	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0.000000	0	0	0	0	90.05
90.06	09006	INFUSION CLINIC	0.000000	0	0	0	0	90.06
91.00	09100	EMERGENCY	0.000000	39,867	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
93.00	04950	OUTPATIENT PSYCH	0.000000	0	0	0	0	93.00
200.00		Total (lines 50 through 199)		296,328	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1320 | Component CCN: 15-M320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V | Date/Time Prepared: 6/29/2020 8:10 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.197071	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.052400	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.205167	0	0	0	0	54.00
60.00	06000	LABORATORY	0.303226	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.701577	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.836134	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.682661	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	2.082275	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.038454	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.463454	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.150552	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.346681	0	0	26	0	73.00
76.00	03160	CARDIOPULMONARY	0.226099	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1.495250	0	0	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	2.260711	0	0	0	0	90.02
90.03	09003	WOUND CLINIC	1.112291	0	0	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0.000000	0	0	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	4.624089	0	0	0	0	90.05
90.06	09006	INFUSION CLINIC	0.132895	0	0	0	0	90.06
91.00	09100	EMERGENCY	0.180541	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.290432	0	0	0	0	92.00
93.00	04950	OUTPATIENT PSYCH	0.960368	0	0	0	0	93.00
200.00		Subtotal (see instructions)		0	0	26	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	26	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1320 | Component CCN: 15-M320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V | Date/Time Prepared: 6/29/2020 8:10 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	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
60.00	06000	LABORATORY	0	0		60.00
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	9		73.00
76.00	03160	CARDIOPULMONARY	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
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
90.03	09003	WOUND CLINIC	0	0		90.03
90.04	09004	OP ORTHO CLINIC	0	0		90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0	0		90.05
90.06	09006	INFUSION CLINIC	0	0		90.06
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
93.00	04950	OUTPATIENT PSYCH	0	0		93.00
200.00		Subtotal (see instructions)	0	9		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	9		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1320 | Component CCN: 15-Z320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepared: 6/29/2020 8:10 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.197071	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.052400	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.205167	0	0	0	0	54.00
60.00	06000	LABORATORY	0.303226	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.701577	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.836134	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.682661	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	2.082275	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.038454	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.463454	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.150552	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.346681	0	0	0	0	73.00
76.00	03160	CARDIOPULMONARY	0.226099	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1.495250	0	0	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	2.260711	0	0	0	0	90.02
90.03	09003	WOUND CLINIC	1.112291	0	0	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0.000000	0	0	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	4.624089	0	0	0	0	90.05
90.06	09006	INFUSION CLINIC	0.132895	0	0	0	0	90.06
91.00	09100	EMERGENCY	0.180541	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.290432	0	0	0	0	92.00
93.00	04950	OUTPATIENT PSYCH	0.960368	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 01/01/2019 To 12/31/2019 | Worksheet D Part V | Date/Time Prepared: 6/29/2020 8:10 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
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
76.00	03160	CARDIOPULMONARY	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
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
90.03	09003	WOUND CLINIC	0	0		90.03
90.04	09004	OP ORTHO CLINIC	0	0		90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0	0		90.05
90.06	09006	INFUSION CLINIC	0	0		90.06
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
93.00	04950	OUTPATIENT PSYCH	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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part I Date/Time Prepared: 6/29/2020 8:10 am

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	584,332	28,935	555,397	2,865	193.86	30.00
40.00	SUBPROVIDER - IPF	196,902	0	196,902	1,250	157.52	40.00
43.00	NURSERY	24,571		24,571	152	161.65	43.00
200.00	Total (lines 30 through 199)	805,805		776,870	4,267		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)		
		6.00	7.00		
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	3	582		30.00
40.00	SUBPROVIDER - IPF	58	9,136		40.00
43.00	NURSERY	7	1,132		43.00
200.00	Total (lines 30 through 199)	68	10,850		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part II Date/Time Prepared: 6/29/2020 8:10 am

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	259,650	20,769,132	0.012502	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,432	1,339,572	0.007041	21,592	152	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	222,171	11,346,101	0.019581	4,804	94	54.00
60.00	06000	LABORATORY	133,397	8,927,999	0.014941	16,022	239	60.00
65.00	06500	RESPIRATORY THERAPY	39,651	1,178,512	0.033645	0	0	65.00
66.00	06600	PHYSICAL THERAPY	139,629	1,417,082	0.098533	494	49	66.00
67.00	06700	OCCUPATIONAL THERAPY	24,799	300,745	0.082459	263	22	67.00
68.00	06800	SPEECH PATHOLOGY	790	14,646	0.053940	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	807	880,483	0.000917	657	1	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,565	1,208,669	0.004604	576	3	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	655	437,550	0.001497	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	77,724	10,726,684	0.007246	9,100	66	73.00
76.00	03160	CARDIOPULMONARY	16,766	2,253,308	0.007441	2,589	19	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	77,604	1,258,334	0.061672	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	103,225	1,068,471	0.096610	0	0	90.02
90.03	09003	WOUND CLINIC	15,122	115,619	0.130792	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0	50,563	0.000000	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	167,602	243,853	0.687308	0	0	90.05
90.06	09006	INFUSION CLINIC	27,435	1,951,392	0.014059	0	0	90.06
91.00	09100	EMERGENCY	232,833	17,740,970	0.013124	5,272	69	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	163,226	4,937,158	0.033061	0	0	92.00
93.00	04950	OUTPATIENT PSYCH	62,675	206,827	0.303031	0	0	93.00
200.00		Total (lines 50 through 199)	1,780,758	88,373,670		61,369	714	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part III Date/Time Prepared: 6/29/2020 8:10 am

Title XIX | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	2,865	0.00	3	30.00
40.00	04000	SUBPROVIDER - IPF	0	0	1,250	0.00	58	40.00
43.00	04300	NURSERY		0	152	0.00	7	43.00
200.00		Total (lines 30 through 199)		0	4,267		68	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
40.00	04000	SUBPROVIDER - IPF	0	40.00
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV Date/Time Prepared: 6/29/2020 8:10 am

Title XIX | Hospital | 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
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	0	0	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	0	0	0	90.02
90.03	09003	WOUND CLINIC	0	0	0	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0	0	0	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0	0	0	0	0	90.05
90.06	09006	INFUSION CLINIC	0	0	0	0	0	90.06
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
93.00	04950	OUTPATIENT PSYCH	0	0	0	0	0	93.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV Date/Time Prepared: 6/29/2020 8:10 am

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	20,769,132	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,339,572	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	11,346,101	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	8,927,999	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,178,512	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,417,082	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	300,745	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	14,646	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	880,483	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,208,669	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	437,550	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,726,684	0.000000	73.00
76.00	03160	CARDIOPULMONARY	0	0	0	2,253,308	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0	0	0	1,258,334	0.000000	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	0	1,068,471	0.000000	90.02
90.03	09003	WOUND CLINIC	0	0	0	115,619	0.000000	90.03
90.04	09004	OP ORTHO CLINIC	0	0	0	50,563	0.000000	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0	0	0	243,853	0.000000	90.05
90.06	09006	INFUSION CLINIC	0	0	0	1,951,392	0.000000	90.06
91.00	09100	EMERGENCY	0	0	0	17,740,970	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	4,937,158	0.000000	92.00
93.00	04950	OUTPATIENT PSYCH	0	0	0	206,827	0.000000	93.00
200.00		Total (lines 50 through 199)	0	0	0	88,373,670		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV Date/Time Prepared: 6/29/2020 8:10 am

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	21,592	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	4,804	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	16,022	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	494	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	263	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	657	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	576	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	9,100	0	0	0	73.00
76.00	03160	CARDIOPULMONARY	0.000000	2,589	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	0.000000	0	0	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0.000000	0	0	0	0	90.02
90.03	09003	WOUND CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0.000000	0	0	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0.000000	0	0	0	0	90.05
90.06	09006	INFUSION CLINIC	0.000000	0	0	0	0	90.06
91.00	09100	EMERGENCY	0.000000	5,272	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
93.00	04950	OUTPATIENT PSYCH	0.000000	0	0	0	0	93.00
200.00		Total (lines 50 through 199)		61,369	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/29/2020 8:10 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,071	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,865	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)	2,023	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	145	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	61	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	778	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)	145	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	118.90	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,133,223	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)	7,253	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)	254,185	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,879,038	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)	4,879,038	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)	1,702.98	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,324,918	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)	1,324,918	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/29/2020 8:10 am

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	905,471	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,230,389	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)	246,932	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)	246,932	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)	842	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,702.98	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,433,909	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/29/2020 8:10 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	584,332	5,133,223	0.113833	1,433,909	163,226	90.00
91.00	Nursing School cost	0	5,133,223	0.000000	1,433,909	0	91.00
92.00	Allied health cost	0	5,133,223	0.000000	1,433,909	0	92.00
93.00	All other Medical Education	0	5,133,223	0.000000	1,433,909	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1320 Component CCN: 15-M320	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 6/29/2020 8:10 am
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,250	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,250	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)	1,250	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) (see instructions)	391	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)	2,491,767	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)	2,491,767	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)	2,491,767	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)	1,993.41	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	779,423	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)	779,423	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-1320 | Component CCN: 15-M320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/29/2020 8:10 am

Title XVIII | Subprovider - IPF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	96,676	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	876,099	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)	3,935	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	3,935	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	872,164	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 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/29/2020 8:10 am

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	0	2,491,767	0.000000	0	0	90.00
91.00	Nursing School cost	0	2,491,767	0.000000	0	0	91.00
92.00	Allied health cost	0	2,491,767	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,491,767	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/29/2020 8:10 am

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,071	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,865	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)	2,023	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	145	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	61	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	3	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)	152	15.00
16.00	Nursery days (title V or XIX only)	7	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	118.90	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,133,223	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)	7,253	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)	254,185	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,879,038	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)	4,879,038	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)	1,702.98	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	5,109	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)	5,109	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/29/2020 8:10 am

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	182,483	152	1,200.55	7	8,404	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	12,552	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	26,065	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)	1,714	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	714	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	2,428	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	23,637	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	842	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,702.98	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,433,909	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/29/2020 8:10 am

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	584,332	5,133,223	0.113833	1,433,909	163,226	90.00
91.00	Nursing School cost	0	5,133,223	0.000000	1,433,909	0	91.00
92.00	Allied health cost	0	5,133,223	0.000000	1,433,909	0	92.00
93.00	All other Medical Education	0	5,133,223	0.000000	1,433,909	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1320 Component CCN: 15-M320	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 6/29/2020 8:10 am
	Title XIX	Subprovider - IPF	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,250	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,250	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)	1,250	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) (see instructions)	58	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)	152	15.00
16.00	Nursery days (title V or XIX only)	7	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	118.90	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)	2,491,767	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)	2,491,767	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)	2,491,767	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)	1,993.41	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	115,618	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)	115,618	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1320 | Component CCN: 15-M320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/29/2020 8:10 am

Title XIX | Subprovider - IPF | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	3,295	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	118,913	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 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/29/2020 8:10 am

Title XIX | Subprovider - IPF | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	196,902	2,491,767	0.079021	0	0	90.00
91.00	Nursing School cost	0	2,491,767	0.000000	0	0	91.00
92.00	Allied health cost	0	2,491,767	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,491,767	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3 | Date/Time Prepared: 6/29/2020 8:10 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,468,059		30.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.197071	750,493	147,900	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.052400	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.205167	189,265	38,831	54.00
60.00	06000	LABORATORY	0.303226	458,941	139,163	60.00
65.00	06500	RESPIRATORY THERAPY	0.701577	254,893	178,827	65.00
66.00	06600	PHYSICAL THERAPY	0.836134	83,635	69,930	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.682661	53,410	36,461	67.00
68.00	06800	SPEECH PATHOLOGY	2.082275	2,028	4,223	68.00
69.00	06900	ELECTROCARDIOLOGY	0.038454	18,396	707	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.463454	100,883	46,755	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.150552	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.346681	591,932	205,212	73.00
76.00	03160	CARDIOPULMONARY	0.226099	157,240	35,552	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1.495250	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	2.260711	0	0	90.02
90.03	09003	WOUND CLINIC	1.112291	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0.000000	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	4.624089	0	0	90.05
90.06	09006	INFUSION CLINIC	0.132895	0	0	90.06
91.00	09100	EMERGENCY	0.180541	10,582	1,910	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.290432	0	0	92.00
93.00	04950	OUTPATIENT PSYCH	0.960368	0	0	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,671,698	905,471	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		2,671,698		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1320 | Component CCN: 15-M320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3 | Date/Time Prepared: 6/29/2020 8:10 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
40.00	04000	SUBPROVIDER - IPF		701,422		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.197071	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.052400	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.205167	5,939	1,218	54.00
60.00	06000	LABORATORY	0.303226	67,733	20,538	60.00
65.00	06500	RESPIRATORY THERAPY	0.701577	6,230	4,371	65.00
66.00	06600	PHYSICAL THERAPY	0.836134	4,398	3,677	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.682661	5,152	3,517	67.00
68.00	06800	SPEECH PATHOLOGY	2.082275	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.038454	10,731	413	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.463454	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.150552	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.346681	155,369	53,863	73.00
76.00	03160	CARDIOPULMONARY	0.226099	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1.495250	227	339	90.01
90.02	09002	JAY FAMILY MEDICINE	2.260711	682	1,542	90.02
90.03	09003	WOUND CLINIC	1.112291	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0.000000	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	4.624089	0	0	90.05
90.06	09006	INFUSION CLINIC	0.132895	0	0	90.06
91.00	09100	EMERGENCY	0.180541	39,867	7,198	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.290432	0	0	92.00
93.00	04950	OUTPATIENT PSYCH	0.960368	0	0	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		296,328	96,676	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)		296,328		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1320 | Component CCN: 15-Z320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3 | Date/Time Prepared: 6/29/2020 8:10 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.197071	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.052400	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.205167	8,835	1,813	54.00
60.00	06000	LABORATORY	0.303226	32,152	9,749	60.00
65.00	06500	RESPIRATORY THERAPY	0.701577	37,031	25,980	65.00
66.00	06600	PHYSICAL THERAPY	0.836134	39,019	32,625	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.682661	28,626	19,542	67.00
68.00	06800	SPEECH PATHOLOGY	2.082275	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.038454	876	34	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.463454	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.150552	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.346681	71,715	24,862	73.00
76.00	03160	CARDIOPULMONARY	0.226099	3,064	693	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1.495250	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	2.260711	0	0	90.02
90.03	09003	WOUND CLINIC	1.112291	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0.000000	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	4.624089	0	0	90.05
90.06	09006	INFUSION CLINIC	0.132895	0	0	90.06
91.00	09100	EMERGENCY	0.180541	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.290432	0	0	92.00
93.00	04950	OUTPATIENT PSYCH	0.960368	0	0	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		221,318	115,298	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)		221,318		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3 | Date/Time Prepared: 6/29/2020 8:10 am

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		5,424		30.00
40.00	04000	SUBPROVIDER - IPF		57,240		40.00
43.00	04300	NURSERY		10,175		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.197071	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.052400	21,592	1,131	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.205167	4,804	986	54.00
60.00	06000	LABORATORY	0.303226	16,022	4,858	60.00
65.00	06500	RESPIRATORY THERAPY	0.701577	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.836134	494	413	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.682661	263	180	67.00
68.00	06800	SPEECH PATHOLOGY	2.082275	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.038454	657	25	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.463454	576	267	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.150552	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.346681	9,100	3,155	73.00
76.00	03160	CARDIOPULMONARY	0.226099	2,589	585	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1.495250	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	2.260711	0	0	90.02
90.03	09003	WOUND CLINIC	1.112291	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0.000000	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	4.624089	0	0	90.05
90.06	09006	INFUSION CLINIC	0.132895	0	0	90.06
91.00	09100	EMERGENCY	0.180541	5,272	952	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.290432	0	0	92.00
93.00	04950	OUTPATIENT PSYCH	0.960368	0	0	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		61,369	12,552	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)		61,369		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1320 | Component CCN: 15-M320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3 | Date/Time Prepared: 6/29/2020 8:10 am

Title XIX | Subprovider - IPF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
40.00	04000	SUBPROVIDER - IPF		46,744		40.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.197071	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.052400	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.205167	808	166	54.00
60.00	06000	LABORATORY	0.303226	3,338	1,012	60.00
65.00	06500	RESPIRATORY THERAPY	0.701577	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.836134	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.682661	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	2.082275	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.038454	876	34	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.463454	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.150552	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.346681	6,007	2,083	73.00
76.00	03160	CARDIOPULMONARY	0.226099	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1.495250	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	2.260711	0	0	90.02
90.03	09003	WOUND CLINIC	1.112291	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0.000000	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	4.624089	0	0	90.05
90.06	09006	INFUSION CLINIC	0.132895	0	0	90.06
91.00	09100	EMERGENCY	0.180541	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.290432	0	0	92.00
93.00	04950	OUTPATIENT PSYCH	0.960368	0	0	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		11,029	3,295	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)		11,029		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1320	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 6/29/2020 8:10 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	7,007,616	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)	7,007,616	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	7,077,692	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	137,802	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	3,534,739	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	3,405,151	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)	3,405,151	30.00
31.00	Primary payer payments	1,763	31.00
32.00	Subtotal (line 30 minus line 31)	3,403,388	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)	800,507	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	520,330	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	570,929	36.00
37.00	Subtotal (see instructions)	3,923,718	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,923,718	40.00
40.01	Sequestration adjustment (see instructions)	78,474	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	4,157,772	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	-312,528	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	379,102	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1320 Component CCN: 15-M320	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 6/29/2020 8:10 am
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	9	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)	9	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	26	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)	26	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)	26	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	17	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	9	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	0	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)	9	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)	9	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	9	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)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	9	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	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)	9	40.00
40.01	Sequestration adjustment (see instructions)	0	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	5	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	4	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	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 01/01/2019 To 12/31/2019 | Worksheet E-1 Part I Date/Time Prepared: 6/29/2020 8:10 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,959,408		2,197,172	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	08/14/2019	381,100	08/14/2019	1,960,600	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)		381,100		1,960,600	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)		2,340,508		4,157,772	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		416,623		312,528	6.02
7.00	Total Medicare program liability (see instructions)		1,923,885		3,845,244	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 01/01/2019 To 12/31/2019 | Worksheet E-1 Part I | Date/Time Prepared: 6/29/2020 8:10 am

Title XVIII | Subprovider - IPF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		564,039		5	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)		564,039		5	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		4	6.01
6.02	SETTLEMENT TO PROGRAM		1		0	6.02
7.00	Total Medicare program liability (see instructions)		564,038		9	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1320 | Component CCN: 15-Z320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E-1 Part I | Date/Time Prepared: 6/29/2020 8:10 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		336,538		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	08/14/2019	51,600		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)		51,600		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)		388,138		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		19,151		0	6.02
7.00	Total Medicare program liability (see instructions)		368,987		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1320	Period: From 01/01/2019 To 12/31/2019	Worksheet E-1 Part II Date/Time Prepared: 6/29/2020 8:10 am
	Title XVIII	Hospital	Cost

			1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		1.00
2.00	Medicare days 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 01/01/2019 To 12/31/2019	Worksheet E-2 Date/Time Prepared: 6/29/2020 8:10 am
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	249,401	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	116,451	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	145	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)	365,852	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	365,852	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)	365,852	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	1,364	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	364,488	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	18,506	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	12,029	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	18,506	0	18.00
19.00	Total (see instructions)	376,517	0	19.00
19.01	Sequestration adjustment (see instructions)	7,530	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
20.00	Interim payments	388,138	0	20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	-19,151	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	19,569	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1320	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part V Date/Time Prepared: 6/29/2020 8:10 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	2,230,389	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)	2,230,389	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,252,693	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)	2,252,693	19.00
20.00	Deductibles (exclude professional component)	301,372	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,951,321	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,951,321	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	18,196	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	11,827	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	16,832	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,963,148	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)	1,963,148	30.00
30.01	Sequestration adjustment (see instructions)	39,263	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	2,340,508	31.00
31.01	Interim payments-PARHM		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	-416,623	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	120,560	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1320 Component CCN: 15-M320	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part II Date/Time Prepared: 6/29/2020 8:10 am
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	374,803	1.00
2.00	Net IPF PPS Outlier Payments	253,942	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)	3.424658	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)	628,745	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)	628,745	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	628,745	18.00
19.00	Deductibles	53,196	19.00
20.00	Subtotal (line 18 minus line 19)	575,549	20.00
21.00	Coinsurance	0	21.00
22.00	Subtotal (line 20 minus line 21)	575,549	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)	575,549	26.00
27.00	Direct graduate medical education payments (see instructions)	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)	575,549	31.00
31.01	Sequestration adjustment (see instructions)	11,511	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	31.02
32.00	Interim payments	564,039	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)	-1	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	253,942	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

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G | Date/Time Prepared: 6/29/2020 8:10 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	4,122,773	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	3,417,610	0	0	0	4.00
5.00	Other receivable	-1,504,147	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	422,405	0	0	0	7.00
8.00	Prepaid expenses	177,617	0	0	0	8.00
9.00	Other current assets	1,524,082	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)	8,160,340	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,006,948	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	19,125,052	0	0	0	15.00
16.00	Accumulated depreciation	-2,361,267	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	8,658,980	0	0	0	23.00
24.00	Accumulated depreciation	-2,815,301	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)	23,614,412	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	31,774,752	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	10,452,000	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,236,430	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	4,744,167	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	16,432,597	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)	16,432,597	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	15,342,155				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)	15,342,155	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	31,774,752	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G-1 | Date/Time Prepared: 6/29/2020 8:10 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		23,031,789		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-7,689,634				2.00
3.00	Total (sum of line 1 and line 2)		15,342,155		0		3.00
4.00	ROUNDING	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)		15,342,155		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)		15,342,155		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	ROUNDING		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G-2 Parts I & II | Date/Time Prepared: 6/29/2020 8:10 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,981,427		3,981,427	1.00
2.00	SUBPROVIDER - IPF	2,212,200		2,212,200	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	195,917		195,917	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)	6,389,544		6,389,544	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	6,389,544		6,389,544	17.00
18.00	Ancillary services	12,006,335	48,794,148	60,800,483	18.00
19.00	Outpatient services	887,238	26,685,949	27,573,187	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	19,283,117	75,480,097	94,763,214	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		39,079,180		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		39,079,180		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1320 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G-3 | Date/Time Prepared: 6/29/2020 8:10 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	94,763,214	1.00
2.00	Less contractual allowances and discounts on patients' accounts	64,386,557	2.00
3.00	Net patient revenues (line 1 minus line 2)	30,376,657	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	39,079,180	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-8,702,523	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	1,012,884	24.00
25.00	Total other income (sum of lines 6-24)	1,012,884	25.00
26.00	Total (line 5 plus line 25)	-7,689,639	26.00
27.00	OTHER EXPENSES (ROUNDINGY)	-5	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	-5	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-7,689,634	29.00