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 01/01/2020 To 12/31/2020	Worksheet S Parts I-III Date/Time Prepared: 7/15/2021 1:03 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 7/15/2021 Time: 1:03 pm
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 01/01/2020 and ending 12/31/2020 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) JON VANATOR
Officer or Administrator of Provider(s)

CFO
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	865,315	1,912,000	0	0	1.00
2.00	Subprovider - IPF	0	3,606	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	577,863	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	1,446,784	1,912,000	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 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 7/15/2021 1:03 pm

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

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	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)	01/01/2020	12/31/2020	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 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I | Date/Time Prepared: 7/15/2021 1:03 pm

		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 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I | Date/Time Prepared: 7/15/2021 1:03 pm

		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 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 7/15/2021 1:03 pm

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

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

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	Y			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 7/15/2021 1:03 pm

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

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

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

		1.00	2.00	3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model 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:	75,703	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I | Date/Time Prepared: 7/15/2021 1:03 pm

		1.00	2.00	
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

	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1320	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 7/15/2021 1:03 pm

		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	29	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part II | Date/Time Prepared: 7/15/2021 1:03 pm

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

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	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	02/25/2021	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	04/02/2021	Y	04/02/2021	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 01/01/2020 To 12/31/2020 | Worksheet S-2 Part II Date/Time Prepared: 7/15/2021 1:03 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00

		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	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 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 7/15/2021 1:03 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I | Date/Time Prepared: 7/15/2021 1:03 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	28	10,248	28,008.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		28	10,248	28,008.00	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)		28	10,248	28,008.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	1	300		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)		29				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 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I | Date/Time Prepared: 7/15/2021 1:03 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	549	9	1,167			1.00
2.00	HMO and other (see instructions)	224	181				2.00
3.00	HMO IPF Subprovider	0	4				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	448	0	448			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	260			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	997	9	1,875			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		2	48			13.00
14.00	Total (see instructions)	997	11	1,923	0.00	209.73	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	44	0	48	0.00	2.60	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)			29			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	212.33	27.00
28.00	Observation Bed Days		9	467			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 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I | Date/Time Prepared: 7/15/2021 1:03 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	186	4	426	1.00
2.00	HMO and other (see instructions)			76	59		2.00
3.00	HMO IPF Subprovider				1		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	186	4	426	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	5	0	6	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 01/01/2020 To 12/31/2020	Worksheet S-10 Date/Time Prepared: 7/15/2021 1:03 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.494923	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	3,988,614	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	12,901,803	6.00
7.00	Medicaid cost (line 1 times line 6)	6,385,399	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)	2,396,785	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)	4,611	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	67,982	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	33,646	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)	29,035	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)	2,425,820	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)	1,695,380	59,891	1,755,271	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	839,083	59,891	898,974	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)	839,083	59,891	898,974	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)	2,712,898	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	220,689	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	339,521	27.01
28.00	Non-Medicare bad debt expense (see instructions)	2,373,377	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,293,471	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,192,445	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,618,265	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A | Date/Time Prepared: 7/15/2021 1:03 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	1,179,228	1,179,228	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	14,339	14,339	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	1,440,465	1,701,795	2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB		0	0	39,881	39,881	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	166,712	27,703	194,415	2,570,179	2,764,594	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	570,589	9,305,265	9,875,854	-203,972	9,671,882	5.00
7.00	00700	OPERATION OF PLANT	303,745	3,431,119	3,734,864	-1,328,212	2,406,652	7.00
7.01	00701	OPERATION OF PLANT - MOB	0	181,111	181,111	-81,526	99,585	7.01
7.02	00702	OPERATION OF PLANT - POB	0	75,509	75,509	-35,030	40,479	7.02
7.03	00703	OPERATION OF PLANT - WJ	0	16,908	16,908	-4,907	12,001	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	35,680	104,982	140,662	-11,581	129,081	8.00
9.00	00900	HOUSEKEEPING	381,538	243,796	625,334	-118,532	506,802	9.00
10.00	01000	DIETARY	360,524	476,059	836,583	-638,726	197,857	10.00
11.00	01100	CAFETERIA	0	0	0	462,163	462,163	11.00
13.00	01300	NURSING ADMINISTRATION	1,173,606	346,448	1,520,054	-206,666	1,313,388	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,727	2,727	260,504	263,231	14.00
15.00	01500	PHARMACY	501,218	1,366,125	1,867,343	-1,180,983	686,360	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	1,746,296	1,549,338	3,295,634	-793,119	2,502,515	30.00
40.00	04000	SUBPROVIDER - IPF	207,970	158,715	366,685	-43,153	323,532	40.00
43.00	04300	NURSERY	0	0	0	25,325	25,325	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	929,473	2,034,856	2,964,329	-651,427	2,312,902	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	7,281	7,281	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	798,673	1,161,462	1,960,135	-809,294	1,150,841	54.00
60.00	06000	LABORATORY	0	2,056,386	2,056,386	-31,638	2,024,748	60.00
65.00	06500	RESPIRATORY THERAPY	383,754	181,145	564,899	-148,293	416,606	65.00
66.00	06600	PHYSICAL THERAPY	468,575	7,536	476,111	-3,257	472,854	66.00
67.00	06700	OCCUPATIONAL THERAPY	85,715	239	85,954	-51	85,903	67.00
68.00	06800	SPEECH PATHOLOGY	17,143	0	17,143	0	17,143	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,570	3,570	-1,275	2,295	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	87,965	87,965	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	20,085	20,085	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,511,327	1,511,327	73.00
76.00	03160	CARDIOPULMONARY	116,255	134,392	250,647	-67,669	182,978	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	609,812	876,406	1,486,218	-482,675	1,003,543	90.01
90.02	09002	JAY FAMILY MEDICINE	626,450	1,080,702	1,707,152	-364,829	1,342,323	90.02
90.03	09003	WOUND CLINIC	0	19,802	19,802	-1,279	18,523	90.03
90.04	09004	OP ORTHO CLINIC	0	0	0	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	260,265	302,209	562,474	-116,946	445,528	90.05
90.06	09006	INFUSION CLINIC	111,570	44,349	155,919	-35,026	120,893	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	0	0	165,976	165,976	90.07
91.00	09100	EMERGENCY	1,121,629	2,011,300	3,132,929	-359,897	2,773,032	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	31,716	31,201	62,917	-30,778	32,139	93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,008,908	27,492,690	38,501,598	144,234	38,645,832	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	119,761	92,351	212,112	-65,845	146,267	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	127,241	96,849	224,090	-49,593	174,497	194.02
194.03	07953	JAY MERIDIAN URGENT CARE	93,511	46,558	140,069	-28,796	111,273	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	11,349,421	27,728,448	39,077,869	0	39,077,869	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A | Date/Time Prepared: 7/15/2021 1:03 pm

		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	-547,155	632,073		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	-14,339	0		1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT-INTEREST	0	0		1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP	194,930	1,896,725		2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB	-1,413	38,468		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	-333,744	2,430,850		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,233,742	8,438,140		5.00
7.00	00700	OPERATION OF PLANT	261,098	2,667,750		7.00
7.01	00701	OPERATION OF PLANT - MOB	0	99,585		7.01
7.02	00702	OPERATION OF PLANT - POB	-35,460	5,019		7.02
7.03	00703	OPERATION OF PLANT - WJ	-12,001	0		7.03
8.00	00800	LAUNDRY & LINEN SERVICE	0	129,081		8.00
9.00	00900	HOUSEKEEPING	0	506,802		9.00
10.00	01000	DIETARY	9,548	207,405		10.00
11.00	01100	CAFETERIA	-122,026	340,137		11.00
13.00	01300	NURSING ADMINISTRATION	348,141	1,661,529		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-28	263,203		14.00
15.00	01500	PHARMACY	216,547	902,907		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	-780,548	1,721,967		30.00
40.00	04000	SUBPROVIDER - IPF	-104,848	218,684		40.00
43.00	04300	NURSERY	0	25,325		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-1,194,749	1,118,153		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	7,281		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	141,261	1,292,102		54.00
60.00	06000	LABORATORY	-5,141	2,019,607		60.00
65.00	06500	RESPIRATORY THERAPY	29,237	445,843		65.00
66.00	06600	PHYSICAL THERAPY	69,436	542,290		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	85,903		67.00
68.00	06800	SPEECH PATHOLOGY	0	17,143		68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,295		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	87,965		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	20,085		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,511,327		73.00
76.00	03160	CARDIOPULMONARY	62,045	245,023		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	-326,852	676,691		90.01
90.02	09002	JAY FAMILY MEDICINE	-597,603	744,720		90.02
90.03	09003	WOUND CLINIC	-18,523	0		90.03
90.04	09004	OP ORTHO CLINIC	0	0		90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	-163,760	281,768		90.05
90.06	09006	INFUSION CLINIC	0	120,893		90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	165,976		90.07
91.00	09100	EMERGENCY	-1,162,057	1,610,975		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
93.00	04950	OUTPATIENT PSYCH	0	32,139		93.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-5,432,003	33,213,829		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	146,267		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	174,497		194.02
194.03	07953	JAY MERIDIAN URGENT CARE	0	111,273		194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-5,432,003	33,645,866		200.00

RECLASSIFICATIONS | Provider CCN: 15-1320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 7/15/2021 1:03 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA				
1.00	CAFETERIA	11.00	252,448	209,715	1.00
	0		252,448	209,715	
	B - DRUGS RECLASS				
1.00	PHARMACY	15.00	0	35,894	1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,511,327	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
	0		0	1,547,221	
	C - SUPPLIES/IMPLANTS				
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	260,504	1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	87,965	2.00
3.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	20,085	3.00
4.00	OPERATION OF PLANT - MOB	7.01	0	34	4.00
5.00	SUBPROVIDER - IPF	40.00	0	100	5.00
6.00	OPERATING ROOM	50.00	0	1,714	6.00
7.00	WOUND CLINIC	90.03	0	43	7.00
8.00	JAY MERIDIAN URGENT CARE	194.03	0	42	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
	0		0	370,487	
	D - LAUNDRY				
1.00	LAUNDRY & LINEN SERVICE	8.00	0	3,281	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	0		0	3,281	
	E - DEPRECIATION				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,154,746	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	14,339	4.00
5.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,436,522	5.00
6.00	CAP REL COSTS-MVBLE EQUIP - MOB	2.01	0	39,881	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

RECLASSIFICATIONS | Provider CCN: 15-1320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 7/15/2021 1:03 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
	0		0	2,755,745	
	G - PROPERTY INSURANCE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	24,482	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	3,943	2.00
	0		0	28,425	
	H - HOUSEKEEPING SUPPLIES				
1.00	HOUSEKEEPING	9.00	0	22,453	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
	0		0	22,453	
	J - EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,578,266	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
	0		0	2,578,266	
	K - NURSERY AND LABOR AND DELIVERY				
1.00	NURSERY	43.00	23,362	1,963	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	6,717	564	2.00
	0		30,079	2,527	
	M - MOTHER BABY				
1.00	HEALTH BEGINNINGS PROGRAM	90.07	157,368	8,608	1.00
	TOTALS		157,368	8,608	
500.00	Grand Total: Increases		439,895	7,526,728	500.00

RECLASSIFICATIONS | Provider CCN: 15-1320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 7/15/2021 1:03 pm

		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	252,448	209,715	0		1.00
	0		252,448	209,715			
	B - DRUGS RECLASS						
1.00	PHARMACY	15.00	0	1,057,073	0		1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	7,568	0		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	173	0		3.00
4.00	DIETARY	10.00	0	79	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	5,521	0		5.00
6.00	OPERATING ROOM	50.00	0	4,724	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	27,109	0		7.00
8.00	RESPIRATORY THERAPY	65.00	0	412	0		8.00
9.00	CARDIOPULMONARY	76.00	0	7,876	0		9.00
10.00	FAMILY PRACTICE OF JAY COUNTY	90.01	0	240,257	0		10.00
11.00	JAY FAMILY MEDICINE	90.02	0	141,025	0		11.00
12.00	JAY FAMILY FIRST HEALTH CARE	90.05	0	23,451	0		12.00
13.00	INFUSION CLINIC	90.06	0	23,321	0		13.00
14.00	EMERGENCY	91.00	0	8,632	0		14.00
	0		0	1,547,221			
	C - SUPPLIES/IMPLANTS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	499	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	12,955	0		2.00
3.00	OPERATION OF PLANT	7.00	0	21,563	0		3.00
4.00	HOUSEKEEPING	9.00	0	14,942	0		4.00
5.00	DIETARY	10.00	0	1,169	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	175	0		6.00
7.00	PHARMACY	15.00	0	16,546	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	79,445	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	34,475	0		9.00
10.00	LABORATORY	60.00	0	10	0		10.00
11.00	RESPIRATORY THERAPY	65.00	0	21,643	0		11.00
12.00	PHYSICAL THERAPY	66.00	0	2,091	0		12.00
13.00	OCCUPATIONAL THERAPY	67.00	0	51	0		13.00
14.00	ELECTROCARDIOLOGY	69.00	0	1,275	0		14.00
15.00	CARDIOPULMONARY	76.00	0	1,204	0		15.00
16.00	FAMILY PRACTICE OF JAY COUNTY	90.01	0	31,788	0		16.00
17.00	JAY FAMILY MEDICINE	90.02	0	16,923	0		17.00
18.00	JAY FAMILY FIRST HEALTH CARE	90.05	0	3,970	0		18.00
19.00	INFUSION CLINIC	90.06	0	7,015	0		19.00
20.00	EMERGENCY	91.00	0	100,810	0		20.00
21.00	OUTPATIENT PSYCH	93.00	0	176	0		21.00
22.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	947	0		22.00
23.00	WEST JAY CLINIC	194.02	0	815	0		23.00
	0		0	370,487			
	D - LAUNDRY						
1.00	HOUSEKEEPING	9.00	0	1,815	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	17	0		2.00
3.00	OPERATING ROOM	50.00	0	1,449	0		3.00
	0		0	3,281			
	E - DEPRECIATION						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	68,344	9		1.00
2.00	OPERATION OF PLANT	7.00	0	1,215,007	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	4,907	9		5.00
6.00	DIETARY	10.00	0	16,100	9		6.00
7.00	PHARMACY	15.00	0	47,217	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	132,381	0		8.00
9.00	SUBPROVIDER - IPF	40.00	0	4,411	0		9.00
10.00	OPERATING ROOM	50.00	0	360,105	0		10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	608,165	0		11.00
12.00	LABORATORY	60.00	0	31,628	0		12.00
13.00	RESPIRATORY THERAPY	65.00	0	26,566	0		13.00
14.00	PHYSICAL THERAPY	66.00	0	1,061	0		14.00
15.00	CARDIOPULMONARY	76.00	0	28,841	0		15.00
16.00	FAMILY PRACTICE OF JAY COUNTY	90.01	0	4,706	0		16.00
17.00	WOUND CLINIC	90.03	0	1,322	0		17.00
18.00	INFUSION CLINIC	90.06	0	445	0		18.00
19.00	EMERGENCY	91.00	0	68,800	0		19.00
20.00	OUTPATIENT PSYCH	93.00	0	9,716	0		20.00
21.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	9,433	0		21.00

RECLASSIFICATIONS | Provider CCN: 15-1320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 7/15/2021 1:03 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	0		0	2,755,745			
	G - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	28,425	12		1.00
2.00		0.00	0	0	12		2.00
	0		0	28,425			
	H - HOUSEKEEPING SUPPLIES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	20	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	455	0		2.00
3.00	OPERATION OF PLANT	7.00	0	16,082	0		3.00
4.00	DIETARY	10.00	0	2	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	24	0		5.00
6.00	PHARMACY	15.00	0	112	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	940	0		7.00
8.00	OPERATING ROOM	50.00	0	758	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	930	0		9.00
10.00	RESPIRATORY THERAPY	65.00	0	117	0		10.00
11.00	PHYSICAL THERAPY	66.00	0	105	0		11.00
12.00	CARDIOPULMONARY	76.00	0	136	0		12.00
13.00	FAMILY PRACTICE OF JAY COUNTY	90.01	0	97	0		13.00
14.00	JAY FAMILY MEDICINE	90.02	0	671	0		14.00
15.00	JAY FAMILY FIRST HEALTH CARE	90.05	0	183	0		15.00
16.00	INFUSION CLINIC	90.06	0	97	0		16.00
17.00	EMERGENCY	91.00	0	1,321	0		17.00
18.00	OUTPATIENT PSYCH	93.00	0	60	0		18.00
19.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	343	0		19.00
	0		0	22,453			
	J - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	93,620	0		1.00
2.00	OPERATION OF PLANT	7.00	0	75,560	0		2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	14,862	0		3.00
4.00	HOUSEKEEPING	9.00	0	124,228	0		4.00
5.00	DIETARY	10.00	0	159,213	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	206,467	0		6.00
7.00	PHARMACY	15.00	0	95,929	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	376,233	0		8.00
9.00	SUBPROVIDER - IPF	40.00	0	38,842	0		9.00
10.00	OPERATING ROOM	50.00	0	286,105	0		10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	138,615	0		11.00
12.00	RESPIRATORY THERAPY	65.00	0	99,555	0		12.00
13.00	CARDIOPULMONARY	76.00	0	29,612	0		13.00
14.00	FAMILY PRACTICE OF JAY COUNTY	90.01	0	205,827	0		14.00
15.00	JAY FAMILY MEDICINE	90.02	0	206,210	0		15.00
16.00	JAY FAMILY FIRST HEALTH CARE	90.05	0	89,342	0		16.00
17.00	INFUSION CLINIC	90.06	0	4,148	0		17.00
18.00	EMERGENCY	91.00	0	180,334	0		18.00
19.00	OUTPATIENT PSYCH	93.00	0	20,826	0		19.00
20.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	55,122	0		20.00
21.00	WEST JAY CLINIC	194.02	0	48,778	0		21.00
22.00	JAY MERIDIAN URGENT CARE	194.03	0	28,838	0		22.00
	0		0	2,578,266			
	K - NURSERY AND LABOR AND DELIVERY						
1.00	ADULTS & PEDIATRICS	30.00	30,079	2,527	0		1.00
2.00		0.00	0	0	0		2.00
	0		30,079	2,527			
	M - MOTHER BABY						
1.00	ADULTS & PEDIATRICS	30.00	157,368	8,608	0		1.00
	TOTALS		157,368	8,608			
500.00	Grand Total: Decreases		439,895	7,526,728			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part I | Date/Time Prepared: 7/15/2021 1:03 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,006,948	0	0	0	17,800	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	19,125,052	0	0	0	147,200	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	8,662,182	724,381	0	724,381	16,448	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	28,794,182	724,381	0	724,381	181,448	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	28,794,182	724,381	0	724,381	181,448	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	989,148	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	18,977,852	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	9,370,115	142,136	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	29,337,115	142,136	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	29,337,115	142,136	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part II | Date/Time Prepared: 7/15/2021 1:03 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
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 01/01/2020 To 12/31/2020 | Worksheet A-7 Part III | Date/Time Prepared: 7/15/2021 1:03 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	29,337,115	0	29,337,115	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)	29,337,115	0	29,337,115	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	607,591	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	1,892,782	0	2.00
2.01	CAP REL COSTS-MVBLE EQUIP - MOB	0	0	0	38,468	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	2,538,841	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	24,482	0	0	632,073	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	3,943	0	0	1,896,725	2.00
2.01	CAP REL COSTS-MVBLE EQUIP - MOB	0	0	0	0	38,468	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	28,425	0	0	2,567,266	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8 | Date/Time Prepared: 7/15/2021 1:03 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-91,526	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	-68,094	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	-2,887,307			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	4,504,515			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-122,026	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8 | Date/Time Prepared: 7/15/2021 1:03 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - CAP REL COSTS-BLDG & FIXT-MOB		0	CAP REL COSTS-BLDG & FIXT-MOB	1.01	0	26.01
26.02	Depreciation - CAP REL COSTS-BLDG & FIXT-POB		0	CAP REL COSTS-BLDG & FIXT-POB	1.02	0	26.02
26.03	Depreciation - CAP REL COSTS-BLDG & FIXT-WJ		0	CAP REL COSTS-BLDG & FIXT-WJ	1.03	0	26.03
26.04	Depreciation - CAP REL COSTS-BLDG & FIXT-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	-2,579,709	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
33.01	HOSPITAL ASSESSMENT FEES	A	-1,894,583	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	MISCELLANEOUS INCOME	B	-162,216	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	MISCELLANEOUS INCOME	B	-35,460	OPERATION OF PLANT - POB	7.02	9	33.03
33.04	MISCELLANEOUS INCOME	B	-12,001	OPERATION OF PLANT - WJ	7.03	9	33.04
33.05	MISCELLANEOUS INCOME	B	-1,696	DIETARY	10.00	9	33.05
33.06	MISCELLANEOUS INCOME	B	-55	NURSING ADMINISTRATION	13.00	0	33.06
33.07	MISCELLANEOUS INCOME	B	-28	CENTRAL SERVICES & SUPPLY	14.00	0	33.07
33.08	MISCELLANEOUS INCOME	B	-3,142	PHARMACY	15.00	0	33.08
33.09	MARKETING EXPENSES	A	-11,455	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	CONTRACTED HOSPITALIST	A	-780,388	ADULTS & PEDIATRICS	30.00	0	33.10
33.11	CONTRACTED CRNA	A	-711,225	OPERATING ROOM	50.00	0	33.11
33.12	MEDICARE DEPRECIATION EXPENSE	A	-405,327	CAP REL COSTS-BLDG & FIXT	1.00	9	33.12
33.13	MEDICARE DEPRECIATION EXPENSE	A	-75,227	CAP REL COSTS-BLDG & FIXT-MOB	1.01	9	33.13
33.14	MEDICARE DEPRECIATION EXPENSE	A	-35,030	CAP REL COSTS-BLDG & FIXT-POB	1.02	9	33.14
33.15	MEDICARE DEPRECIATION EXPENSE	A	-14,339	CAP REL COSTS-BLDG & FIXT-WJ	1.03	9	33.15
33.16	MEDICARE DEPRECIATION EXPENSE	A	-14,667	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.16
33.17	MEDICARE DEPRECIATION EXPENSE	A	-1,413	CAP REL COSTS-MVBLE EQUIP - MOB	2.01	9	33.17
33.18	MARKETING EXPENSES	A	-160	ADULTS & PEDIATRICS	30.00	0	33.18
33.19	MARKETING EXPENSES	A	-60	OPERATING ROOM	50.00	0	33.19
33.20	MARKETING EXPENSES	A	-171	EMERGENCY	91.00	0	33.20
33.21	MISCELLANEOUS INCOME	B	-836	OPERATION OF PLANT	7.00	0	33.21
33.22	MISCELLANEOUS INCOME	B	-23,236	RADIOLOGY-DIAGNOSTIC	54.00	9	33.22
33.23	MISCELLANEOUS INCOME	B	-5,141	LABORATORY	60.00	0	33.23

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8 | Date/Time Prepared: 7/15/2021 1:03 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-5,432,003				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8-1 | Date/Time Prepared: 7/15/2021 1:03 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	17,792	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	209,597	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	2,247,931	1,966	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	6,461,183	6,302,296	3.01
3.02	5.00	ADMINISTRATIVE & GENERAL	RELATED PARTY	761,743	86,118	3.02
3.03	7.00	OPERATION OF PLANT	RELATED PARTY	261,934	0	3.03
3.04	10.00	DIETARY	RELATED PARTY	11,244	0	3.04
3.05	13.00	NURSING ADMINISTRATION	RELATED PARTY	348,196	0	3.05
3.06	15.00	PHARMACY	RELATED PARTY	219,689	0	3.06
3.07	54.00	RADIOLOGY-DIAGNOSTIC	RELATED PARTY	164,497	0	3.07
3.08	65.00	RESPIRATORY THERAPY	RELATED PARTY	29,237	0	3.08
3.09	66.00	PHYSICAL THERAPY	RELATED PARTY	69,436	0	3.09
3.10	76.00	CARDIOPULMONARY	RELATED PARTY	92,416	0	3.10
3.11	4.00	EMPLOYEE BENEFITS DEPARTMENT		11,902	11,902	3.11
3.12	5.00	ADMINISTRATIVE & GENERAL		75,618	75,618	3.12
3.13	7.00	OPERATION OF PLANT		231,598	231,598	3.13
3.14	10.00	DIETARY		55,294	55,294	3.14
3.15	15.00	PHARMACY		88,767	88,767	3.15
3.16	30.00	ADULTS & PEDIATRICS		805,870	805,870	3.16
3.17	40.00	SUBPROVIDER - IPF		100,260	100,260	3.17
3.18	50.00	OPERATING ROOM		521,997	521,997	3.18
3.19	54.00	RADIOLOGY-DIAGNOSTIC		341	341	3.19
3.20	60.00	LABORATORY		1,939,030	1,939,030	3.20
3.21	65.00	RESPIRATORY THERAPY		1,338	1,338	3.21
3.22	66.00	PHYSICAL THERAPY		470,237	470,237	3.22
3.23	67.00	OCCUPATIONAL THERAPY		85,903	85,903	3.23
3.24	68.00	SPEECH PATHOLOGY		17,143	17,143	3.24
3.25	69.00	ELECTROCARDIOLOGY		1,060	1,060	3.25
3.26	76.00	CARDIOPULMONARY		56,944	56,944	3.26
3.27	90.01	FAMILY PRACTICE OF JAY COUNT		326,852	326,852	3.27
3.28	90.02	JAY FAMILY MEDICINE		663,500	663,500	3.28
3.29	90.03	WOUND CLINIC		18,523	18,523	3.29
3.30	90.05	JAY FAMILY FIRST HEALTH CARE		164,335	164,335	3.30
3.31	90.06	INFUSION CLINIC		55	55	3.31
3.32	91.00	EMERGENCY		1,551,509	1,551,509	3.32
3.33	93.00	OUTPATIENT PSYCH		380	380	3.33
3.34	192.00	PHYSICIANS' PRIVATE OFFICES		1,101	1,101	3.34
3.35	194.02	WEST JAY CLINIC		35,577	35,577	3.35
4.00	194.03	JAY MERIDIAN URGENT CARE		9,353	9,353	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			18,129,382	13,624,867	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 01/01/2020 To 12/31/2020	Worksheet A-8-1 Date/Time Prepared: 7/15/2021 1:03 pm

				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 01/01/2020 To 12/31/2020 | Worksheet A-8-1 | Date/Time Prepared: 7/15/2021 1:03 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	17,792	9		1.00
2.00	209,597	9		2.00
3.00	2,245,965	0		3.00
3.01	158,887	0		3.01
3.02	675,625	0		3.02
3.03	261,934	0		3.03
3.04	11,244	0		3.04
3.05	348,196	0		3.05
3.06	219,689	0		3.06
3.07	164,497	0		3.07
3.08	29,237	0		3.08
3.09	69,436	0		3.09
3.10	92,416	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	4,504,515			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 01/01/2020 To 12/31/2020	Worksheet A-8-1 Date/Time Prepared: 7/15/2021 1:03 pm

	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 01/01/2020 To 12/31/2020 | Worksheet A-8-2 | Date/Time Prepared: 7/15/2021 1:03 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	40.00	SUBPROVIDER - IPF	104,848	104,848	0	0	0	1.00
2.00	50.00	OPERATING ROOM	483,464	483,464	0	0	0	2.00
3.00	76.00	CARDIOPULMONARY	30,371	30,371	0	0	0	3.00
4.00	90.01	FAMILY PRACTICE OF JAY COUNTY	326,852	326,852	0	0	0	4.00
5.00	90.02	JAY FAMILY MEDICINE	597,603	597,603	0	0	0	5.00
6.00	90.03	WOUND CLINIC	18,523	18,523	0	0	0	6.00
7.00	90.05	JAY FAMILY FIRST HEALTH CARE	163,760	163,760	0	0	0	7.00
8.00	91.00	EMERGENCY	1,434,073	1,161,886	272,187	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			3,159,494	2,887,307	272,187		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	76.00	CARDIOPULMONARY	0	0	0	0	0	3.00
4.00	90.01	FAMILY PRACTICE OF JAY COUNTY	0	0	0	0	0	4.00
5.00	90.02	JAY FAMILY MEDICINE	0	0	0	0	0	5.00
6.00	90.03	WOUND CLINIC	0	0	0	0	0	6.00
7.00	90.05	JAY FAMILY FIRST HEALTH CARE	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	40.00	SUBPROVIDER - IPF	0	0	0	104,848		1.00
2.00	50.00	OPERATING ROOM	0	0	0	483,464		2.00
3.00	76.00	CARDIOPULMONARY	0	0	0	30,371		3.00
4.00	90.01	FAMILY PRACTICE OF JAY COUNTY	0	0	0	326,852		4.00
5.00	90.02	JAY FAMILY MEDICINE	0	0	0	597,603		5.00
6.00	90.03	WOUND CLINIC	0	0	0	18,523		6.00
7.00	90.05	JAY FAMILY FIRST HEALTH CARE	0	0	0	163,760		7.00
8.00	91.00	EMERGENCY	0	0	0	1,161,886		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	2,887,307		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I | Date/Time Prepared: 7/15/2021 1:03 pm

		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	632,073	632,073				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	1,896,725					2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB	38,468					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	2,430,850	888	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,438,140	84,531	0	0	0	5.00
7.00	00700	OPERATION OF PLANT	2,667,750	122,238	0	0	0	7.00
7.01	00701	OPERATION OF PLANT - MOB	99,585	0	0	0	0	7.01
7.02	00702	OPERATION OF PLANT - POB	5,019	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	129,081	4,670	0	0	0	8.00
9.00	00900	HOUSEKEEPING	506,802	4,717	0	0	0	9.00
10.00	01000	DIETARY	207,405	10,070	0	0	0	10.00
11.00	01100	CAFETERIA	340,137	23,513	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,661,529	8,718	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	263,203	0	0	0	0	14.00
15.00	01500	PHARMACY	902,907	7,861	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	1,721,967	97,454	0	0	0	30.00
40.00	04000	SUBPROVIDER - IPF	218,684	2,350	0	0	0	40.00
43.00	04300	NURSERY	25,325	2,123	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,118,153	31,382	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,281	873	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,292,102	39,258	0	0	0	54.00
60.00	06000	LABORATORY	2,019,607	20,557	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	445,843	5,746	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	542,290	25,281	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	85,903	4,725	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	17,143	189	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,295	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	87,965	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	20,085	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,511,327	0	0	0	0	73.00
76.00	03160	CARDIOPULMONARY	245,023	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	676,691	0	0	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	744,720	0	0	0	0	90.02
90.03	09003	WOUND CLINIC	0	2,681	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	281,768	30,407	0	0	0	90.05
90.06	09006	INFUSION CLINIC	120,893	4,858	0	0	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	165,976	20,596	0	0	0	90.07
91.00	09100	EMERGENCY	1,610,975	37,498	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	32,139	12,350	0	0	0	93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	33,213,829	605,534	0	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,061	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	146,267	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT	0	20,478	0	0	0	194.00
194.02	07952	WEST JAY CLINIC	174,497	0	0	0	0	194.02
194.03	07953	JAY MERIDIAN URGENT CARE	111,273	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers			0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	33,645,866	632,073	0	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 7/15/2021 1:03 pm

		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		1,896,725				2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB		0	38,468			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	2,666	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	253,659	2,509	0	0	5.00
7.00	00700	OPERATION OF PLANT	0	366,819	0	0	0	7.00
7.01	00701	OPERATION OF PLANT - MOB	0	0	877	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	14,012	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	14,154	0	0	0	9.00
10.00	01000	DIETARY	0	30,218	0	0	0	10.00
11.00	01100	CAFETERIA	0	70,557	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	26,161	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	23,590	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	292,441	0	0	0	30.00
40.00	04000	SUBPROVIDER - IPF	0	7,053	0	0	0	40.00
43.00	04300	NURSERY	0	6,369	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	94,170	1,618	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,618	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	117,807	0	0	0	54.00
60.00	06000	LABORATORY	0	61,687	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	17,244	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	75,864	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	14,177	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	566	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	2,681	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	15,441	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	15,094	0	0	90.02
90.03	09003	WOUND CLINIC	0	8,044	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	91,245	248	0	0	90.05
90.06	09006	INFUSION CLINIC	0	14,578	0	0	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	61,805	0	0	0	90.07
91.00	09100	EMERGENCY	0	112,523	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	0	37,059	0	0	0	93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,817,086	38,468	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	18,188	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	61,451	0	0	0	194.00
194.02	07952	WEST JAY CLINIC	0	0	0	0	0	194.02
194.03	07953	JAY MERIDIAN URGENT CARE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,896,725	38,468	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 7/15/2021 1:03 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT - MOB	
			4.00	4A	5.00	7.00	7.01	
		GENERAL SERVICE COST CENTERS						
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	2,434,404					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	124,214	8,903,053	8,903,053			5.00
7.00	00700	OPERATION OF PLANT	66,123	3,222,930	1,159,683	4,382,613		7.00
7.01	00701	OPERATION OF PLANT - MOB	0	100,462	36,149	24,516	161,127	7.01
7.02	00702	OPERATION OF PLANT - POB	0	5,019	1,806	30,398	0	7.02
7.03	00703	OPERATION OF PLANT - WJ	0	0	0	0	0	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	7,767	155,530	55,963	29,360	0	8.00
9.00	00900	HOUSEKEEPING	83,059	608,732	219,036	29,657	0	9.00
10.00	01000	DIETARY	23,527	271,220	97,591	63,318	0	10.00
11.00	01100	CAFETERIA	54,956	489,163	176,013	147,840	0	11.00
13.00	01300	NURSING ADMINISTRATION	255,487	1,951,895	702,339	54,816	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	263,203	94,707	0	0	14.00
15.00	01500	PHARMACY	109,112	1,043,470	375,466	49,428	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	339,349	2,451,211	882,005	612,765	0	30.00
40.00	04000	SUBPROVIDER - IPF	45,274	273,361	98,362	14,779	0	40.00
43.00	04300	NURSERY	5,086	38,903	13,998	13,346	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	202,341	1,447,664	520,904	558,985	7,431	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,462	12,234	4,402	5,487	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	173,866	1,623,033	584,006	246,845	0	54.00
60.00	06000	LABORATORY	0	2,101,851	756,296	129,255	0	60.00
65.00	06500	RESPIRATORY THERAPY	83,541	552,374	198,757	36,132	0	65.00
66.00	06600	PHYSICAL THERAPY	102,006	745,441	268,228	158,962	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	18,660	123,465	44,426	29,706	0	67.00
68.00	06800	SPEECH PATHOLOGY	3,732	21,630	7,783	1,186	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,295	826	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	87,965	31,652	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	20,085	7,227	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,511,327	543,812	0	0	73.00
76.00	03160	CARDIOPULMONARY	25,308	273,012	98,236	74,933	12,312	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	132,752	824,884	296,813	431,658	70,923	90.01
90.02	09002	JAY FAMILY MEDICINE	136,374	896,188	322,470	421,920	69,324	90.02
90.03	09003	WOUND CLINIC	0	10,725	3,859	16,855	0	90.03
90.04	09004	OP ORTHO CLINIC	0	0	0	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	56,658	460,326	165,636	198,109	1,137	90.05
90.06	09006	INFUSION CLINIC	24,288	164,617	59,233	30,547	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	34,258	282,635	101,699	129,502	0	90.07
91.00	09100	EMERGENCY	244,172	2,005,168	721,508	235,773	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0				92.00
93.00	04950	OUTPATIENT PSYCH	6,904	88,452	31,827	77,652	0	93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,360,276	33,033,523	8,682,718	3,853,730	161,127	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	24,249	8,725	38,109	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	26,071	172,338	62,011	308,878	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT	0	81,929	29,480	128,761	0	194.00
194.02	07952	WEST JAY CLINIC	27,700	202,197	72,755	53,135	0	194.02
194.03	07953	JAY MERIDIAN URGENT CARE	20,357	131,630	47,364	0	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)	2,434,404	33,645,866	8,903,053	4,382,613	161,127	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I | Date/Time Prepared: 7/15/2021 1:03 pm

		Cost Center Description	OPERATION OF PLANT - POB	OPERATION OF PLANT - WJ	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			7.02	7.03	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
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	37,223					7.02
7.03	00703	OPERATION OF PLANT - WJ	0	0				7.03
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	240,853			8.00
9.00	00900	HOUSEKEEPING	0	0	0	857,425		9.00
10.00	01000	DIETARY	0	0	7,348	12,739	452,216	10.00
11.00	01100	CAFETERIA	0	0	0	29,744	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	11,028	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	9,944	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	75,488	123,281	443,134	30.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	2,973	9,082	40.00
43.00	04300	NURSERY	0	0	0	2,685	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	26,706	0	60,957	112,461	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,104	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	33,098	49,662	0	54.00
60.00	06000	LABORATORY	0	0	0	26,005	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	7,269	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	160	31,981	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	5,977	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	239	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	15,076	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	7,003	86,844	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	551	84,885	0	90.02
90.03	09003	WOUND CLINIC	0	0	0	3,391	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	459	39,857	0	90.05
90.06	09006	INFUSION CLINIC	0	0	0	6,146	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	0	0	26,054	0	90.07
91.00	09100	EMERGENCY	0	0	55,570	47,435	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	0	0	0	15,623	0	93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	26,706	0	240,634	752,403	452,216	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	7,667	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	10,517	0	72	62,142	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT	0	0	0	25,905	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	147	9,308	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)	37,223	0	240,853	857,425	452,216	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I | Date/Time Prepared: 7/15/2021 1:03 pm

		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	842,760					11.00
13.00	01300	NURSING ADMINISTRATION	71,142	2,791,220				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	357,910			14.00
15.00	01500	PHARMACY	30,744	0	5,889	1,514,941		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	128,469	673,523	59,537	5,293	0	30.00
40.00	04000	SUBPROVIDER - IPF	12,872	72,752	111	0	0	40.00
43.00	04300	NURSERY	2,723	14,625	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	77,875	409,889	0	2,313	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	446	2,625	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	57,626	0	31,143	2,124	0	54.00
60.00	06000	LABORATORY	56,240	0	12	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	29,061	0	19,514	236	0	65.00
66.00	06600	PHYSICAL THERAPY	22,328	0	1,957	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,594	0	45	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	842	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	521	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	77,836	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	17,772	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,479,960	0	73.00
76.00	03160	CARDIOPULMONARY	8,565	1,500	1,078	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	82,776	398,264	27,959	14,663	0	90.01
90.02	09002	JAY FAMILY MEDICINE	83,915	450,765	15,652	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	33,665	146,630	3,737	353	0	90.05
90.06	09006	INFUSION CLINIC	7,377	55,502	6,310	1,969	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	10,941	75,003	1,644	0	0	90.07
91.00	09100	EMERGENCY	83,221	490,142	85,344	8,030	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	7,822	0	231	0	0	93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	814,244	2,791,220	356,292	1,514,941	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	15,545	0	897	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT	0	0	0	0	0	194.00
194.02	07952	WEST JAY CLINIC	0	0	721	0	0	194.02
194.03	07953	JAY MERIDIAN URGENT CARE	12,971	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)	842,760	2,791,220	357,910	1,514,941	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I | Date/Time Prepared: 7/15/2021 1:03 pm

		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	5,454,706	0	5,454,706		30.00
40.00	04000	SUBPROVIDER - IPF	0	484,292	0	484,292		40.00
43.00	04300	NURSERY	0	86,280	0	86,280		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,225,185	0	3,225,185		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	26,298	0	26,298		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,627,537	0	2,627,537		54.00
60.00	06000	LABORATORY	0	3,069,659	0	3,069,659		60.00
65.00	06500	RESPIRATORY THERAPY	0	843,343	0	843,343		65.00
66.00	06600	PHYSICAL THERAPY	0	1,229,057	0	1,229,057		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	209,213	0	209,213		67.00
68.00	06800	SPEECH PATHOLOGY	0	31,680	0	31,680		68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,642	0	3,642		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	197,453	0	197,453		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	45,084	0	45,084		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,535,099	0	3,535,099		73.00
76.00	03160	CARDIOPULMONARY	0	484,712	0	484,712		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	2,241,787	0	2,241,787		90.01
90.02	09002	JAY FAMILY MEDICINE	0	2,345,670	0	2,345,670		90.02
90.03	09003	WOUND CLINIC	0	34,830	0	34,830		90.03
90.04	09004	OP ORTHO CLINIC	0	0	0	0		90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0	1,049,909	0	1,049,909		90.05
90.06	09006	INFUSION CLINIC	0	331,701	0	331,701		90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	627,478	0	627,478		90.07
91.00	09100	EMERGENCY	0	3,732,191	0	3,732,191		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
93.00	04950	OUTPATIENT PSYCH	0	221,607	0	221,607		93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	32,138,413	0	32,138,413		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	78,750	0	78,750		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	632,400	0	632,400		192.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
194.00	07950	VACANT	0	266,075	0	266,075		194.00
194.02	07952	WEST JAY CLINIC	0	328,808	0	328,808		194.02
194.03	07953	JAY MERIDIAN URGENT CARE	0	201,420	0	201,420		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	33,645,866	0	33,645,866		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II Date/Time Prepared: 7/15/2021 1:03 pm

		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	888	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	84,531	0	0	0	5.00
7.00	00700	OPERATION OF PLANT	0	122,238	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	4,670	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	4,717	0	0	0	9.00
10.00	01000	DIETARY	0	10,070	0	0	0	10.00
11.00	01100	CAFETERIA	0	23,513	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	8,718	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	7,861	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	97,454	0	0	0	30.00
40.00	04000	SUBPROVIDER - IPF	0	2,350	0	0	0	40.00
43.00	04300	NURSERY	0	2,123	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	31,382	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	873	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	39,258	0	0	0	54.00
60.00	06000	LABORATORY	0	20,557	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	5,746	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	25,281	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,725	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	189	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	2,681	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	30,407	0	0	0	90.05
90.06	09006	INFUSION CLINIC	0	4,858	0	0	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	20,596	0	0	0	90.07
91.00	09100	EMERGENCY	0	37,498	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	0	12,350	0	0	0	93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	605,534	0	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,061	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT	0	20,478	0	0	0	194.00
194.02	07952	WEST JAY CLINIC	0	0	0	0	0	194.02
194.03	07953	JAY MERIDIAN URGENT CARE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	632,073	0	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II Date/Time Prepared: 7/15/2021 1:03 pm

		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	2,666	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	253,659	2,509	0	0	5.00
7.00	00700	OPERATION OF PLANT	0	366,819	0	0	0	7.00
7.01	00701	OPERATION OF PLANT - MOB	0	0	877	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	14,012	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	14,154	0	0	0	9.00
10.00	01000	DIETARY	0	30,218	0	0	0	10.00
11.00	01100	CAFETERIA	0	70,557	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	26,161	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	23,590	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	292,441	0	0	0	30.00
40.00	04000	SUBPROVIDER - IPF	0	7,053	0	0	0	40.00
43.00	04300	NURSERY	0	6,369	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	94,170	1,618	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,618	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	117,807	0	0	0	54.00
60.00	06000	LABORATORY	0	61,687	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	17,244	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	75,864	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	14,177	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	566	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	2,681	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	15,441	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	15,094	0	0	90.02
90.03	09003	WOUND CLINIC	0	8,044	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	91,245	248	0	0	90.05
90.06	09006	INFUSION CLINIC	0	14,578	0	0	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	61,805	0	0	0	90.07
91.00	09100	EMERGENCY	0	112,523	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	0	37,059	0	0	0	93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,817,086	38,468	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	18,188	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	61,451	0	0	0	194.00
194.02	07952	WEST JAY CLINIC	0	0	0	0	0	194.02
194.03	07953	JAY MERIDIAN URGENT CARE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,896,725	38,468	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II Date/Time Prepared: 7/15/2021 1:03 pm

		Cost Center Description	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT - MOB	
			2A	4.00	5.00	7.00	7.01	
		GENERAL SERVICE COST CENTERS						
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	3,554	3,554				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	340,699	181	340,880			5.00
7.00	00700	OPERATION OF PLANT	489,057	97	44,399	533,553		7.00
7.01	00701	OPERATION OF PLANT - MOB	877	0	1,384	2,985	5,246	7.01
7.02	00702	OPERATION OF PLANT - POB	0	0	69	3,701	0	7.02
7.03	00703	OPERATION OF PLANT - WJ	0	0	0	0	0	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	18,682	11	2,143	3,574	0	8.00
9.00	00900	HOUSEKEEPING	18,871	121	8,387	3,611	0	9.00
10.00	01000	DIETARY	40,288	34	3,737	7,708	0	10.00
11.00	01100	CAFETERIA	94,070	80	6,739	17,999	0	11.00
13.00	01300	NURSING ADMINISTRATION	34,879	373	26,891	6,673	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	3,626	0	0	14.00
15.00	01500	PHARMACY	31,451	159	14,376	6,018	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	389,895	497	33,770	74,597	0	30.00
40.00	04000	SUBPROVIDER - IPF	9,403	66	3,766	1,799	0	40.00
43.00	04300	NURSERY	8,492	7	536	1,625	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	127,170	296	19,944	68,053	242	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,491	2	169	668	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	157,065	254	22,361	30,052	0	54.00
60.00	06000	LABORATORY	82,244	0	28,957	15,736	0	60.00
65.00	06500	RESPIRATORY THERAPY	22,990	122	7,610	4,399	0	65.00
66.00	06600	PHYSICAL THERAPY	101,145	149	10,270	19,352	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	18,902	27	1,701	3,617	0	67.00
68.00	06800	SPEECH PATHOLOGY	755	5	298	144	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	32	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,212	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	277	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	20,822	0	0	73.00
76.00	03160	CARDIOPULMONARY	2,681	37	3,761	9,123	401	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	15,441	194	11,364	52,551	2,309	90.01
90.02	09002	JAY FAMILY MEDICINE	15,094	199	12,347	51,366	2,257	90.02
90.03	09003	WOUND CLINIC	10,725	0	148	2,052	0	90.03
90.04	09004	OP ORTHO CLINIC	0	0	0	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	121,900	83	6,342	24,118	37	90.05
90.06	09006	INFUSION CLINIC	19,436	35	2,268	3,719	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	82,401	50	3,894	15,766	0	90.07
91.00	09100	EMERGENCY	150,021	357	27,625	28,704	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
93.00	04950	OUTPATIENT PSYCH	49,409	10	1,219	9,454	0	93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,461,088	3,446	332,444	469,164	5,246	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	24,249	0	334	4,640	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	38	2,374	37,604	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT	81,929	0	1,129	15,676	0	194.00
194.02	07952	WEST JAY CLINIC	0	40	2,786	6,469	0	194.02
194.03	07953	JAY MERIDIAN URGENT CARE	0	30	1,813	0	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)	2,567,266	3,554	340,880	533,553	5,246	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II Date/Time Prepared: 7/15/2021 1:03 pm

		Cost Center Description	OPERATION OF PLANT - POB	OPERATION OF PLANT - WJ	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			7.02	7.03	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
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	3,770					7.02
7.03	00703	OPERATION OF PLANT - WJ	0	0				7.03
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	24,410			8.00
9.00	00900	HOUSEKEEPING	0	0	0	30,990		9.00
10.00	01000	DIETARY	0	0	745	460	52,972	10.00
11.00	01100	CAFETERIA	0	0	0	1,075	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	399	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	359	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	7,651	4,455	51,908	30.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	107	1,064	40.00
43.00	04300	NURSERY	0	0	0	97	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,705	0	6,178	4,065	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	40	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	3,354	1,795	0	54.00
60.00	06000	LABORATORY	0	0	0	940	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	263	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	16	1,156	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	216	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	9	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	545	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	710	3,139	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	56	3,068	0	90.02
90.03	09003	WOUND CLINIC	0	0	0	123	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	46	1,441	0	90.05
90.06	09006	INFUSION CLINIC	0	0	0	222	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	0	0	942	0	90.07
91.00	09100	EMERGENCY	0	0	5,632	1,714	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	0	0	0	565	0	93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,705	0	24,388	27,195	52,972	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	277	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,065	0	7	2,246	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT	0	0	0	936	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	15	336	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)	3,770	0	24,410	30,990	52,972	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II Date/Time Prepared: 7/15/2021 1:03 pm

		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	119,963					11.00
13.00	01300	NURSING ADMINISTRATION	10,127	79,342				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	3,626			14.00
15.00	01500	PHARMACY	4,376	0	60	56,799		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	18,288	19,144	603	198	0	30.00
40.00	04000	SUBPROVIDER - IPF	1,832	2,068	1	0	0	40.00
43.00	04300	NURSERY	388	416	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,085	11,651	0	87	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	63	75	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,203	0	315	80	0	54.00
60.00	06000	LABORATORY	8,006	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	4,137	0	198	9	0	65.00
66.00	06600	PHYSICAL THERAPY	3,178	0	20	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	796	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	120	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	5	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	789	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	180	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	55,487	0	73.00
76.00	03160	CARDIOPULMONARY	1,219	43	11	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	11,783	11,321	283	550	0	90.01
90.02	09002	JAY FAMILY MEDICINE	11,945	12,813	159	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	4,792	4,168	38	13	0	90.05
90.06	09006	INFUSION CLINIC	1,050	1,578	64	74	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	1,557	2,132	17	0	0	90.07
91.00	09100	EMERGENCY	11,846	13,933	865	301	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	1,113	0	2	0	0	93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	115,904	79,342	3,610	56,799	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	2,213	0	9	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT	0	0	0	0	0	194.00
194.02	07952	WEST JAY CLINIC	0	0	7	0	0	194.02
194.03	07953	JAY MERIDIAN URGENT CARE	1,846	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)	119,963	79,342	3,626	56,799	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II Date/Time Prepared: 7/15/2021 1:03 pm

		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	601,006	0	601,006		30.00
40.00	04000	SUBPROVIDER - IPF	0	20,106	0	20,106		40.00
43.00	04300	NURSERY	0	11,561	0	11,561		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	251,476	0	251,476		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,508	0	4,508		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	223,479	0	223,479		54.00
60.00	06000	LABORATORY	0	135,883	0	135,883		60.00
65.00	06500	RESPIRATORY THERAPY	0	39,728	0	39,728		65.00
66.00	06600	PHYSICAL THERAPY	0	135,286	0	135,286		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	25,259	0	25,259		67.00
68.00	06800	SPEECH PATHOLOGY	0	1,331	0	1,331		68.00
69.00	06900	ELECTROCARDIOLOGY	0	37	0	37		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,001	0	2,001		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	457	0	457		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	76,309	0	76,309		73.00
76.00	03160	CARDIOPULMONARY	0	17,821	0	17,821		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	109,645	0	109,645		90.01
90.02	09002	JAY FAMILY MEDICINE	0	109,304	0	109,304		90.02
90.03	09003	WOUND CLINIC	0	13,048	0	13,048		90.03
90.04	09004	OP ORTHO CLINIC	0	0	0	0		90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0	162,978	0	162,978		90.05
90.06	09006	INFUSION CLINIC	0	28,446	0	28,446		90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	106,759	0	106,759		90.07
91.00	09100	EMERGENCY	0	240,998	0	240,998		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
93.00	04950	OUTPATIENT PSYCH	0	61,772	0	61,772		93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,379,198	0	2,379,198		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	29,500	0	29,500		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	45,556	0	45,556		192.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
194.00	07950	VACANT	0	99,670	0	99,670		194.00
194.02	07952	WEST JAY CLINIC	0	9,302	0	9,302		194.02
194.03	07953	JAY MERIDIAN URGENT CARE	0	4,040	0	4,040		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	2,567,266	0	2,567,266		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/15/2021 1:03 pm

		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	80,405					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MOB	0	21,755				1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT-POB	0	0	9,538			1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT-WJ	0	0	0	4,803		1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT-INTEREST	0	0	0	0	80,405	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	15,550	0	0	0	15,550	7.00
7.01	00701	OPERATION OF PLANT - MOB	0	496	615	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	1,281	0	0	0	1,281	10.00
11.00	01100	CAFETERIA	2,991	0	0	0	2,991	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	12,397	0	0	0	12,397	30.00
40.00	04000	SUBPROVIDER - IPF	299	0	0	0	299	40.00
43.00	04300	NURSERY	270	0	0	0	270	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	111	0	0	0	111	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	3,216	0	0	0	3,216	66.00
67.00	06700	OCCUPATIONAL THERAPY	601	0	0	0	601	67.00
68.00	06800	SPEECH PATHOLOGY	24	0	0	0	24	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	8,733	0	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0	8,536	0	0	0	90.02
90.03	09003	WOUND CLINIC	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
90.07	09007	HEALTH BEGINNINGS PROGRAM	2,620	0	0	0	2,620	90.07
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)	77,029	21,755	7,017	0	77,029	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	1,075	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)	632,073	0	0	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.861116	0.000000	0.000000	0.000000	0.000000	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/15/2021 1:03 pm

		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 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/15/2021 1:03 pm

		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	80,405					2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB	0	21,755				2.01
2.02	00202	CAP REL COSTS-MVBLE EQUIP - POB	0	0	9,538			2.02
2.03	00203	CAP REL COSTS-MVBLE EQUIP - WJ	0	0	0	4,803		2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	113	0	0	0	11,182,709	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,753	1,419	0	0	570,589	5.00
7.00	00700	OPERATION OF PLANT	15,550	0	0	0	303,745	7.00
7.01	00701	OPERATION OF PLANT - MOB	0	496	615	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	35,680	8.00
9.00	00900	HOUSEKEEPING	600	0	0	0	381,538	9.00
10.00	01000	DIETARY	1,281	0	0	0	108,076	10.00
11.00	01100	CAFETERIA	2,991	0	0	0	252,448	11.00
13.00	01300	NURSING ADMINISTRATION	1,109	0	0	0	1,173,606	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	1,000	0	0	0	501,218	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	12,397	0	0	0	1,558,849	30.00
40.00	04000	SUBPROVIDER - IPF	299	0	0	0	207,970	40.00
43.00	04300	NURSERY	270	0	0	0	23,362	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,992	915	6,402	0	929,473	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	111	0	0	0	6,717	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,994	0	0	0	798,673	54.00
60.00	06000	LABORATORY	2,615	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	731	0	0	0	383,754	65.00
66.00	06600	PHYSICAL THERAPY	3,216	0	0	0	468,575	66.00
67.00	06700	OCCUPATIONAL THERAPY	601	0	0	0	85,715	67.00
68.00	06800	SPEECH PATHOLOGY	24	0	0	0	17,143	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	116,255	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	8,733	0	0	609,812	90.01
90.02	09002	JAY FAMILY MEDICINE	0	8,536	0	0	626,450	90.02
90.03	09003	WOUND CLINIC	341	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	3,868	140	0	0	260,265	90.05
90.06	09006	INFUSION CLINIC	618	0	0	0	111,570	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	2,620	0	0	0	157,368	90.07
91.00	09100	EMERGENCY	4,770	0	0	0	1,121,629	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	1,571	0	0	0	31,716	93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	77,029	21,755	7,017	0	10,842,196	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	119,761	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	1,075	127,241	194.02
194.03	07953	JAY MERIDIAN URGENT CARE	0	0	0	0	93,511	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)	1,896,725	38,468	0	0	2,434,404	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/15/2021 1:03 pm

		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	
203.00		Unit cost multiplier (Wkst. B, Part I)	23.589640	1.768237	0.000000	0.000000	0.217694	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)					3,554	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)					0.000318	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 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/15/2021 1:03 pm

		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	-8,903,053	24,742,813				5.00
7.00	00700	OPERATION OF PLANT	0	3,222,930	88,666			7.00
7.01	00701	OPERATION OF PLANT - MOB	0	100,462	496	19,840		7.01
7.02	00702	OPERATION OF PLANT - POB	0	5,019	615	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	155,530	594	0	0	8.00
9.00	00900	HOUSEKEEPING	0	608,732	600	0	0	9.00
10.00	01000	DIETARY	0	271,220	1,281	0	0	10.00
11.00	01100	CAFETERIA	0	489,163	2,991	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,951,895	1,109	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	263,203	0	0	0	14.00
15.00	01500	PHARMACY	0	1,043,470	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	2,451,211	12,397	0	0	30.00
40.00	04000	SUBPROVIDER - IPF	0	273,361	299	0	0	40.00
43.00	04300	NURSERY	0	38,903	270	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,447,664	11,309	915	6,402	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	12,234	111	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,623,033	4,994	0	0	54.00
60.00	06000	LABORATORY	0	2,101,851	2,615	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	552,374	731	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	745,441	3,216	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	123,465	601	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	21,630	24	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,295	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	87,965	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	20,085	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,511,327	0	0	0	73.00
76.00	03160	CARDIOPULMONARY	0	273,012	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	824,884	8,733	8,733	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0	896,188	8,536	8,536	0	90.02
90.03	09003	WOUND CLINIC	0	10,725	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	460,326	4,008	140	0	90.05
90.06	09006	INFUSION CLINIC	0	164,617	618	0	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	282,635	2,620	0	0	90.07
91.00	09100	EMERGENCY	0	2,005,168	4,770	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	0	88,452	1,571	0	0	93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-8,903,053	24,130,470	77,966	19,840	6,402	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	24,249	771	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	172,338	6,249	0	2,521	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT	0	81,929	2,605	0	0	194.00
194.02	07952	WEST JAY CLINIC	0	202,197	1,075	0	0	194.02
194.03	07953	JAY MERIDIAN URGENT CARE	0	131,630	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)		8,903,053	4,382,613	161,127	37,223	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.359824	49.428338	8.121321	4.171579	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		340,880	533,553	5,246	3,770	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/15/2021 1:03 pm

		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)		0.013777	6.017560	0.264415	0.422504	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 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/15/2021 1:03 pm

		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	4,803					7.03
8.00	00800	LAUNDRY & LINEN SERVICE	0	57,233				8.00
9.00	00900	HOUSEKEEPING	0	0	86,222			9.00
10.00	01000	DIETARY	0	1,746	1,281	7,170		10.00
11.00	01100	CAFETERIA	0	0	2,991	0	17,023	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	1,109	0	1,437	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	1,000	0	621	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	17,938	12,397	7,026	2,595	30.00
40.00	04000	SUBPROVIDER - IPF	0	0	299	144	260	40.00
43.00	04300	NURSERY	0	0	270	0	55	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	14,485	11,309	0	1,573	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	111	0	9	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,865	4,994	0	1,164	54.00
60.00	06000	LABORATORY	0	0	2,615	0	1,136	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	731	0	587	65.00
66.00	06600	PHYSICAL THERAPY	0	38	3,216	0	451	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	601	0	113	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	24	0	17	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	1,516	0	173	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	1,664	8,733	0	1,672	90.01
90.02	09002	JAY FAMILY MEDICINE	0	131	8,536	0	1,695	90.02
90.03	09003	WOUND CLINIC	0	0	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	109	4,008	0	680	90.05
90.06	09006	INFUSION CLINIC	0	0	618	0	149	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	0	2,620	0	221	90.07
91.00	09100	EMERGENCY	0	13,205	4,770	0	1,681	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	0	0	1,571	0	158	93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	57,181	75,661	7,170	16,447	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	17	6,249	0	314	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	1,075	0	0	0	0	194.02
194.03	07953	JAY MERIDIAN URGENT CARE	0	35	936	0	262	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	240,853	857,425	452,216	842,760	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	4.208289	9.944388	63.070572	49.507137	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	24,410	30,990	52,972	119,963	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/15/2021 1:03 pm

		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	0.426502	0.359421	7.388006	7.047113	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 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/15/2021 1:03 pm

		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	7,443					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	404,488				14.00
15.00	01500	PHARMACY	0	6,655	1,547,048			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	64,936,178		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,796	67,285	5,405	5,729,911	0	30.00
40.00	04000	SUBPROVIDER - IPF	194	126	0	84,316	0	40.00
43.00	04300	NURSERY	39	0	0	62,174	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,093	0	2,362	7,458,543	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7	0	0	409,615	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	35,196	2,169	9,185,078	0	54.00
60.00	06000	LABORATORY	0	13	0	6,327,341	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	22,054	241	1,033,757	0	65.00
66.00	06600	PHYSICAL THERAPY	0	2,212	0	1,133,177	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	51	0	300,700	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	31,750	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	589	0	934,484	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	87,965	0	423,231	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	20,085	0	221,726	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,511,326	9,444,428	0	73.00
76.00	03160	CARDIOPULMONARY	4	1,218	0	1,648,097	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	1,062	31,598	14,974	1,108,454	0	90.01
90.02	09002	JAY FAMILY MEDICINE	1,202	17,689	0	908,443	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	391	4,223	360	107,798	0	90.05
90.06	09006	INFUSION CLINIC	148	7,131	2,011	2,031,982	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	200	1,858	0	24,186	0	90.07
91.00	09100	EMERGENCY	1,307	96,450	8,200	16,165,070	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	0	261	0	161,917	0	93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,443	402,659	1,547,048	64,936,178	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	0	1,014	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT	0	0	0	0	0	194.00
194.02	07952	WEST JAY CLINIC	0	815	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)	2,791,220	357,910	1,514,941	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	375.012764	0.884847	0.979246	0.000000	0.000000	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/15/2021 1:03 pm

		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	
204.00		Cost to be allocated (per Wkst. B, Part II)	79,342	3,626	56,799	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	10.659949	0.008964	0.036714	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 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/15/2021 1:03 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,454,706		5,454,706	0	5,454,706	30.00
40.00	04000	SUBPROVIDER - IPF	484,292		484,292	0	484,292	40.00
43.00	04300	NURSERY	86,280		86,280	0	86,280	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,225,185		3,225,185	0	3,225,185	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	26,298		26,298	0	26,298	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,627,537		2,627,537	0	2,627,537	54.00
60.00	06000	LABORATORY	3,069,659		3,069,659	0	3,069,659	60.00
65.00	06500	RESPIRATORY THERAPY	843,343	0	843,343	0	843,343	65.00
66.00	06600	PHYSICAL THERAPY	1,229,057	0	1,229,057	0	1,229,057	66.00
67.00	06700	OCCUPATIONAL THERAPY	209,213	0	209,213	0	209,213	67.00
68.00	06800	SPEECH PATHOLOGY	31,680	0	31,680	0	31,680	68.00
69.00	06900	ELECTROCARDIOLOGY	3,642		3,642	0	3,642	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	197,453		197,453	0	197,453	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	45,084		45,084	0	45,084	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,535,099		3,535,099	0	3,535,099	73.00
76.00	03160	CARDIOPULMONARY	484,712		484,712	0	484,712	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	2,241,787		2,241,787	0	2,241,787	90.01
90.02	09002	JAY FAMILY MEDICINE	2,345,670		2,345,670	0	2,345,670	90.02
90.03	09003	WOUND CLINIC	34,830		34,830	0	34,830	90.03
90.04	09004	OP ORTHO CLINIC	0		0	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	1,049,909		1,049,909	0	1,049,909	90.05
90.06	09006	INFUSION CLINIC	331,701		331,701	0	331,701	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	627,478		627,478	0	627,478	90.07
91.00	09100	EMERGENCY	3,732,191		3,732,191	0	3,732,191	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,210,856		1,210,856		1,210,856	92.00
93.00	04950	OUTPATIENT PSYCH	221,607		221,607	0	221,607	93.00
200.00		Subtotal (see instructions)	33,349,269	0	33,349,269	0	33,349,269	200.00
201.00		Less Observation Beds	1,210,856		1,210,856		1,210,856	201.00
202.00		Total (see instructions)	32,138,413	0	32,138,413	0	32,138,413	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/15/2021 1:03 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,247,104		3,247,104			30.00
40.00	04000	SUBPROVIDER - IPF	84,316		84,316			40.00
43.00	04300	NURSERY	62,174		62,174			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,244,886	6,213,657	7,458,543	0.432415	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	274,814	134,801	409,615	0.064202	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	452,983	8,732,095	9,185,078	0.286066	0.000000	54.00
60.00	06000	LABORATORY	712,007	5,615,334	6,327,341	0.485142	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	589,338	444,419	1,033,757	0.815804	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	307,090	826,087	1,133,177	1.084612	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	204,165	96,535	300,700	0.695753	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	22,562	9,188	31,750	0.997795	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	46,404	888,080	934,484	0.003897	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	145,897	277,334	423,231	0.466537	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,626	212,100	221,726	0.203332	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,005,785	7,438,643	9,444,428	0.374305	0.000000	73.00
76.00	03160	CARDIOPULMONARY	224,110	1,423,987	1,648,097	0.294104	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	0	1,108,454	1,108,454	2.022445	0.000000	90.01
90.02	09002	JAY FAMILY MEDICINE	0	908,443	908,443	2.582077	0.000000	90.02
90.03	09003	WOUND CLINIC	0	0	0	0.000000	0.000000	90.03
90.04	09004	OP ORTHO CLINIC	0	0	0	0.000000	0.000000	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0	107,798	107,798	9.739596	0.000000	90.05
90.06	09006	INFUSION CLINIC	0	2,031,982	2,031,982	0.163240	0.000000	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	24,186	24,186	25.943852	0.000000	90.07
91.00	09100	EMERGENCY	420,597	15,744,473	16,165,070	0.230880	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	10,898	2,471,909	2,482,807	0.487696	0.000000	92.00
93.00	04950	OUTPATIENT PSYCH	0	161,917	161,917	1.368646	0.000000	93.00
200.00		Subtotal (see instructions)	10,064,756	54,871,422	64,936,178			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	10,064,756	54,871,422	64,936,178			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/15/2021 1:03 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio
			11.00
		INPATIENT ROUTINE SERVICE COST CENTERS	
30.00	03000	ADULTS & PEDIATRICS	
40.00	04000	SUBPROVIDER - IPF	
43.00	04300	NURSERY	
		ANCILLARY SERVICE COST CENTERS	
50.00	05000	OPERATING ROOM	0.432415
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.064202
53.00	05300	ANESTHESIOLOGY	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.286066
60.00	06000	LABORATORY	0.485142
65.00	06500	RESPIRATORY THERAPY	0.815804
66.00	06600	PHYSICAL THERAPY	1.084612
67.00	06700	OCCUPATIONAL THERAPY	0.695753
68.00	06800	SPEECH PATHOLOGY	0.997795
69.00	06900	ELECTROCARDIOLOGY	0.003897
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.466537
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.203332
73.00	07300	DRUGS CHARGED TO PATIENTS	0.374305
76.00	03160	CARDIOPULMONARY	0.294104
		OUTPATIENT SERVICE COST CENTERS	
90.00	09000	CLINIC	0.000000
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	2.022445
90.02	09002	JAY FAMILY MEDICINE	2.582077
90.03	09003	WOUND CLINIC	0.000000
90.04	09004	OP ORTHO CLINIC	0.000000
90.05	09005	JAY FAMILY FIRST HEALTH CARE	9.739596
90.06	09006	INFUSION CLINIC	0.163240
90.07	09007	HEALTH BEGINNINGS PROGRAM	25.943852
91.00	09100	EMERGENCY	0.230880
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.487696
93.00	04950	OUTPATIENT PSYCH	1.368646
200.00		Subtotal (see instructions)	
201.00		Less Observation Beds	
202.00		Total (see instructions)	

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/15/2021 1:03 pm

Title XIX | Hospital | PPS

		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	5,454,706		5,454,706	0	5,454,706	30.00
40.00	04000	SUBPROVIDER - IPF	484,292		484,292	0	484,292	40.00
43.00	04300	NURSERY	86,280		86,280	0	86,280	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,225,185		3,225,185	0	3,225,185	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	26,298		26,298	0	26,298	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,627,537		2,627,537	0	2,627,537	54.00
60.00	06000	LABORATORY	3,069,659		3,069,659	0	3,069,659	60.00
65.00	06500	RESPIRATORY THERAPY	843,343	0	843,343	0	843,343	65.00
66.00	06600	PHYSICAL THERAPY	1,229,057	0	1,229,057	0	1,229,057	66.00
67.00	06700	OCCUPATIONAL THERAPY	209,213	0	209,213	0	209,213	67.00
68.00	06800	SPEECH PATHOLOGY	31,680	0	31,680	0	31,680	68.00
69.00	06900	ELECTROCARDIOLOGY	3,642		3,642	0	3,642	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	197,453		197,453	0	197,453	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	45,084		45,084	0	45,084	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,535,099		3,535,099	0	3,535,099	73.00
76.00	03160	CARDIOPULMONARY	484,712		484,712	0	484,712	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	2,241,787		2,241,787	0	2,241,787	90.01
90.02	09002	JAY FAMILY MEDICINE	2,345,670		2,345,670	0	2,345,670	90.02
90.03	09003	WOUND CLINIC	34,830		34,830	0	34,830	90.03
90.04	09004	OP ORTHO CLINIC	0		0	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	1,049,909		1,049,909	0	1,049,909	90.05
90.06	09006	INFUSION CLINIC	331,701		331,701	0	331,701	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	627,478		627,478	0	627,478	90.07
91.00	09100	EMERGENCY	3,732,191		3,732,191	0	3,732,191	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,210,856		1,210,856		1,210,856	92.00
93.00	04950	OUTPATIENT PSYCH	221,607		221,607	0	221,607	93.00
200.00		Subtotal (see instructions)	33,349,269	0	33,349,269	0	33,349,269	200.00
201.00		Less Observation Beds	1,210,856		1,210,856		1,210,856	201.00
202.00		Total (see instructions)	32,138,413	0	32,138,413	0	32,138,413	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/15/2021 1:03 pm

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	3,247,104		3,247,104			30.00
40.00	04000	SUBPROVIDER - IPF	84,316		84,316			40.00
43.00	04300	NURSERY	62,174		62,174			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,244,886	6,213,657	7,458,543	0.432415	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	274,814	134,801	409,615	0.064202	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	452,983	8,732,095	9,185,078	0.286066	0.000000	54.00
60.00	06000	LABORATORY	712,007	5,615,334	6,327,341	0.485142	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	589,338	444,419	1,033,757	0.815804	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	307,090	826,087	1,133,177	1.084612	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	204,165	96,535	300,700	0.695753	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	22,562	9,188	31,750	0.997795	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	46,404	888,080	934,484	0.003897	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	145,897	277,334	423,231	0.466537	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,626	212,100	221,726	0.203332	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,005,785	7,438,643	9,444,428	0.374305	0.000000	73.00
76.00	03160	CARDIOPULMONARY	224,110	1,423,987	1,648,097	0.294104	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	0	1,108,454	1,108,454	2.022445	0.000000	90.01
90.02	09002	JAY FAMILY MEDICINE	0	908,443	908,443	2.582077	0.000000	90.02
90.03	09003	WOUND CLINIC	0	0	0	0.000000	0.000000	90.03
90.04	09004	OP ORTHO CLINIC	0	0	0	0.000000	0.000000	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0	107,798	107,798	9.739596	0.000000	90.05
90.06	09006	INFUSION CLINIC	0	2,031,982	2,031,982	0.163240	0.000000	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	24,186	24,186	25.943852	0.000000	90.07
91.00	09100	EMERGENCY	420,597	15,744,473	16,165,070	0.230880	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	10,898	2,471,909	2,482,807	0.487696	0.000000	92.00
93.00	04950	OUTPATIENT PSYCH	0	161,917	161,917	1.368646	0.000000	93.00
200.00		Subtotal (see instructions)	10,064,756	54,871,422	64,936,178			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	10,064,756	54,871,422	64,936,178			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/15/2021 1:03 pm

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	0.432415		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.064202		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.286066		54.00
60.00	06000	LABORATORY	0.485142		60.00
65.00	06500	RESPIRATORY THERAPY	0.815804		65.00
66.00	06600	PHYSICAL THERAPY	1.084612		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.695753		67.00
68.00	06800	SPEECH PATHOLOGY	0.997795		68.00
69.00	06900	ELECTROCARDIOLOGY	0.003897		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.466537		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.203332		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.374305		73.00
76.00	03160	CARDIOPULMONARY	0.294104		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	2.022445		90.01
90.02	09002	JAY FAMILY MEDICINE	2.582077		90.02
90.03	09003	WOUND CLINIC	0.000000		90.03
90.04	09004	OP ORTHO CLINIC	0.000000		90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	9.739596		90.05
90.06	09006	INFUSION CLINIC	0.163240		90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	25.943852		90.07
91.00	09100	EMERGENCY	0.230880		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.487696		92.00
93.00	04950	OUTPATIENT PSYCH	1.368646		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 01/01/2020 To 12/31/2020 | Worksheet C Part II Date/Time Prepared: 7/15/2021 1:03 pm

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	3,225,185	251,476	2,973,709	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	26,298	4,508	21,790	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,627,537	223,479	2,404,058	0	0	54.00
60.00	06000	LABORATORY	3,069,659	135,883	2,933,776	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	843,343	39,728	803,615	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,229,057	135,286	1,093,771	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	209,213	25,259	183,954	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	31,680	1,331	30,349	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,642	37	3,605	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	197,453	2,001	195,452	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	45,084	457	44,627	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,535,099	76,309	3,458,790	0	0	73.00
76.00	03160	CARDIOPULMONARY	484,712	17,821	466,891	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	2,241,787	109,645	2,132,142	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	2,345,670	109,304	2,236,366	0	0	90.02
90.03	09003	WOUND CLINIC	34,830	13,048	21,782	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	1,049,909	162,978	886,931	0	0	90.05
90.06	09006	INFUSION CLINIC	331,701	28,446	303,255	0	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	627,478	106,759	520,719	0	0	90.07
91.00	09100	EMERGENCY	3,732,191	240,998	3,491,193	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,210,856	133,413	1,077,443	0	0	92.00
93.00	04950	OUTPATIENT PSYCH	221,607	61,772	159,835	0	0	93.00
200.00		Subtotal (sum of lines 50 thru 199)	27,323,991	1,879,938	25,444,053	0	0	200.00
201.00		Less Observation Beds	1,210,856	133,413	1,077,443	0	0	201.00
202.00		Total (line 200 minus line 201)	26,113,135	1,746,525	24,366,610	0	0	202.00

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

Provider CCN: 15-1320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part II | Date/Time Prepared: 7/15/2021 1:03 pm

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	3,225,185	7,458,543	0.432415		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	26,298	409,615	0.064202		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,627,537	9,185,078	0.286066		54.00
60.00	06000	LABORATORY	3,069,659	6,327,341	0.485142		60.00
65.00	06500	RESPIRATORY THERAPY	843,343	1,033,757	0.815804		65.00
66.00	06600	PHYSICAL THERAPY	1,229,057	1,133,177	1.084612		66.00
67.00	06700	OCCUPATIONAL THERAPY	209,213	300,700	0.695753		67.00
68.00	06800	SPEECH PATHOLOGY	31,680	31,750	0.997795		68.00
69.00	06900	ELECTROCARDIOLOGY	3,642	934,484	0.003897		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	197,453	423,231	0.466537		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	45,084	221,726	0.203332		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,535,099	9,444,428	0.374305		73.00
76.00	03160	CARDIOPULMONARY	484,712	1,648,097	0.294104		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0.000000		90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	2,241,787	1,108,454	2.022445		90.01
90.02	09002	JAY FAMILY MEDICINE	2,345,670	908,443	2.582077		90.02
90.03	09003	WOUND CLINIC	34,830	0	0.000000		90.03
90.04	09004	OP ORTHO CLINIC	0	0	0.000000		90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	1,049,909	107,798	9.739596		90.05
90.06	09006	INFUSION CLINIC	331,701	2,031,982	0.163240		90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	627,478	24,186	25.943852		90.07
91.00	09100	EMERGENCY	3,732,191	16,165,070	0.230880		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,210,856	2,482,807	0.487696		92.00
93.00	04950	OUTPATIENT PSYCH	221,607	161,917	1.368646		93.00
200.00		Subtotal (sum of lines 50 thru 199)	27,323,991	61,542,584			200.00
201.00		Less Observation Beds	1,210,856	0			201.00
202.00		Total (line 200 minus line 201)	26,113,135	61,542,584			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part II Date/Time Prepared: 7/15/2021 1:03 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	251,476	7,458,543	0.033717	208,793	7,040	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,508	409,615	0.011005	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	223,479	9,185,078	0.024331	128,582	3,129	54.00
60.00	06000	LABORATORY	135,883	6,327,341	0.021476	260,631	5,597	60.00
65.00	06500	RESPIRATORY THERAPY	39,728	1,033,757	0.038431	249,902	9,604	65.00
66.00	06600	PHYSICAL THERAPY	135,286	1,133,177	0.119386	57,423	6,856	66.00
67.00	06700	OCCUPATIONAL THERAPY	25,259	300,700	0.084001	27,028	2,270	67.00
68.00	06800	SPEECH PATHOLOGY	1,331	31,750	0.041921	8,356	350	68.00
69.00	06900	ELECTROCARDIOLOGY	37	934,484	0.000040	15,556	1	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,001	423,231	0.004728	43,110	204	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	457	221,726	0.002061	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	76,309	9,444,428	0.008080	808,809	6,535	73.00
76.00	03160	CARDIOPULMONARY	17,821	1,648,097	0.010813	111,694	1,208	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	109,645	1,108,454	0.098917	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	109,304	908,443	0.120320	0	0	90.02
90.03	09003	WOUND CLINIC	13,048	0	0.000000	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0	0	0.000000	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	162,978	107,798	1.511883	0	0	90.05
90.06	09006	INFUSION CLINIC	28,446	2,031,982	0.013999	0	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	106,759	24,186	4.414083	0	0	90.07
91.00	09100	EMERGENCY	240,998	16,165,070	0.014909	25,958	387	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	133,413	2,482,807	0.053735	9,225	496	92.00
93.00	04950	OUTPATIENT PSYCH	61,772	161,917	0.381504	0	0	93.00
200.00		Total (lines 50 through 199)	1,879,938	61,542,584		1,955,067	43,677	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV Date/Time Prepared: 7/15/2021 1:03 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	0	0	0	0	90.07
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
93.00	04950	OUTPATIENT PSYCH	0	0	0	0	0	93.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV Date/Time Prepared: 7/15/2021 1:03 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	7,458,543	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	409,615	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	9,185,078	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	6,327,341	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,033,757	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,133,177	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	300,700	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	31,750	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	934,484	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	423,231	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	221,726	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,444,428	0.000000	73.00
76.00	03160	CARDIOPULMONARY	0	0	0	1,648,097	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	1,108,454	0.000000	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	0	908,443	0.000000	90.02
90.03	09003	WOUND CLINIC	0	0	0	0	0.000000	90.03
90.04	09004	OP ORTHO CLINIC	0	0	0	0	0.000000	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0	0	0	107,798	0.000000	90.05
90.06	09006	INFUSION CLINIC	0	0	0	2,031,982	0.000000	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	0	0	24,186	0.000000	90.07
91.00	09100	EMERGENCY	0	0	0	16,165,070	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	2,482,807	0.000000	92.00
93.00	04950	OUTPATIENT PSYCH	0	0	0	161,917	0.000000	93.00
200.00		Total (lines 50 through 199)	0	0	0	61,542,584		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 7/15/2021 1:03 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	208,793	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	128,582	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	260,631	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	249,902	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	57,423	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	27,028	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	8,356	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	15,556	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	43,110	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	808,809	0	0	0	73.00
76.00	03160	CARDIOPULMONARY	0.000000	111,694	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
90.07	09007	HEALTH BEGINNINGS PROGRAM	0.000000	0	0	0	0	90.07
91.00	09100	EMERGENCY	0.000000	25,958	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	9,225	0	0	0	92.00
93.00	04950	OUTPATIENT PSYCH	0.000000	0	0	0	0	93.00
200.00		Total (lines 50 through 199)		1,955,067	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 7/15/2021 1:03 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.432415	0	1,529,890	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.064202	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.286066	0	2,006,990	0	0	54.00
60.00	06000	LABORATORY	0.485142	0	1,336,970	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.815804	0	120,746	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1.084612	0	265,725	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.695753	0	19,216	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.997795	0	4,390	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.003897	0	221,237	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.466537	0	64,965	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.203332	0	45,727	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.374305	0	1,912,028	167,841	0	73.00
76.00	03160	CARDIOPULMONARY	0.294104	0	436,450	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	2.022445	0	267,935	29,247	0	90.01
90.02	09002	JAY FAMILY MEDICINE	2.582077	0	384,881	38,005	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	9.739596	0	48,061	3,868	0	90.05
90.06	09006	INFUSION CLINIC	0.163240	0	1,196,570	0	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	25.943852	0	0	0	0	90.07
91.00	09100	EMERGENCY	0.230880	0	2,962,630	3,453	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.487696	0	839,516	1,467	0	92.00
93.00	04950	OUTPATIENT PSYCH	1.368646	0	22,427	0	0	93.00
200.00		Subtotal (see instructions)		0	13,686,354	243,881	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	13,686,354	243,881	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 7/15/2021 1:03 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	661,547	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	574,132	0		54.00
60.00	06000	LABORATORY	648,620	0		60.00
65.00	06500	RESPIRATORY THERAPY	98,505	0		65.00
66.00	06600	PHYSICAL THERAPY	288,209	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	13,370	0		67.00
68.00	06800	SPEECH PATHOLOGY	4,380	0		68.00
69.00	06900	ELECTROCARDIOLOGY	862	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	30,309	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,298	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	715,682	62,824		73.00
76.00	03160	CARDIOPULMONARY	128,362	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	541,884	59,150		90.01
90.02	09002	JAY FAMILY MEDICINE	993,792	98,132		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	468,095	37,673		90.05
90.06	09006	INFUSION CLINIC	195,328	0		90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	0		90.07
91.00	09100	EMERGENCY	684,012	797		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	409,429	715		92.00
93.00	04950	OUTPATIENT PSYCH	30,695	0		93.00
200.00		Subtotal (see instructions)	6,496,511	259,291		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	6,496,511	259,291		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-1320 | Component CCN: 15-M320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part II | Date/Time Prepared: 7/15/2021 1:03 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	251,476	7,458,543	0.033717	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,508	409,615	0.011005	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	223,479	9,185,078	0.024331	2,124	52	54.00
60.00	06000	LABORATORY	135,883	6,327,341	0.021476	7,333	157	60.00
65.00	06500	RESPIRATORY THERAPY	39,728	1,033,757	0.038431	0	0	65.00
66.00	06600	PHYSICAL THERAPY	135,286	1,133,177	0.119386	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	25,259	300,700	0.084001	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,331	31,750	0.041921	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	37	934,484	0.000040	666	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,001	423,231	0.004728	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	457	221,726	0.002061	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	76,309	9,444,428	0.008080	12,145	98	73.00
76.00	03160	CARDIOPULMONARY	17,821	1,648,097	0.010813	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	109,645	1,108,454	0.098917	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	109,304	908,443	0.120320	0	0	90.02
90.03	09003	WOUND CLINIC	13,048	0	0.000000	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0	0	0.000000	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	162,978	107,798	1.511883	0	0	90.05
90.06	09006	INFUSION CLINIC	28,446	2,031,982	0.013999	0	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	106,759	24,186	4.414083	0	0	90.07
91.00	09100	EMERGENCY	240,998	16,165,070	0.014909	5,711	85	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,482,807	0.000000	0	0	92.00
93.00	04950	OUTPATIENT PSYCH	61,772	161,917	0.381504	0	0	93.00
200.00		Total (lines 50 through 199)	1,746,525	61,542,584		27,979	392	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1320 | Component CCN: 15-M320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 7/15/2021 1:03 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	0	0	0	0	90.07
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
93.00	04950	OUTPATIENT PSYCH	0	0	0	0	0	93.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1320 | Component CCN: 15-M320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 7/15/2021 1:03 pm

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	7,458,543	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	409,615	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	9,185,078	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	6,327,341	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,033,757	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,133,177	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	300,700	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	31,750	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	934,484	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	423,231	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	221,726	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,444,428	0.000000	73.00
76.00	03160	CARDIOPULMONARY	0	0	0	1,648,097	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	1,108,454	0.000000	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	0	908,443	0.000000	90.02
90.03	09003	WOUND CLINIC	0	0	0	0	0.000000	90.03
90.04	09004	OP ORTHO CLINIC	0	0	0	0	0.000000	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0	0	0	107,798	0.000000	90.05
90.06	09006	INFUSION CLINIC	0	0	0	2,031,982	0.000000	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	0	0	24,186	0.000000	90.07
91.00	09100	EMERGENCY	0	0	0	16,165,070	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	2,482,807	0.000000	92.00
93.00	04950	OUTPATIENT PSYCH	0	0	0	161,917	0.000000	93.00
200.00		Total (lines 50 through 199)	0	0	0	61,542,584		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1320 | Component CCN: 15-M320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 7/15/2021 1:03 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	2,124	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	7,333	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	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	666	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	12,145	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	0	0	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0.000000	0	0	0	0	90.02
90.03	09003	WOUND CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0.000000	0	0	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0.000000	0	0	0	0	90.05
90.06	09006	INFUSION CLINIC	0.000000	0	0	0	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0.000000	0	0	0	0	90.07
91.00	09100	EMERGENCY	0.000000	5,711	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)		27,979	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-1320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part I Date/Time Prepared: 7/15/2021 1:03 pm

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	601,006	134,200	466,806	1,634	285.68	30.00
40.00	SUBPROVIDER - IPF	20,106	0	20,106	48	418.88	40.00
43.00	NURSERY	11,561		11,561	48	240.85	43.00
200.00	Total (lines 30 through 199)	632,673		498,473	1,730		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	9	2,571	30.00
40.00	SUBPROVIDER - IPF	0	0	40.00
43.00	NURSERY	2	482	43.00
200.00	Total (lines 30 through 199)	11	3,053	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part II Date/Time Prepared: 7/15/2021 1:03 pm

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	251,476	7,458,543	0.033717	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,508	409,615	0.011005	25,287	278	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	223,479	9,185,078	0.024331	494	12	54.00
60.00	06000	LABORATORY	135,883	6,327,341	0.021476	5,654	121	60.00
65.00	06500	RESPIRATORY THERAPY	39,728	1,033,757	0.038431	0	0	65.00
66.00	06600	PHYSICAL THERAPY	135,286	1,133,177	0.119386	302	36	66.00
67.00	06700	OCCUPATIONAL THERAPY	25,259	300,700	0.084001	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,331	31,750	0.041921	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	37	934,484	0.000040	222	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,001	423,231	0.004728	1,197	6	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	457	221,726	0.002061	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	76,309	9,444,428	0.008080	2,984	24	73.00
76.00	03160	CARDIOPULMONARY	17,821	1,648,097	0.010813	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	109,645	1,108,454	0.098917	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	109,304	908,443	0.120320	0	0	90.02
90.03	09003	WOUND CLINIC	13,048	0	0.000000	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0	0	0.000000	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	162,978	107,798	1.511883	0	0	90.05
90.06	09006	INFUSION CLINIC	28,446	2,031,982	0.013999	0	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	106,759	24,186	4.414083	0	0	90.07
91.00	09100	EMERGENCY	240,998	16,165,070	0.014909	7,016	105	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	133,413	2,482,807	0.053735	0	0	92.00
93.00	04950	OUTPATIENT PSYCH	61,772	161,917	0.381504	0	0	93.00
200.00		Total (lines 50 through 199)	1,879,938	61,542,584		43,156	582	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part III Date/Time Prepared: 7/15/2021 1:03 pm

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	1,634	0.00	9	30.00
40.00	04000	SUBPROVIDER - IPF	0	0	48	0.00	0	40.00
43.00	04300	NURSERY		0	48	0.00	2	43.00
200.00		Total (lines 30 through 199)		0	1,730		11	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 01/01/2020 To 12/31/2020 | Worksheet D Part IV Date/Time Prepared: 7/15/2021 1:03 pm

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
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	0	0	0	0	90.07
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
93.00	04950	OUTPATIENT PSYCH	0	0	0	0	0	93.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV Date/Time Prepared: 7/15/2021 1:03 pm

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	7,458,543	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	409,615	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	9,185,078	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	6,327,341	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,033,757	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,133,177	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	300,700	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	31,750	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	934,484	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	423,231	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	221,726	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,444,428	0.000000	73.00
76.00	03160	CARDIOPULMONARY	0	0	0	1,648,097	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	1,108,454	0.000000	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	0	908,443	0.000000	90.02
90.03	09003	WOUND CLINIC	0	0	0	0	0.000000	90.03
90.04	09004	OP ORTHO CLINIC	0	0	0	0	0.000000	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0	0	0	107,798	0.000000	90.05
90.06	09006	INFUSION CLINIC	0	0	0	2,031,982	0.000000	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	0	0	24,186	0.000000	90.07
91.00	09100	EMERGENCY	0	0	0	16,165,070	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	2,482,807	0.000000	92.00
93.00	04950	OUTPATIENT PSYCH	0	0	0	161,917	0.000000	93.00
200.00		Total (lines 50 through 199)	0	0	0	61,542,584		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV Date/Time Prepared: 7/15/2021 1:03 pm

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	25,287	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	494	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	5,654	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	302	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	222	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	1,197	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	2,984	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	0	0	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0.000000	0	0	0	0	90.02
90.03	09003	WOUND CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0.000000	0	0	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0.000000	0	0	0	0	90.05
90.06	09006	INFUSION CLINIC	0.000000	0	0	0	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0.000000	0	0	0	0	90.07
91.00	09100	EMERGENCY	0.000000	7,016	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)		43,156	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/15/2021 1:03 pm

Title XVIII | Hospital

	Cost Center Description	Cost	
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,342	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,634	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)	1,167	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	448	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	260	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)	549	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)	448	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	216.95	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)	5,454,706	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)	56,407	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)	1,217,999	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,236,707	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)	4,236,707	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,592.84	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,423,469	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)	1,423,469	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/15/2021 1:03 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						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)	913,063	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,336,532	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)	1,161,592	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)	1,161,592	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)	467	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,592.84	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,210,856	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/15/2021 1:03 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	601,006	5,454,706	0.110181	1,210,856	133,413	90.00
91.00	Nursing School cost	0	5,454,706	0.000000	1,210,856	0	91.00
92.00	Allied health cost	0	5,454,706	0.000000	1,210,856	0	92.00
93.00	All other Medical Education	0	5,454,706	0.000000	1,210,856	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-1320	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1
Component CCN: 15-M320		Date/Time Prepared: 7/15/2021 1:03 pm
Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	48	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	48	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)	48	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)	44	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	216.95	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)	484,292	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)	484,292	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)	484,292	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)	10,089.42	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	443,934	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)	443,934	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-1320 | Component CCN: 15-M320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/15/2021 1:03 pm

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						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)	10,034	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	453,968	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)	392	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	392	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	453,576	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 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/15/2021 1:03 pm

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	0	484,292	0.000000	0	0	90.00
91.00	Nursing School cost	0	484,292	0.000000	0	0	91.00
92.00	Allied health cost	0	484,292	0.000000	0	0	92.00
93.00	All other Medical Education	0	484,292	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/15/2021 1:03 pm

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,342	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,634	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)	1,167	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	448	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	260	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	9	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	48	15.00
16.00	Nursery days (title V or XIX only)	2	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	216.95	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)	5,454,706	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)	56,407	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)	1,217,999	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,236,707	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)	4,236,707	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,592.84	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	23,336	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)	23,336	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/15/2021 1:03 pm

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)	86,280	48	1,797.50	2	3,595	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)	8,131	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	35,062	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)	3,053	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	582	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	3,635	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	31,427	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)	467	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,592.84	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,210,856	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/15/2021 1:03 pm

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	601,006	5,454,706	0.110181	1,210,856	133,413	90.00
91.00	Nursing School cost	0	5,454,706	0.000000	1,210,856	0	91.00
92.00	Allied health cost	0	5,454,706	0.000000	1,210,856	0	92.00
93.00	All other Medical Education	0	5,454,706	0.000000	1,210,856	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1320 Component CCN: 15-M320	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/15/2021 1:03 pm
	Title XIX	Subprovider - IPF	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	48	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	48	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)	48	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)	0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	48	15.00
16.00	Nursery days (title V or XIX only)	2	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)	484,292	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)	484,292	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)	484,292	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)	10,089.42	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	0	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	0	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-1320 | Component CCN: 15-M320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/15/2021 1:03 pm

Title XIX | Subprovider - IPF | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	0	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	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 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/15/2021 1:03 pm

Title XIX | Subprovider - IPF | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	20,106	484,292	0.041516	0	0	90.00
91.00	Nursing School cost	0	484,292	0.000000	0	0	91.00
92.00	Allied health cost	0	484,292	0.000000	0	0	92.00
93.00	All other Medical Education	0	484,292	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3 | Date/Time Prepared: 7/15/2021 1:03 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,171,634		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	0.432415	208,793	90,285	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.064202	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.286066	128,582	36,783	54.00
60.00	06000	LABORATORY	0.485142	260,631	126,443	60.00
65.00	06500	RESPIRATORY THERAPY	0.815804	249,902	203,871	65.00
66.00	06600	PHYSICAL THERAPY	1.084612	57,423	62,282	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.695753	27,028	18,805	67.00
68.00	06800	SPEECH PATHOLOGY	0.997795	8,356	8,338	68.00
69.00	06900	ELECTROCARDIOLOGY	0.003897	15,556	61	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.466537	43,110	20,112	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.203332	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.374305	808,809	302,741	73.00
76.00	03160	CARDIOPULMONARY	0.294104	111,694	32,850	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	2.022445	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	2.582077	0	0	90.02
90.03	09003	WOUND CLINIC	0.000000	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0.000000	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	9.739596	0	0	90.05
90.06	09006	INFUSION CLINIC	0.163240	0	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	25.943852	0	0	90.07
91.00	09100	EMERGENCY	0.230880	25,958	5,993	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.487696	9,225	4,499	92.00
93.00	04950	OUTPATIENT PSYCH	1.368646	0	0	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,955,067	913,063	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,955,067		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1320 | Component CCN: 15-M320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3 | Date/Time Prepared: 7/15/2021 1:03 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
40.00	04000	SUBPROVIDER - IPF		55,388		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.432415	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.064202	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.286066	2,124	608	54.00
60.00	06000	LABORATORY	0.485142	7,333	3,558	60.00
65.00	06500	RESPIRATORY THERAPY	0.815804	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1.084612	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.695753	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.997795	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.003897	666	3	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.466537	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.203332	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.374305	12,145	4,546	73.00
76.00	03160	CARDIOPULMONARY	0.294104	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	2.022445	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	2.582077	0	0	90.02
90.03	09003	WOUND CLINIC	0.000000	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0.000000	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	9.739596	0	0	90.05
90.06	09006	INFUSION CLINIC	0.163240	0	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	25.943852	0	0	90.07
91.00	09100	EMERGENCY	0.230880	5,711	1,319	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.487696	0	0	92.00
93.00	04950	OUTPATIENT PSYCH	1.368646	0	0	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		27,979	10,034	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)		27,979		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1320 | Component CCN: 15-Z320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3 | Date/Time Prepared: 7/15/2021 1:03 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.432415	4,925	2,130	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.064202	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.286066	23,143	6,620	54.00
60.00	06000	LABORATORY	0.485142	59,083	28,664	60.00
65.00	06500	RESPIRATORY THERAPY	0.815804	119,908	97,821	65.00
66.00	06600	PHYSICAL THERAPY	1.084612	138,067	149,749	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.695753	94,400	65,679	67.00
68.00	06800	SPEECH PATHOLOGY	0.997795	8,269	8,251	68.00
69.00	06900	ELECTROCARDIOLOGY	0.003897	3,896	15	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.466537	73	34	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.203332	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.374305	217,965	81,585	73.00
76.00	03160	CARDIOPULMONARY	0.294104	3,287	967	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	2.022445	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	2.582077	0	0	90.02
90.03	09003	WOUND CLINIC	0.000000	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0.000000	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	9.739596	0	0	90.05
90.06	09006	INFUSION CLINIC	0.163240	0	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	25.943852	0	0	90.07
91.00	09100	EMERGENCY	0.230880	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.487696	0	0	92.00
93.00	04950	OUTPATIENT PSYCH	1.368646	0	0	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		673,016	441,515	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)		673,016		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3 | Date/Time Prepared: 7/15/2021 1:03 pm

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		18,300		30.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY		2,868		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.432415	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.064202	25,287	1,623	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.286066	494	141	54.00
60.00	06000	LABORATORY	0.485142	5,654	2,743	60.00
65.00	06500	RESPIRATORY THERAPY	0.815804	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1.084612	302	328	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.695753	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.997795	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.003897	222	1	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.466537	1,197	558	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.203332	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.374305	2,984	1,117	73.00
76.00	03160	CARDIOPULMONARY	0.294104	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	2.022445	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	2.582077	0	0	90.02
90.03	09003	WOUND CLINIC	0.000000	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0.000000	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	9.739596	0	0	90.05
90.06	09006	INFUSION CLINIC	0.163240	0	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	25.943852	0	0	90.07
91.00	09100	EMERGENCY	0.230880	7,016	1,620	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.487696	0	0	92.00
93.00	04950	OUTPATIENT PSYCH	1.368646	0	0	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		43,156	8,131	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)		43,156		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E Part B Date/Time Prepared: 7/15/2021 1:03 pm

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,755,802	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)	6,755,802	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)	6,823,360	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)	120,178	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	2,373,977	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)	4,329,205	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)	4,329,205	30.00
31.00	Primary payer payments	1,520	31.00
32.00	Subtotal (line 30 minus line 31)	4,327,685	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)	322,544	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	209,654	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	301,765	36.00
37.00	Subtotal (see instructions)	4,537,339	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)	4,537,339	40.00
40.01	Sequestration adjustment (see instructions)	29,946	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	2,595,393	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)	1,912,000	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	500,226	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 01/01/2020 To 12/31/2020 | Worksheet E-1 Part I Date/Time Prepared: 7/15/2021 1:03 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,300,830		2,595,393	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,300,830		2,595,393	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		865,315		1,912,000	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,166,145		4,507,393	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 01/01/2020 To 12/31/2020 | Worksheet E-1 Part I | Date/Time Prepared: 7/15/2021 1:03 pm

Title XVIII | Subprovider - IPF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		33,054		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		33,054		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		3,606		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		36,660		0	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1320 | Component CCN: 15-Z320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-1 Part I | Date/Time Prepared: 7/15/2021 1:03 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,027,616		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,027,616		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		577,863		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,605,479		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 01/01/2020 To 12/31/2020	Worksheet E-1 Part II Date/Time Prepared: 7/15/2021 1:03 pm
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 15-1320 | Component CCN: 15-Z320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-2 | Date/Time Prepared: 7/15/2021 1:03 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,173,208	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)	445,930	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	448	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,619,138	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,619,138	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,619,138	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	2,992	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	1,616,146	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	1,616,146	0	19.00
19.01	Sequestration adjustment (see instructions)	10,667	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	1,027,616	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)	577,863	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	119,532	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 01/01/2020 To 12/31/2020	Worksheet E-3 Part V Date/Time Prepared: 7/15/2021 1:03 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	2,336,532	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)	2,336,532	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,359,897	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)	2,359,897	19.00
20.00	Deductibles (exclude professional component)	187,220	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	2,172,677	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	2,172,677	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	12,093	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	7,860	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	9,413	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	2,180,537	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	2,180,537	30.00
30.01	Sequestration adjustment (see instructions)	14,392	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	1,300,830	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)	865,315	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	174,006	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN:15-1320 Component CCN:15-M320	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part II Date/Time Prepared: 7/15/2021 1:03 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	30,874	1.00
2.00	Net IPF PPS Outlier Payments	5,671	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)	0.131148	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)	36,545	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)	36,545	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	36,545	18.00
19.00	Deductibles	2,816	19.00
20.00	Subtotal (line 18 minus line 19)	33,729	20.00
21.00	Coinsurance	0	21.00
22.00	Subtotal (line 20 minus line 21)	33,729	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	4,884	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	3,175	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	2,204	25.00
26.00	Subtotal (sum of lines 22 and 24)	36,904	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)	36,904	31.00
31.01	Sequestration adjustment (see instructions)	244	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	31.02
32.00	Interim payments	33,054	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)	3,606	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	5,671	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 01/01/2020 To 12/31/2020 | Worksheet G | Date/Time Prepared: 7/15/2021 1:03 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	5,167,550	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	3,830,256	0	0	0	4.00
5.00	Other receivable	-1,839,569	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	674,891	0	0	0	7.00
8.00	Prepaid expenses	166,217	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	7,999,345	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	989,148	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	18,977,852	0	0	0	15.00
16.00	Accumulated depreciation	-3,608,716	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	42,146	0	0	0	21.00
22.00	Accumulated depreciation	-7,902	0	0	0	22.00
23.00	Major movable equipment	9,330,969	0	0	0	23.00
24.00	Accumulated depreciation	-4,426,346	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)	21,297,151	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	2	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	29,296,498	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	12,520,605	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,292,499	0	0	0	38.00
39.00	Payroll taxes payable	62,980	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	3,381,198				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	661,344	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	17,918,626	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)	17,918,626	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	11,377,872				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)	11,377,872	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	29,296,498	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G-1 | Date/Time Prepared: 7/15/2021 1:03 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		15,342,155		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-3,964,283				2.00
3.00	Total (sum of line 1 and line 2)		11,377,872		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		11,377,872		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)		11,377,872		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-1320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G-2 Parts I & II Date/Time Prepared: 7/15/2021 1:03 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,702,795		2,702,795	1.00
2.00	SUBPROVIDER - IPF	84,316		84,316	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	606,483		606,483	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)	3,393,594		3,393,594	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)	3,393,594		3,393,594	17.00
18.00	Ancillary services	6,239,667	32,312,260	38,551,927	18.00
19.00	Outpatient services	431,495	22,559,162	22,990,657	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)	10,064,756	54,871,422	64,936,178	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		39,077,869		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)		39,077,869		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1320 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G-3 | Date/Time Prepared: 7/15/2021 1:03 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	64,936,178	1.00
2.00	Less contractual allowances and discounts on patients' accounts	35,296,908	2.00
3.00	Net patient revenues (line 1 minus line 2)	29,639,270	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	39,077,869	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-9,438,599	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	1,071,493	24.00
24.50	COVID-19 PHE Funding	4,402,823	24.50
25.00	Total other income (sum of lines 6-24)	5,474,316	25.00
26.00	Total (line 5 plus line 25)	-3,964,283	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-3,964,283	29.00