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 01/01/2021 To 12/31/2021	Worksheet S Parts I-III Date/Time Prepared: 5/27/2022 8:00 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/27/2022 Time: 8:00 am
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

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 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 01/01/2021 and ending 12/31/2021 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.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1		2		
1	Jon Vanator		Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Jon Vanator			2
3	Signatory Title	CFO			3
4	Date	(Dated when report is electronica			4

	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	-534,505	-441,144	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	-374,578	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	-909,083	-441,144	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1320 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I | Date/Time Prepared: 5/27/2022 8:00 am

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

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	IU HEALTH JAY HOSPITAL	151320	99915	1	01/01/2004	N	O	P	3.00
4.00	Subprovider - IPF									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)	01/01/2021	12/31/2021	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
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? 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	22.04
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1320 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I | Date/Time Prepared: 5/27/2022 8:00 am

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

		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. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1320 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I Date/Time Prepared: 5/27/2022 8:00 am

		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

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1320	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/27/2022 8:00 am

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

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

				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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1320 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I | Date/Time Prepared: 5/27/2022 8:00 am

		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.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

		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

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				V	XIX	
				1.00	2.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N		108.00
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
					1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N	110.00
				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:	68,922	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1320 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I Date/Time Prepared: 5/27/2022 8:00 am

		1.00	2.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15H059	140.00

	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 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/27/2022 8:00 am

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			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	16	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1320 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part II | Date/Time Prepared: 5/27/2022 8:00 am

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	02/25/2022	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 a nursing program? 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 programs 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	04/04/2022	Y	04/04/2022	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 01/01/2021 To 12/31/2021 | Worksheet S-2 Part II Date/Time Prepared: 5/27/2022 8:00 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	Y	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	Y		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RHONDA	UTTER	41.00
42.00	Enter the employer/company name of the cost report preparer.	INDIANA UNIVERSITY HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-962-1093	RUTTER@IUHEALTH.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1320	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Prepared: 5/27/2022 8:00 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1320 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part I | Date/Time Prepared: 5/27/2022 8:00 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	21	7,665	41,928.00	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)		21	7,665	41,928.00	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)		21	7,665	41,928.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	0	0		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)		21				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 01/01/2021 To 12/31/2021 | Worksheet S-3 Part I | Date/Time Prepared: 5/27/2022 8:00 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	652	40	1,808			1.00
2.00	HMO and other (see instructions)	479	231				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	640	0	640			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	563			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,292	40	3,011			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		0	0			13.00
14.00	Total (see instructions)	1,292	40	3,011	0.00	200.52	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	0	0	0	0.00	0.00	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)			62			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	200.52	27.00
28.00	Observation Bed Days		6	578			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 01/01/2021 To 12/31/2021 | Worksheet S-3 Part I | Date/Time Prepared: 5/27/2022 8:00 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	184	7	617	1.00
2.00	HMO and other (see instructions)			114	58		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	184	7	617	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	0	0	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)						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 01/01/2021 To 12/31/2021	Worksheet S-10 Date/Time Prepared: 5/27/2022 8:00 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.403021	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	6,285,485	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	17,795,434	6.00
7.00	Medicaid cost (line 1 times line 6)	7,171,934	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)	886,449	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)	23,372	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	109,502	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	44,132	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)	20,760	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)	907,209	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)	1,565,718	300,801	1,866,519	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	631,017	300,801	931,818	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)	631,017	300,801	931,818	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)	2,310,576	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	329,027	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	506,195	27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,804,381	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	904,371	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,836,189	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,743,398	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1320 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A | Date/Time Prepared: 5/27/2022 8:00 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	1,185,030	1,185,030	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	9,433	9,433	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		0	0	1,427,820	1,427,820	2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB		0	0	32,830	32,830	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	9,578	14,939	24,517	2,869,475	2,893,992	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	371,866	9,627,024	9,998,890	-250,071	9,748,819	5.00
7.00	00700	OPERATION OF PLANT	550,238	4,131,845	4,682,083	-1,501,301	3,180,782	7.00
7.01	00701	OPERATION OF PLANT - MOB	0	122,523	122,523	-77,751	44,772	7.01
7.02	00702	OPERATION OF PLANT - POB	0	99,873	99,873	-36,385	63,488	7.02
7.03	00703	OPERATION OF PLANT - WJ	0	0	0	0	0	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	32,912	25,959	58,871	74,105	132,976	8.00
9.00	00900	HOUSEKEEPING	337,050	336,679	673,729	-127,337	546,392	9.00
10.00	01000	DIETARY	314,982	565,238	880,220	-475,108	405,112	10.00
11.00	01100	CAFETERIA	0	0	0	296,795	296,795	11.00
13.00	01300	NURSING ADMINISTRATION	1,258,054	741,996	2,000,050	-399,868	1,600,182	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	-20,420	-20,420	734,508	714,088	14.00
15.00	01500	PHARMACY	525,491	1,939,302	2,464,793	-1,467,221	997,572	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	1,786,997	1,486,549	3,273,546	-530,893	2,742,653	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
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	767,852	1,379,150	2,147,002	-784,697	1,362,305	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	888,451	1,166,468	2,054,919	-923,982	1,130,937	54.00
60.00	06000	LABORATORY	8,405	1,939,862	1,948,267	-16,824	1,931,443	60.00
65.00	06500	RESPIRATORY THERAPY	399,367	202,820	602,187	-124,237	477,950	65.00
66.00	06600	PHYSICAL THERAPY	504,725	28,456	533,181	-3,341	529,840	66.00
67.00	06700	OCCUPATIONAL THERAPY	92,328	126	92,454	-126	92,328	67.00
68.00	06800	SPEECH PATHOLOGY	18,466	0	18,466	0	18,466	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,907	1,907	-998	909	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	93,761	93,761	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	21,599	21,599	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,868,075	1,868,075	73.00
76.00	03160	CARDIOPULMONARY	150,728	145,169	295,897	-72,460	223,437	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	672,637	650,032	1,322,669	-470,173	852,496	90.01
90.02	09002	JAY FAMILY MEDICINE	731,449	859,860	1,591,309	-498,162	1,093,147	90.02
90.03	09003	WOUND CLINIC	0	1,322	1,322	-1,322	0	90.03
90.04	09004	OP ORTHO CLINIC	0	0	0	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	343,466	252,141	595,607	-168,699	426,908	90.05
90.06	09006	INFUSION CLINIC	121,830	38,316	160,146	-41,219	118,927	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	254,932	131,632	386,564	-122,398	264,166	90.07
91.00	09100	EMERGENCY	1,271,815	2,152,012	3,423,827	-536,220	2,887,607	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	36,071	32,885	68,956	-35,543	33,413	93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,449,690	28,053,665	39,503,355	57,352	39,560,707	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	327	327	0	327	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	104,313	93,938	198,251	-57,369	140,882	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	0	0	0	194.02
194.03	07953	JAY MERIDIAN URGENT CARE	0	-17	-17	17	0	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	11,554,003	28,147,913	39,701,916	0	39,701,916	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1320 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A | Date/Time Prepared: 5/27/2022 8:00 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-347,981	837,049		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	-69,804	-34,774		1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT-WJ	-9,433	0		1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT-INTEREST	0	0		1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP	445,067	1,872,887		2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB	-1,056	31,774		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	-709,014	2,184,978		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,781,751	7,967,068		5.00
7.00	00700	OPERATION OF PLANT	75,766	3,256,548		7.00
7.01	00701	OPERATION OF PLANT - MOB	0	44,772		7.01
7.02	00702	OPERATION OF PLANT - POB	0	63,488		7.02
7.03	00703	OPERATION OF PLANT - WJ	0	0		7.03
8.00	00800	LAUNDRY & LINEN SERVICE	0	132,976		8.00
9.00	00900	HOUSEKEEPING	0	546,392		9.00
10.00	01000	DIETARY	11,798	416,910		10.00
11.00	01100	CAFETERIA	-62,507	234,288		11.00
13.00	01300	NURSING ADMINISTRATION	85,431	1,685,613		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	714,088		14.00
15.00	01500	PHARMACY	75,367	1,072,939		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	-763,852	1,978,801		30.00
40.00	04000	SUBPROVIDER - IPF	0	0		40.00
43.00	04300	NURSERY	0	0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-466,621	895,684		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	-13,730	1,117,207		54.00
60.00	06000	LABORATORY	-1,510	1,929,933		60.00
65.00	06500	RESPIRATORY THERAPY	4,813	482,763		65.00
66.00	06600	PHYSICAL THERAPY	74,126	603,966		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	92,328		67.00
68.00	06800	SPEECH PATHOLOGY	0	18,466		68.00
69.00	06900	ELECTROCARDIOLOGY	0	909		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	93,761		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	21,599		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,868,075		73.00
76.00	03160	CARDIOPULMONARY	22,351	245,788		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	-116,580	735,916		90.01
90.02	09002	JAY FAMILY MEDICINE	-315,629	777,518		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	-57,653	369,255		90.05
90.06	09006	INFUSION CLINIC	0	118,927		90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	264,166		90.07
91.00	09100	EMERGENCY	-1,262,129	1,625,478		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
93.00	04950	OUTPATIENT PSYCH	-2,131	31,282		93.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-5,261,889	34,298,818		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	327		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	140,882		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	0		194.02
194.03	07953	JAY MERIDIAN URGENT CARE	0	0		194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-5,261,889	34,440,027		200.00

RECLASSIFICATIONS | Provider CCN: 15-1320 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-6 | Date/Time Prepared: 5/27/2022 8:00 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA					
1.00	CAFETERIA	11.00	132,622	164,173		1.00
	0		132,622	164,173		
	B - DRUGS RECLASS					
1.00	PHARMACY	15.00	0	77,380		1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,868,075		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
	0		0	1,945,455		
	C - SUPPLIES/IMPLANTS					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	734,511		1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	93,761		2.00
3.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	21,599		3.00
4.00	ADMINISTRATIVE & GENERAL	5.00	0	3,541		4.00
5.00	JAY MERIDIAN URGENT CARE	194.03	0	17		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
	0		0	853,429		
	D - LAUNDRY					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	106,478		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
	0		0	106,478		
	E - DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,155,069		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	9,433		4.00

RECLASSIFICATIONS | Provider CCN: 15-1320 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-6 | Date/Time Prepared: 5/27/2022 8:00 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
5.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,399,498		5.00
6.00	CAP REL COSTS-MVBLE EQUIP - MOB	2.01	0	32,830		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
	0		0	2,707,087		
	F - PROPERTY TAXES					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	25,856		1.00
	0		0	25,856		
	G - PROPERTY INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	4,105		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	28,322		2.00
	0		0	32,427		
	H - HOUSEKEEPING SUPPLIES					
1.00	HOUSEKEEPING	9.00	0	668		1.00
2.00	OPERATION OF PLANT	7.00	0	3,262		2.00
3.00	NURSING ADMINISTRATION	13.00	0	10		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
	0		0	3,940		
	J - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,861,176		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
	0		0	2,861,176		
	N - ACCRUED PTO					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	18,341	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	13,144	0		2.00
3.00	OPERATION OF PLANT	7.00	4,645	0		3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	270	0		4.00
5.00	NURSING ADMINISTRATION	13.00	6,599	0		5.00
6.00	OPERATING ROOM	50.00	13,865	0		6.00

RECLASSIFICATIONS | Provider CCN: 15-1320 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-6 | Date/Time Prepared: 5/27/2022 8:00 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
7.00	RADIOLOGY-DIAGNOSTIC	54.00	6,355	0	7.00
8.00	LABORATORY	60.00	205	0	8.00
9.00	CARDIOPULMONARY	76.00	1,278	0	9.00
10.00	FAMILY PRACTICE OF JAY COUNTY	90.01	4,810	0	10.00
11.00	HEALTH BEGINNINGS PROGRAM	90.07	7,323	0	11.00
	0		76,835	0	
	O - PREMIUM WAGES				
1.00	ADULTS & PEDIATRICS	30.00	24,401	3,451	1.00
2.00	RESPIRATORY THERAPY	65.00	33,861	4,788	2.00
	TOTALS		58,262	8,239	
500.00	Grand Total: Increases		267,719	8,708,260	500.00

RECLASSIFICATIONS | Provider CCN: 15-1320 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-6 | Date/Time Prepared: 5/27/2022 8:00 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA						
1.00	DIETARY	10.00	132,622	164,173	0		1.00
	0		132,622	164,173			
	B - DRUGS RECLASS						
1.00	PHARMACY	15.00	0	1,382,398	0		1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	9,875	0		2.00
3.00	OPERATION OF PLANT	7.00	0	42,250	0		3.00
4.00	NURSING ADMINISTRATION	13.00	0	128	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	20,386	0		5.00
6.00	OPERATING ROOM	50.00	0	10,485	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	76,397	0		7.00
8.00	RESPIRATORY THERAPY	65.00	0	1,949	0		8.00
9.00	ELECTROCARDIOLOGY	69.00	0	25	0		9.00
10.00	CARDIOPULMONARY	76.00	0	990	0		10.00
11.00	FAMILY PRACTICE OF JAY COUNTY	90.01	0	146,530	0		11.00
12.00	JAY FAMILY MEDICINE	90.02	0	150,764	0		12.00
13.00	JAY FAMILY FIRST HEALTH CARE	90.05	0	43,346	0		13.00
14.00	INFUSION CLINIC	90.06	0	7,447	0		14.00
15.00	HEALTH BEGINNINGS PROGRAM	90.07	0	195	0		15.00
16.00	EMERGENCY	91.00	0	52,173	0		16.00
17.00	OUTPATIENT PSYCH	93.00	0	117	0		17.00
	0		0	1,945,455			
	C - SUPPLIES/IMPLANTS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	165	0		1.00
2.00	OPERATION OF PLANT	7.00	0	147,839	0		2.00
3.00	OPERATION OF PLANT - MOB	7.01	0	1,469	0		3.00
4.00	OPERATION OF PLANT - POB	7.02	0	1,215	0		4.00
5.00	LAUNDRY & LINEN SERVICE	8.00	0	23,094	0		5.00
6.00	HOUSEKEEPING	9.00	0	29,657	0		6.00
7.00	DIETARY	10.00	0	5,688	0		7.00
8.00	NURSING ADMINISTRATION	13.00	0	100,104	0		8.00
9.00	PHARMACY	15.00	0	8,730	0		9.00
10.00	ADULTS & PEDIATRICS	30.00	0	152,936	0		10.00
11.00	OPERATING ROOM	50.00	0	150,788	0		11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	11,891	0		12.00
13.00	LABORATORY	60.00	0	11,584	0		13.00
14.00	RESPIRATORY THERAPY	65.00	0	24,615	0		14.00
15.00	PHYSICAL THERAPY	66.00	0	3,331	0		15.00
16.00	OCCUPATIONAL THERAPY	67.00	0	126	0		16.00
17.00	ELECTROCARDIOLOGY	69.00	0	973	0		17.00
18.00	CARDIOPULMONARY	76.00	0	2,004	0		18.00
19.00	FAMILY PRACTICE OF JAY COUNTY	90.01	0	27,661	0		19.00
20.00	JAY FAMILY MEDICINE	90.02	0	23,806	0		20.00
21.00	JAY FAMILY FIRST HEALTH CARE	90.05	0	9,015	0		21.00
22.00	INFUSION CLINIC	90.06	0	3,395	0		22.00
23.00	HEALTH BEGINNINGS PROGRAM	90.07	0	427	0		23.00
24.00	EMERGENCY	91.00	0	111,209	0		24.00
25.00	OUTPATIENT PSYCH	93.00	0	226	0		25.00
26.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	1,481	0		26.00
	0		0	853,429			
	D - LAUNDRY						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	26	0		1.00
2.00	OPERATION OF PLANT - POB	7.02	0	140	0		2.00
3.00	HOUSEKEEPING	9.00	0	14,553	0		3.00
4.00	DIETARY	10.00	0	242	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	34,636	0		5.00
6.00	OPERATING ROOM	50.00	0	18,927	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	12,981	0		7.00
8.00	FAMILY PRACTICE OF JAY COUNTY	90.01	0	2,137	0		8.00
9.00	JAY FAMILY MEDICINE	90.02	0	251	0		9.00
10.00	JAY FAMILY FIRST HEALTH CARE	90.05	0	321	0		10.00
11.00	HEALTH BEGINNINGS PROGRAM	90.07	0	32	0		11.00
12.00	EMERGENCY	91.00	0	21,937	0		12.00
13.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	295	0		13.00
	0		0	106,478			
	E - DEPRECIATION						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	110,011	9		1.00
2.00	OPERATION OF PLANT	7.00	0	1,179,278	9		2.00
3.00	OPERATION OF PLANT - MOB	7.01	0	76,282	9		3.00
4.00	OPERATION OF PLANT - POB	7.02	0	35,030	9		4.00
5.00	DIETARY	10.00	0	14,834	9		5.00

RECLASSIFICATIONS | Provider CCN: 15-1320 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-6 | Date/Time Prepared: 5/27/2022 8:00 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
6.00	PHARMACY	15.00	0	39,601	9		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	65,570	0		7.00
8.00	OPERATING ROOM	50.00	0	382,359	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	614,711	0		9.00
10.00	LABORATORY	60.00	0	5,094	0		10.00
11.00	RESPIRATORY THERAPY	65.00	0	24,411	0		11.00
12.00	CARDIOPULMONARY	76.00	0	25,500	0		12.00
13.00	FAMILY PRACTICE OF JAY COUNTY	90.01	0	6,275	0		13.00
14.00	WOUND CLINIC	90.03	0	1,322	0		14.00
15.00	JAY FAMILY FIRST HEALTH CARE	90.05	0	1,052	0		15.00
16.00	INFUSION CLINIC	90.06	0	445	0		16.00
17.00	HEALTH BEGINNINGS PROGRAM	90.07	0	35,383	0		17.00
18.00	EMERGENCY	91.00	0	67,336	0		18.00
19.00	OUTPATIENT PSYCH	93.00	0	13,158	0		19.00
20.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	9,435	0		20.00
	0		0	2,707,087			
	F - PROPERTY TAXES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	25,856	13		1.00
	0		0	25,856			
	G - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	32,427	12		1.00
2.00		0.00	0	0	12		2.00
	0		0	32,427			
	H - HOUSEKEEPING SUPPLIES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	694	0		2.00
3.00	DIETARY	10.00	0	40	0		3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	3	0		4.00
5.00	PHARMACY	15.00	0	457	0		5.00
6.00	ADULTS & PEDIATRICS	30.00	0	1,064	0		6.00
7.00	OPERATING ROOM	50.00	0	246	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	245	0		8.00
9.00	LABORATORY	60.00	0	7	0		9.00
10.00	PHYSICAL THERAPY	66.00	0	10	0		10.00
11.00	CARDIOPULMONARY	76.00	0	3	0		11.00
12.00	FAMILY PRACTICE OF JAY COUNTY	90.01	0	69	0		12.00
13.00	JAY FAMILY MEDICINE	90.02	0	105	0		13.00
14.00	JAY FAMILY FIRST HEALTH CARE	90.05	0	43	0		14.00
15.00	INFUSION CLINIC	90.06	0	7	0		15.00
16.00	EMERGENCY	91.00	0	510	0		16.00
17.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	435	0		17.00
	0		0	3,940			
	J - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	97,742	0		1.00
2.00	OPERATION OF PLANT	7.00	0	139,841	0		2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	9,549	0		3.00
4.00	HOUSEKEEPING	9.00	0	78,006	0		4.00
5.00	DIETARY	10.00	0	155,736	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	239,744	0		6.00
7.00	PHARMACY	15.00	0	111,001	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	272,139	0		8.00
9.00	OPERATING ROOM	50.00	0	235,757	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	214,112	0		10.00
11.00	LABORATORY	60.00	0	344	0		11.00
12.00	RESPIRATORY THERAPY	65.00	0	101,944	0		12.00
13.00	CARDIOPULMONARY	76.00	0	45,241	0		13.00
14.00	FAMILY PRACTICE OF JAY COUNTY	90.01	0	292,311	0		14.00
15.00	JAY FAMILY MEDICINE	90.02	0	309,950	0		15.00
16.00	JAY FAMILY FIRST HEALTH CARE	90.05	0	111,362	0		16.00
17.00	INFUSION CLINIC	90.06	0	17,995	0		17.00
18.00	HEALTH BEGINNINGS PROGRAM	90.07	0	93,684	0		18.00
19.00	EMERGENCY	91.00	0	267,555	0		19.00
20.00	OUTPATIENT PSYCH	93.00	0	21,602	0		20.00
21.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	45,561	0		21.00
	0		0	2,861,176			
	N - ACCRUED PTO						
1.00	HOUSEKEEPING	9.00	5,789	0	0		1.00
2.00	DIETARY	10.00	1,773	0	0		2.00
3.00	PHARMACY	15.00	2,414	0	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	12,014	0	0		4.00
5.00	RESPIRATORY THERAPY	65.00	9,967	0	0		5.00

RECLASSIFICATIONS | Provider CCN: 15-1320 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-6 | Date/Time Prepared: 5/27/2022 8:00 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
6.00	JAY FAMILY MEDICINE	90.02	13,286	0	0		6.00
7.00	JAY FAMILY FIRST HEALTH CARE	90.05	3,560	0	0		7.00
8.00	INFUSION CLINIC	90.06	11,930	0	0		8.00
9.00	EMERGENCY	91.00	15,500	0	0		9.00
10.00	OUTPATIENT PSYCH	93.00	440	0	0		10.00
11.00	PHYSICIANS' PRIVATE OFFICES	192.00	162	0	0		11.00
	0		76,835	0			
	O - PREMIUM WAGES						
1.00	NURSING ADMINISTRATION	13.00	58,262	8,239	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		58,262	8,239			
500.00	Grand Total: Decreases		267,719	8,708,260			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1320 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-7 Part I | Date/Time Prepared: 5/27/2022 8:00 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	989,148	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	18,977,852	0	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	9,370,115	505,030	0	505,030	3,400	5.00
6.00	Movable Equipment	0	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	29,337,115	505,030	0	505,030	3,400	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	29,337,115	505,030	0	505,030	3,400	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	9,871,745	1,677,694	5.00
6.00	Movable Equipment	0	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	29,838,745	1,677,694	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	29,838,745	1,677,694	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1320 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-7 Part II | Date/Time Prepared: 5/27/2022 8:00 am

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

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1320 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-7 Part III | Date/Time Prepared: 5/27/2022 8:00 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	29,838,745	0	29,838,745	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)	29,838,745	0	29,838,745	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	807,088	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	-34,774	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	1,844,565	0	2.00
2.01	CAP REL COSTS-MVBLE EQUIP - MOB	0	0	0	31,774	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	2,648,653	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	4,105	25,856	0	837,049	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	-34,774	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	28,322	0	0	1,872,887	2.00
2.01	CAP REL COSTS-MVBLE EQUIP - MOB	0	0	0	0	31,774	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	32,427	25,856	0	2,706,936	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1320 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8 | Date/Time Prepared: 5/27/2022 8:00 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-14,643	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	-34,093	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	-1,965,195			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	3,339,882			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-62,507	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 01/01/2021 To 12/31/2021 | Worksheet A-8 | Date/Time Prepared: 5/27/2022 8:00 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
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	-2,861,176	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
33.01	HOSPITAL ASSESSMENT FEES	A	-2,157,432	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	MISCELLANEOUS INCOME	B	23,438	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	MISCELLANEOUS INCOME	B	-479	PHARMACY	15.00	0	33.03
33.04	CONTRACTED HOSPITALIST	A	-763,852	ADULTS & PEDIATRICS	30.00	0	33.04
33.05	CONTRACTED CRNA	A	-257,945	OPERATING ROOM	50.00	0	33.05
33.06	MEDICARE DEPRECIATION EXPENSE	A	-470,972	CAP REL COSTS-BLDG & FIXT	1.00	9	33.06
33.07	MEDICARE DEPRECIATION EXPENSE	A	-75,227	CAP REL COSTS-BLDG & FIXT-MOB	1.01	9	33.07
33.08	MEDICARE DEPRECIATION EXPENSE	A	-35,030	CAP REL COSTS-BLDG & FIXT-POB	1.02	9	33.08
33.09	MEDICARE DEPRECIATION EXPENSE	A	-9,433	CAP REL COSTS-BLDG & FIXT-WJ	1.03	9	33.09
33.10	MEDICARE DEPRECIATION EXPENSE	A	254,008	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.10
33.11	MEDICARE DEPRECIATION EXPENSE	A	-1,056	CAP REL COSTS-MVBLE EQUIP - MOB	2.01	9	33.11
33.12	MISCELLANEOUS INCOME	B	-41,000	RADIOLOGY-DIAGNOSTIC	54.00	0	33.12
33.13	MISCELLANEOUS INCOME	B	-1,510	LABORATORY	60.00	0	33.13
33.14	MISCELLANEOUS INCOME	B	-34,774	CAP REL COSTS-BLDG & FIXT-POB	1.02	9	33.14
33.15	MISC NON-ALLOWABLE	A	-973	DIETARY	10.00	0	33.15
33.16	MISC NON-ALLOWABLE	A	-1,026	NURSING ADMINISTRATION	13.00	0	33.16
33.17	MISC NON-ALLOWABLE	A	67	CARDIOPULMONARY	76.00	0	33.17
33.18	MISC NON-ALLOWABLE	A	-631	OUTPATIENT PSYCH	93.00	0	33.18
33.19	MISCELLANEOUS INCOME	B	-1,500	OUTPATIENT PSYCH	93.00	0	33.19
33.20	MISCELLANEOUS INCOME	B	80	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.20
33.21	MISCELLANEOUS INCOME	B	-30	JAY FAMILY MEDICINE	90.02	0	33.21
33.22	MISC NON-ALLOWABLE	A	-11,870	ADMINISTRATIVE & GENERAL	5.00	0	33.22
33.23	PRESIDENT EXPENSE	A	-77,010	ADMINISTRATIVE & GENERAL	5.00	0	33.23

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1320 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8 | Date/Time Prepared: 5/27/2022 8:00 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-5,261,889				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 01/01/2021 To 12/31/2021 | Worksheet A-8-1 | Date/Time Prepared: 5/27/2022 8:00 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	171,727	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	191,059	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	2,081,779	0	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	6,390,874	6,151,816	3.01
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	RELATED PARTY	70,303	0	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	RELATED PARTY	753,298	551,233	4.01
4.02	7.00	OPERATION OF PLANT	RELATED PARTY	204,971	129,205	4.02
4.03	10.00	DIETARY	RELATED PARTY	12,771	0	4.03
4.04	13.00	NURSING ADMINISTRATION	RELATED PARTY	325,389	238,932	4.04
4.05	15.00	PHARMACY	RELATED PARTY	294,069	218,223	4.05
4.06	50.00	OPERATING ROOM	RELATED PARTY	15,314	10,756	4.06
4.07	54.00	RADIOLOGY-DIAGNOSTIC	RELATED PARTY	132,559	105,289	4.07
4.08	65.00	RESPIRATORY THERAPY	RELATED PARTY	24,270	19,457	4.08
4.09	66.00	PHYSICAL THERAPY	RELATED PARTY	97,851	23,725	4.09
4.10	76.00	CARDIOPULMONARY	RELATED PARTY	36,804	14,520	4.10
4.11	4.00	EMPLOYEE BENEFITS DEPARTMENT	SHARED EMPLOYEES	13,510	13,510	4.11
4.12	5.00	ADMINISTRATIVE & GENERAL	SHARED EMPLOYEES	205,895	205,895	4.12
4.13	7.00	OPERATION OF PLANT	SHARED EMPLOYEES	-4,138	-4,138	4.13
4.14	10.00	DIETARY	SHARED EMPLOYEES	38,353	38,353	4.14
4.15	15.00	PHARMACY	SHARED EMPLOYEES	113,272	113,272	4.15
4.16	30.00	ADULTS & PEDIATRICS	SHARED EMPLOYEES	776,049	776,049	4.16
4.17	50.00	OPERATING ROOM	SHARED EMPLOYEES	227,289	227,289	4.17
4.18	60.00	LABORATORY	SHARED EMPLOYEES	1,803,268	1,803,268	4.18
4.19	66.00	PHYSICAL THERAPY	SHARED EMPLOYEES	504,725	504,725	4.19
4.20	67.00	OCCUPATIONAL THERAPY	SHARED EMPLOYEES	92,328	92,328	4.20
4.21	68.00	SPEECH PATHOLOGY	SHARED EMPLOYEES	18,466	18,466	4.21
4.22	76.00	CARDIOPULMONARY	SHARED EMPLOYEES	45,612	45,612	4.22
4.23	90.01	FAMILY PRACTICE OF JAY COUNT	SHARED EMPLOYEES	116,580	116,580	4.23
4.24	90.02	JAY FAMILY MEDICINE	SHARED EMPLOYEES	315,599	315,599	4.24
4.25	90.05	JAY FAMILY FIRST HEALTH CARE	SHARED EMPLOYEES	57,653	57,653	4.25
4.26	91.00	EMERGENCY	SHARED EMPLOYEES	1,514,318	1,514,318	4.26
4.27	192.00	PHYSICIANS' PRIVATE OFFICES	SHARED EMPLOYEES	12,351	12,351	4.27
4.28	0.00			0	0	4.28
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			16,654,168	13,314,286	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 01/01/2021 To 12/31/2021	Worksheet A-8-1 Date/Time Prepared: 5/27/2022 8:00 am

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1320 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8-1 | Date/Time Prepared: 5/27/2022 8:00 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	171,727	9		1.00
2.00	191,059	9		2.00
3.00	2,081,779	0		3.00
3.01	239,058	0		3.01
4.00	70,303	0		4.00
4.01	202,065	0		4.01
4.02	75,766	0		4.02
4.03	12,771	0		4.03
4.04	86,457	0		4.04
4.05	75,846	0		4.05
4.06	4,558	0		4.06
4.07	27,270	0		4.07
4.08	4,813	0		4.08
4.09	74,126	0		4.09
4.10	22,284	0		4.10
4.11	0	0		4.11
4.12	0	0		4.12
4.13	0	0		4.13
4.14	0	0		4.14
4.15	0	0		4.15
4.16	0	0		4.16
4.17	0	0		4.17
4.18	0	0		4.18
4.19	0	0		4.19
4.20	0	0		4.20
4.21	0	0		4.21
4.22	0	0		4.22
4.23	0	0		4.23
4.24	0	0		4.24
4.25	0	0		4.25
4.26	0	0		4.26
4.27	0	0		4.27
4.28	0	0		4.28
5.00	3,339,882			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

(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 01/01/2021 To 12/31/2021 | Worksheet A-8-2 | Date/Time Prepared: 5/27/2022 8:00 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	50.00	OPERATING ROOM	213,234	213,234	0	0	0	1.00
2.00	90.01	FAMILY PRACTICE OF JAY COUNTY	116,580	116,580	0	0	0	2.00
3.00	90.02	JAY FAMILY MEDICINE	315,599	315,599	0	0	0	3.00
4.00	90.05	JAY FAMILY FIRST HEALTH CARE	57,653	57,653	0	0	0	4.00
5.00	91.00	EMERGENCY	1,388,786	1,262,129	126,657	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,091,852	1,965,195	126,657		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	50.00	OPERATING ROOM	0	0	0	0	0	1.00
2.00	90.01	FAMILY PRACTICE OF JAY COUNTY	0	0	0	0	0	2.00
3.00	90.02	JAY FAMILY MEDICINE	0	0	0	0	0	3.00
4.00	90.05	JAY FAMILY FIRST HEALTH CARE	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	50.00	OPERATING ROOM	0	0	0	213,234		1.00
2.00	90.01	FAMILY PRACTICE OF JAY COUNTY	0	0	0	116,580		2.00
3.00	90.02	JAY FAMILY MEDICINE	0	0	0	315,599		3.00
4.00	90.05	JAY FAMILY FIRST HEALTH CARE	0	0	0	57,653		4.00
5.00	91.00	EMERGENCY	0	0	0	1,262,129		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,965,195		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1320 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I Date/Time Prepared: 5/27/2022 8:00 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	BLDG & FIXT-MOB	BLDG & FIXT-POB	BLDG & FIXT-WJ	
			0	1.00	1.01	1.02	1.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	837,049	837,049				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	-34,774	0	0	-34,774		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	1,872,887					2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB	31,774					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	2,184,978	1,153	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,967,068	109,751	0	0	0	5.00
7.00	00700	OPERATION OF PLANT	3,256,548	189,759	0	0	0	7.00
7.01	00701	OPERATION OF PLANT - MOB	44,772	0	0	0	0	7.01
7.02	00702	OPERATION OF PLANT - POB	63,488	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	132,976	6,063	0	0	0	8.00
9.00	00900	HOUSEKEEPING	546,392	6,124	0	0	0	9.00
10.00	01000	DIETARY	416,910	25,139	0	0	0	10.00
11.00	01100	CAFETERIA	234,288	18,464	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,685,613	11,319	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	714,088	0	0	0	0	14.00
15.00	01500	PHARMACY	1,072,939	10,207	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	1,978,801	100,586	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
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	895,684	40,745	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	1,117,207	50,971	0	0	0	54.00
60.00	06000	LABORATORY	1,929,933	26,690	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	482,763	7,461	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	603,966	33,018	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	92,328	5,991	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	18,466	194	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	909	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	93,761	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	21,599	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,868,075	0	0	0	0	73.00
76.00	03160	CARDIOPULMONARY	245,788	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	735,916	0	0	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	777,518	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	369,255	39,479	0	0	0	90.05
90.06	09006	INFUSION CLINIC	118,927	6,308	0	0	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	264,166	32,069	0	0	0	90.07
91.00	09100	EMERGENCY	1,625,478	48,685	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	31,282	16,034	0	0	0	93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	34,298,818	786,210	0	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	327	7,869	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	140,882	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT	0	26,588	0	0	0	194.00
194.02	07952	WEST JAY CLINIC	0	0	0	0	0	194.02
194.03	07953	JAY MERIDIAN URGENT CARE	0	16,382	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	-34,774	0	201.00
202.00		TOTAL (sum lines 118 through 201)	34,440,027	837,049	0	-34,774	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1320 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I Date/Time Prepared: 5/27/2022 8:00 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT-INTEREST	MVBLE EQUIP	MVBLE EQUIP - MOB	MVBLE EQUIP - POB	MVBLE EQUIP - WJ	
			1.04	2.00	2.01	2.02	2.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MOB						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT-POB						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT-WJ						1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT-INTEREST	0					1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,872,887				2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB		0	31,774			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	2,581	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	245,566	2,073	0	0	5.00
7.00	00700	OPERATION OF PLANT	0	424,587	0	0	0	7.00
7.01	00701	OPERATION OF PLANT - MOB	0	0	724	0	0	7.01
7.02	00702	OPERATION OF PLANT - POB	0	0	0	0	0	7.02
7.03	00703	OPERATION OF PLANT - WJ	0	0	0	0	0	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	0	13,565	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	13,702	0	0	0	9.00
10.00	01000	DIETARY	0	56,248	0	0	0	10.00
11.00	01100	CAFETERIA	0	41,312	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	25,326	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	22,837	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	225,059	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
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	91,165	1,336	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	114,048	0	0	0	54.00
60.00	06000	LABORATORY	0	59,719	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	16,694	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	73,878	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	13,405	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	434	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	2,214	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	12,756	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	12,467	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	88,334	204	0	0	90.05
90.06	09006	INFUSION CLINIC	0	14,113	0	0	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	71,754	0	0	0	90.07
91.00	09100	EMERGENCY	0	108,933	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	0	35,877	0	0	0	93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,759,137	31,774	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	17,607	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	59,490	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	36,653	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	1,872,887	31,774	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1320 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I Date/Time Prepared: 5/27/2022 8:00 am

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT - MOB	
			4.00	4A	5.00	7.00	7.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MOB						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT-POB						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT-WJ						1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT-INTEREST						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB						2.01
2.02	00202	CAP REL COSTS-MVBLE EQUIP - POB						2.02
2.03	00203	CAP REL COSTS-MVBLE EQUIP - WJ						2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,188,712					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	73,110	8,397,568	8,397,568			5.00
7.00	00700	OPERATION OF PLANT	105,368	3,976,262	1,280,458	5,256,720		7.00
7.01	00701	OPERATION OF PLANT - MOB	0	45,496	14,651	30,263	90,410	7.01
7.02	00702	OPERATION OF PLANT - POB	0	63,488	20,445	37,524	0	7.02
7.03	00703	OPERATION OF PLANT - WJ	0	0	0	0	0	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	6,301	158,905	51,172	36,243	0	8.00
9.00	00900	HOUSEKEEPING	62,904	629,122	202,594	36,609	0	9.00
10.00	01000	DIETARY	34,292	532,589	171,508	150,279	0	10.00
11.00	01100	CAFETERIA	25,184	319,248	102,806	110,376	0	11.00
13.00	01300	NURSING ADMINISTRATION	229,084	1,951,342	628,385	67,665	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	714,088	229,956	0	0	14.00
15.00	01500	PHARMACY	99,328	1,205,311	388,143	61,015	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	341,690	2,646,136	852,127	601,300	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
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	148,442	1,177,372	379,146	690,016	4,170	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	169,917	1,452,143	467,629	304,707	0	54.00
60.00	06000	LABORATORY	1,635	2,017,977	649,843	159,553	0	60.00
65.00	06500	RESPIRATORY THERAPY	80,374	587,292	189,124	44,602	0	65.00
66.00	06600	PHYSICAL THERAPY	95,843	806,705	259,781	197,382	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	17,532	129,256	41,624	35,816	0	67.00
68.00	06800	SPEECH PATHOLOGY	3,507	22,601	7,278	1,159	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	909	293	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	93,761	30,194	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	21,599	6,955	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,868,075	601,571	0	0	73.00
76.00	03160	CARDIOPULMONARY	28,865	276,867	89,159	92,498	6,908	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	128,642	877,314	282,519	532,841	39,796	90.01
90.02	09002	JAY FAMILY MEDICINE	136,373	926,358	298,312	520,821	38,898	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	64,545	561,817	180,920	244,547	638	90.05
90.06	09006	INFUSION CLINIC	20,869	160,217	51,594	37,707	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	49,800	417,789	134,539	191,708	0	90.07
91.00	09100	EMERGENCY	238,564	2,021,660	651,029	291,040	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0				92.00
93.00	04950	OUTPATIENT PSYCH	6,766	89,959	28,969	95,854	0	93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,168,935	34,149,226	8,292,724	4,571,525	90,410	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	25,803	8,309	47,042	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	19,777	160,659	51,737	381,281	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT	0	86,078	27,719	158,943	0	194.00
194.02	07952	WEST JAY CLINIC	0	0	0	0	0	194.02
194.03	07953	JAY MERIDIAN URGENT CARE	0	53,035	17,079	97,929	0	194.03
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	-34,774	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,188,712	34,440,027	8,397,568	5,256,720	90,410	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1320 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I Date/Time Prepared: 5/27/2022 8:00 am

		Cost Center Description	OPERATION OF PLANT - POB	OPERATION OF PLANT - WJ	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			7.02	7.03	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MOB						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT-POB						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT-WJ						1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT-INTEREST						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB						2.01
2.02	00202	CAP REL COSTS-MVBLE EQUIP - POB						2.02
2.03	00203	CAP REL COSTS-MVBLE EQUIP - WJ						2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT - MOB						7.01
7.02	00702	OPERATION OF PLANT - POB	121,457					7.02
7.03	00703	OPERATION OF PLANT - WJ	0	0				7.03
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	246,320			8.00
9.00	00900	HOUSEKEEPING	0	0	0	868,325		9.00
10.00	01000	DIETARY	0	0	0	25,506	879,882	10.00
11.00	01100	CAFETERIA	0	0	0	18,733	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	11,484	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	10,356	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	246,320	102,055	879,882	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
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	87,142	0	0	117,112	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	51,716	0	54.00
60.00	06000	LABORATORY	0	0	0	27,080	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	7,570	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	33,501	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	6,079	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	197	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	15,699	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	90,436	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	0	88,396	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	41,506	0	90.05
90.06	09006	INFUSION CLINIC	0	0	0	6,400	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	0	0	32,538	0	90.07
91.00	09100	EMERGENCY	0	0	0	49,397	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	0	0	0	16,269	0	93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	87,142	0	246,320	752,030	879,882	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	7,984	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	34,315	0	0	64,713	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT	0	0	0	26,977	0	194.00
194.02	07952	WEST JAY CLINIC	0	0	0	0	0	194.02
194.03	07953	JAY MERIDIAN URGENT CARE	0	0	0	16,621	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)	121,457	0	246,320	868,325	879,882	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1320 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I | Date/Time Prepared: 5/27/2022 8:00 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MOB						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT-POB						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT-WJ						1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT-INTEREST						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB						2.01
2.02	00202	CAP REL COSTS-MVBLE EQUIP - POB						2.02
2.03	00203	CAP REL COSTS-MVBLE EQUIP - WJ						2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT - MOB						7.01
7.02	00702	OPERATION OF PLANT - POB						7.02
7.03	00703	OPERATION OF PLANT - WJ						7.03
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	551,163					11.00
13.00	01300	NURSING ADMINISTRATION	47,715	2,706,591				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	944,044			14.00
15.00	01500	PHARMACY	20,871	0	8,195	1,693,891		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	80,159	865,914	213,126	13,214	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
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	41,301	455,543	150,399	5,013	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	42,522	0	30,227	5,074	0	54.00
60.00	06000	LABORATORY	39,332	0	19,429	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	17,138	0	41,155	0	0	65.00
66.00	06600	PHYSICAL THERAPY	14,084	0	6,083	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,328	0	211	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	747	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	1,633	22	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	157,328	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	36,242	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,626,492	0	73.00
76.00	03160	CARDIOPULMONARY	7,330	2,177	3,445	105	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	57,183	167,087	46,906	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	61,900	218,791	40,486	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	27,047	88,714	14,191	0	0	90.05
90.06	09006	INFUSION CLINIC	4,378	69,121	5,042	5,406	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	16,086	142,051	1,460	152	0	90.07
91.00	09100	EMERGENCY	51,346	697,193	165,392	38,413	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	7,771	0	513	0	0	93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	542,238	2,706,591	941,463	1,693,891	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	8,925	0	2,581	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	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)	551,163	2,706,591	944,044	1,693,891	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1320 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I | Date/Time Prepared: 5/27/2022 8:00 am

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MOB						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT-POB						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT-WJ						1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT-INTEREST						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB						2.01
2.02	00202	CAP REL COSTS-MVBLE EQUIP - POB						2.02
2.03	00203	CAP REL COSTS-MVBLE EQUIP - WJ						2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT - MOB						7.01
7.02	00702	OPERATION OF PLANT - POB						7.02
7.03	00703	OPERATION OF PLANT - WJ						7.03
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	0					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	6,500,233	0	6,500,233		30.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0		40.00
43.00	04300	NURSERY	0	0	0	0		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,107,214	0	3,107,214		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,354,018	0	2,354,018		54.00
60.00	06000	LABORATORY	0	2,913,214	0	2,913,214		60.00
65.00	06500	RESPIRATORY THERAPY	0	886,881	0	886,881		65.00
66.00	06600	PHYSICAL THERAPY	0	1,317,536	0	1,317,536		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	218,314	0	218,314		67.00
68.00	06800	SPEECH PATHOLOGY	0	31,982	0	31,982		68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,857	0	2,857		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	281,283	0	281,283		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	64,796	0	64,796		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,096,138	0	4,096,138		73.00
76.00	03160	CARDIOPULMONARY	0	494,188	0	494,188		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	2,094,082	0	2,094,082		90.01
90.02	09002	JAY FAMILY MEDICINE	0	2,193,962	0	2,193,962		90.02
90.03	09003	WOUND CLINIC	0	0	0	0		90.03
90.04	09004	OP ORTHO CLINIC	0	0	0	0		90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0	1,159,380	0	1,159,380		90.05
90.06	09006	INFUSION CLINIC	0	339,865	0	339,865		90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	936,323	0	936,323		90.07
91.00	09100	EMERGENCY	0	3,965,470	0	3,965,470		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
93.00	04950	OUTPATIENT PSYCH	0	239,335	0	239,335		93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	33,197,071	0	33,197,071		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	89,138	0	89,138		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	704,211	0	704,211		192.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
194.00	07950	VACANT	0	299,717	0	299,717		194.00
194.02	07952	WEST JAY CLINIC	0	0	0	0		194.02
194.03	07953	JAY MERIDIAN URGENT CARE	0	184,664	0	184,664		194.03
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	-34,774	0	-34,774		201.00
202.00		TOTAL (sum lines 118 through 201)	0	34,440,027	0	34,440,027		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1320 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II Date/Time Prepared: 5/27/2022 8:00 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	BLDG & FIXT-MOB	BLDG & FIXT-POB	BLDG & FIXT-WJ	
			0	1.00	1.01	1.02	1.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MOB						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT-POB						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT-WJ						1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT-INTEREST						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB						2.01
2.02	00202	CAP REL COSTS-MVBLE EQUIP - POB						2.02
2.03	00203	CAP REL COSTS-MVBLE EQUIP - WJ						2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,153	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	109,751	0	0	0	5.00
7.00	00700	OPERATION OF PLANT	0	189,759	0	0	0	7.00
7.01	00701	OPERATION OF PLANT - MOB	0	0	0	0	0	7.01
7.02	00702	OPERATION OF PLANT - POB	0	0	0	0	0	7.02
7.03	00703	OPERATION OF PLANT - WJ	0	0	0	0	0	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	0	6,063	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	6,124	0	0	0	9.00
10.00	01000	DIETARY	0	25,139	0	0	0	10.00
11.00	01100	CAFETERIA	0	18,464	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	11,319	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	10,207	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	100,586	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
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	40,745	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	50,971	0	0	0	54.00
60.00	06000	LABORATORY	0	26,690	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	7,461	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	33,018	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5,991	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	194	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	39,479	0	0	0	90.05
90.06	09006	INFUSION CLINIC	0	6,308	0	0	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	32,069	0	0	0	90.07
91.00	09100	EMERGENCY	0	48,685	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	0	16,034	0	0	0	93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	786,210	0	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7,869	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	26,588	0	0	0	194.00
194.02	07952	WEST JAY CLINIC	0	0	0	0	0	194.02
194.03	07953	JAY MERIDIAN URGENT CARE	0	16,382	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	-34,774	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	837,049	0	-34,774	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1320 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II Date/Time Prepared: 5/27/2022 8:00 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT-INTEREST	MVBLE EQUIP	MVBLE EQUIP - MOB	MVBLE EQUIP - POB	MVBLE EQUIP - WJ	
			1.04	2.00	2.01	2.02	2.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MOB						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT-POB						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT-WJ						1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT-INTEREST						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB						2.01
2.02	00202	CAP REL COSTS-MVBLE EQUIP - POB						2.02
2.03	00203	CAP REL COSTS-MVBLE EQUIP - WJ						2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,581	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	245,566	2,073	0	0	5.00
7.00	00700	OPERATION OF PLANT	0	424,587	0	0	0	7.00
7.01	00701	OPERATION OF PLANT - MOB	0	0	724	0	0	7.01
7.02	00702	OPERATION OF PLANT - POB	0	0	0	0	0	7.02
7.03	00703	OPERATION OF PLANT - WJ	0	0	0	0	0	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	0	13,565	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	13,702	0	0	0	9.00
10.00	01000	DIETARY	0	56,248	0	0	0	10.00
11.00	01100	CAFETERIA	0	41,312	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	25,326	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	22,837	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	225,059	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
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	91,165	1,336	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	114,048	0	0	0	54.00
60.00	06000	LABORATORY	0	59,719	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	16,694	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	73,878	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	13,405	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	434	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	2,214	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	12,756	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	12,467	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	88,334	204	0	0	90.05
90.06	09006	INFUSION CLINIC	0	14,113	0	0	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	71,754	0	0	0	90.07
91.00	09100	EMERGENCY	0	108,933	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	0	35,877	0	0	0	93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,759,137	31,774	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	17,607	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	59,490	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	36,653	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	1,872,887	31,774	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1320 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II Date/Time Prepared: 5/27/2022 8:00 am

		Cost Center Description	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT - MOB	
			2A	4.00	5.00	7.00	7.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MOB						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT-POB						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT-WJ						1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT-INTEREST						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB						2.01
2.02	00202	CAP REL COSTS-MVBLE EQUIP - POB						2.02
2.03	00203	CAP REL COSTS-MVBLE EQUIP - WJ						2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,734	3,734				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	357,390	125	357,515			5.00
7.00	00700	OPERATION OF PLANT	614,346	180	54,510	669,036		7.00
7.01	00701	OPERATION OF PLANT - MOB	724	0	624	3,852	5,200	7.01
7.02	00702	OPERATION OF PLANT - POB	0	0	870	4,776	0	7.02
7.03	00703	OPERATION OF PLANT - WJ	0	0	0	0	0	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	19,628	11	2,179	4,613	0	8.00
9.00	00900	HOUSEKEEPING	19,826	107	8,625	4,659	0	9.00
10.00	01000	DIETARY	81,387	59	7,302	19,126	0	10.00
11.00	01100	CAFETERIA	59,776	43	4,377	14,048	0	11.00
13.00	01300	NURSING ADMINISTRATION	36,645	391	26,753	8,612	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	9,790	0	0	14.00
15.00	01500	PHARMACY	33,044	169	16,525	7,765	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	325,645	581	36,279	76,529	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
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	133,246	253	16,142	87,820	240	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	165,019	290	19,909	38,781	0	54.00
60.00	06000	LABORATORY	86,409	3	27,666	20,307	0	60.00
65.00	06500	RESPIRATORY THERAPY	24,155	137	8,052	5,677	0	65.00
66.00	06600	PHYSICAL THERAPY	106,896	164	11,060	25,121	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	19,396	30	1,772	4,558	0	67.00
68.00	06800	SPEECH PATHOLOGY	628	6	310	148	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	12	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,285	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	296	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	25,611	0	0	73.00
76.00	03160	CARDIOPULMONARY	2,214	49	3,796	11,772	397	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	12,756	219	12,028	67,816	2,289	90.01
90.02	09002	JAY FAMILY MEDICINE	12,467	233	12,700	66,286	2,237	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	128,017	110	7,703	31,124	37	90.05
90.06	09006	INFUSION CLINIC	20,421	36	2,197	4,799	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	103,823	85	5,728	24,399	0	90.07
91.00	09100	EMERGENCY	157,618	407	27,717	37,041	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
93.00	04950	OUTPATIENT PSYCH	51,911	12	1,233	12,200	0	93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,577,121	3,700	353,051	581,829	5,200	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	25,476	0	354	5,987	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	34	2,203	48,527	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT	86,078	0	1,180	20,229	0	194.00
194.02	07952	WEST JAY CLINIC	0	0	0	0	0	194.02
194.03	07953	JAY MERIDIAN URGENT CARE	53,035	0	727	12,464	0	194.03
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	-34,774	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,706,936	3,734	357,515	669,036	5,200	202.00

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		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	5,646					7.02
7.03	00703	OPERATION OF PLANT - WJ	0	0				7.03
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	26,431			8.00
9.00	00900	HOUSEKEEPING	0	0	0	33,217		9.00
10.00	01000	DIETARY	0	0	0	976	108,850	10.00
11.00	01100	CAFETERIA	0	0	0	717	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	439	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	396	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	26,431	3,904	108,850	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
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,051	0	0	4,476	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	1,978	0	54.00
60.00	06000	LABORATORY	0	0	0	1,036	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	290	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,282	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	233	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	8	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	601	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	3,460	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	0	3,382	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	1,588	0	90.05
90.06	09006	INFUSION CLINIC	0	0	0	245	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	0	0	1,245	0	90.07
91.00	09100	EMERGENCY	0	0	0	1,890	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	0	0	0	622	0	93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,051	0	26,431	28,768	108,850	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	305	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,595	0	0	2,476	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT	0	0	0	1,032	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	636	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)	5,646	0	26,431	33,217	108,850	202.00

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		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MOB						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT-POB						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT-WJ						1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT-INTEREST						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB						2.01
2.02	00202	CAP REL COSTS-MVBLE EQUIP - POB						2.02
2.03	00203	CAP REL COSTS-MVBLE EQUIP - WJ						2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT - MOB						7.01
7.02	00702	OPERATION OF PLANT - POB						7.02
7.03	00703	OPERATION OF PLANT - WJ						7.03
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	78,961					11.00
13.00	01300	NURSING ADMINISTRATION	6,836	79,676				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	9,790			14.00
15.00	01500	PHARMACY	2,990	0	85	60,974		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,483	25,489	2,211	476	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
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,917	13,410	1,560	180	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	6,092	0	313	183	0	54.00
60.00	06000	LABORATORY	5,635	0	201	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,455	0	427	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,018	0	63	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	763	0	2	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	107	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	17	1	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,632	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	376	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	58,547	0	73.00
76.00	03160	CARDIOPULMONARY	1,050	64	36	4	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	8,192	4,919	486	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	8,868	6,441	420	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	3,875	2,612	147	0	0	90.05
90.06	09006	INFUSION CLINIC	627	2,035	52	195	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	2,305	4,182	15	5	0	90.07
91.00	09100	EMERGENCY	7,356	20,524	1,715	1,383	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	1,113	0	5	0	0	93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	77,682	79,676	9,763	60,974	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,279	0	27	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	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)	78,961	79,676	9,790	60,974	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1320 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II Date/Time Prepared: 5/27/2022 8:00 am

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MOB						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT-POB						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT-WJ						1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT-INTEREST						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB						2.01
2.02	00202	CAP REL COSTS-MVBLE EQUIP - POB						2.02
2.03	00203	CAP REL COSTS-MVBLE EQUIP - WJ						2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT - MOB						7.01
7.02	00702	OPERATION OF PLANT - POB						7.02
7.03	00703	OPERATION OF PLANT - WJ						7.03
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	0					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	617,878	0	617,878		30.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0		40.00
43.00	04300	NURSERY	0	0	0	0		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	267,295	0	267,295		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	232,565	0	232,565		54.00
60.00	06000	LABORATORY	0	141,257	0	141,257		60.00
65.00	06500	RESPIRATORY THERAPY	0	41,193	0	41,193		65.00
66.00	06600	PHYSICAL THERAPY	0	146,604	0	146,604		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	26,754	0	26,754		67.00
68.00	06800	SPEECH PATHOLOGY	0	1,207	0	1,207		68.00
69.00	06900	ELECTROCARDIOLOGY	0	30	0	30		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,917	0	2,917		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	672	0	672		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	84,158	0	84,158		73.00
76.00	03160	CARDIOPULMONARY	0	19,983	0	19,983		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	112,165	0	112,165		90.01
90.02	09002	JAY FAMILY MEDICINE	0	113,034	0	113,034		90.02
90.03	09003	WOUND CLINIC	0	0	0	0		90.03
90.04	09004	OP ORTHO CLINIC	0	0	0	0		90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	0	175,213	0	175,213		90.05
90.06	09006	INFUSION CLINIC	0	30,607	0	30,607		90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	141,787	0	141,787		90.07
91.00	09100	EMERGENCY	0	255,651	0	255,651		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
93.00	04950	OUTPATIENT PSYCH	0	67,096	0	67,096		93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,478,066	0	2,478,066		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	32,122	0	32,122		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	56,141	0	56,141		192.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
194.00	07950	VACANT	0	108,519	0	108,519		194.00
194.02	07952	WEST JAY CLINIC	0	0	0	0		194.02
194.03	07953	JAY MERIDIAN URGENT CARE	0	66,862	0	66,862		194.03
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	-34,774	0	-34,774		201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,706,936	0	2,706,936		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1320 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/27/2022 8:00 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	BLDG & FIXT-MOB (SQUARE FEET-MOB)	BLDG & FIXT-POB (SQUARE FEET-POB)	BLDG & FIXT-WJ (SQUARE FEET-WJ)	BLDG & FIXT-INTEREST (SQUARE FEET)	
			1.00	1.01	1.02	1.03	1.04	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	82,011					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MOB	0	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	3,728		1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT-INTEREST	0	0	0	0	82,011	1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB						2.01
2.02	00202	CAP REL COSTS-MVBLE EQUIP - POB						2.02
2.03	00203	CAP REL COSTS-MVBLE EQUIP - WJ						2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	113	0	0	0	113	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,753	1,419	0	0	10,753	5.00
7.00	00700	OPERATION OF PLANT	18,592	0	0	0	18,592	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	2,463	0	0	0	2,463	10.00
11.00	01100	CAFETERIA	1,809	0	0	0	1,809	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	9,855	0	0	0	9,855	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
		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	0	0	0	0	0	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	3,235	0	0	0	3,235	66.00
67.00	06700	OCCUPATIONAL THERAPY	587	0	0	0	587	67.00
68.00	06800	SPEECH PATHOLOGY	19	0	0	0	19	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	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	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	3,142	0	0	0	3,142	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)	77,030	21,755	7,017	0	77,030	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	771	0	0	0	771	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	2,521	3,728	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT	2,605	0	0	0	2,605	194.00
194.02	07952	WEST JAY CLINIC	0	0	0	0	0	194.02
194.03	07953	JAY MERIDIAN URGENT CARE	1,605	0	0	0	1,605	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	837,049	0	-34,774	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	10.206545	0.000000	0.000000	0.000000	0.000000	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1320 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/27/2022 8:00 am

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

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1320 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/27/2022 8:00 am

		Cost Center Description	CAPITAL RELATED COSTS					
			MVBLE EQUIP (SQUARE FEET)	MVBLE EQUIP - MOB (SQUARE FEET-MOB)	MVBLE EQUIP - POB (SQUARE FEET-POB)	MVBLE EQUIP - WJ (SQUARE FEET-WJ)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
			2.00	2.01	2.02	2.03	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MOB						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT-POB						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT-WJ						1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT-INTEREST						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP	82,011					2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB	0	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	3,728		2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	113	0	0	0	11,526,084	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,753	1,419	0	0	385,010	5.00
7.00	00700	OPERATION OF PLANT	18,592	0	0	0	554,883	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	33,182	8.00
9.00	00900	HOUSEKEEPING	600	0	0	0	331,261	9.00
10.00	01000	DIETARY	2,463	0	0	0	180,587	10.00
11.00	01100	CAFETERIA	1,809	0	0	0	132,622	11.00
13.00	01300	NURSING ADMINISTRATION	1,109	0	0	0	1,206,391	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	1,000	0	0	0	523,077	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	9,855	0	0	0	1,799,384	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
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,992	915	6,402	0	781,717	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	4,994	0	0	0	894,806	54.00
60.00	06000	LABORATORY	2,615	0	0	0	8,610	60.00
65.00	06500	RESPIRATORY THERAPY	731	0	0	0	423,261	65.00
66.00	06600	PHYSICAL THERAPY	3,235	0	0	0	504,725	66.00
67.00	06700	OCCUPATIONAL THERAPY	587	0	0	0	92,328	67.00
68.00	06800	SPEECH PATHOLOGY	19	0	0	0	18,466	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	152,006	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	677,447	90.01
90.02	09002	JAY FAMILY MEDICINE	0	8,536	0	0	718,163	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	3,868	140	0	0	339,906	90.05
90.06	09006	INFUSION CLINIC	618	0	0	0	109,900	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	3,142	0	0	0	262,255	90.07
91.00	09100	EMERGENCY	4,770	0	0	0	1,256,315	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	1,571	0	0	0	35,631	93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	77,030	21,755	7,017	0	11,421,933	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	104,151	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	0	0	194.02
194.03	07953	JAY MERIDIAN URGENT CARE	1,605	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)	1,872,887	31,774	0	0	2,188,712	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1320 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/27/2022 8:00 am

		Cost Center Description	CAPITAL RELATED COSTS					
			MVBLE EQUIP (SQUARE FEET)	MVBLE EQUIP - MOB (SQUARE FEET-MOB)	MVBLE EQUIP - POB (SQUARE FEET-POB)	MVBLE EQUIP - WJ (SQUARE FEET-WJ)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
			2.00	2.01	2.02	2.03	4.00	
203.00		Unit cost multiplier (Wkst. B, Part I)	22.837022	1.460538	0.000000	0.000000	0.189892	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)					3,734	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)					0.000324	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 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/27/2022 8:00 am

		Cost Center Description	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT - MOB (SQUARE FEET-MOB)	OPERATION OF PLANT - POB (SQUARE FEET-POB)	
			5A	5.00	7.00	7.01	7.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MOB						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT-POB						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT-WJ						1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT-INTEREST						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB						2.01
2.02	00202	CAP REL COSTS-MVBLE EQUIP - POB						2.02
2.03	00203	CAP REL COSTS-MVBLE EQUIP - WJ						2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-8,397,568	26,077,233				5.00
7.00	00700	OPERATION OF PLANT	0	3,976,262	86,155			7.00
7.01	00701	OPERATION OF PLANT - MOB	0	45,496	496	19,840		7.01
7.02	00702	OPERATION OF PLANT - POB	0	63,488	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	158,905	594	0	0	8.00
9.00	00900	HOUSEKEEPING	0	629,122	600	0	0	9.00
10.00	01000	DIETARY	0	532,589	2,463	0	0	10.00
11.00	01100	CAFETERIA	0	319,248	1,809	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,951,342	1,109	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	714,088	0	0	0	14.00
15.00	01500	PHARMACY	0	1,205,311	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	2,646,136	9,855	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
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,177,372	11,309	915	6,402	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	1,452,143	4,994	0	0	54.00
60.00	06000	LABORATORY	0	2,017,977	2,615	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	587,292	731	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	806,705	3,235	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	129,256	587	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	22,601	19	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	909	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	93,761	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	21,599	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,868,075	0	0	0	73.00
76.00	03160	CARDIOPULMONARY	0	276,867	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	877,314	8,733	8,733	0	90.01
90.02	09002	JAY FAMILY MEDICINE	0	926,358	8,536	8,536	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	561,817	4,008	140	0	90.05
90.06	09006	INFUSION CLINIC	0	160,217	618	0	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	417,789	3,142	0	0	90.07
91.00	09100	EMERGENCY	0	2,021,660	4,770	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	0	89,959	1,571	0	0	93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-8,397,568	25,751,658	74,925	19,840	6,402	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	25,803	771	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	160,659	6,249	0	2,521	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT	0	86,078	2,605	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	53,035	1,605	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)		8,397,568	5,256,720	90,410	121,457	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.322027	61.014683	4.556956	13.611678	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		357,515	669,036	5,200	5,646	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1320 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/27/2022 8:00 am

		Cost Center Description	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT - MOB (SQUARE FEET-MOB)	OPERATION OF PLANT - POB (SQUARE FEET-POB)	
			5A	5.00	7.00	7.01	7.02	
205.00		Unit cost multiplier (Wkst. B, Part II)		0.013710	7.765492	0.262097	0.632747	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 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/27/2022 8:00 am

		Cost Center Description	OPERATION OF PLANT - WJ (SQUARE FEET-WJ)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	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	3,728					7.03
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,808				8.00
9.00	00900	HOUSEKEEPING	0	0	83,850			9.00
10.00	01000	DIETARY	0	0	2,463	8,790		10.00
11.00	01100	CAFETERIA	0	0	1,809	0	16,241	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	1,109	0	1,406	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	1,000	0	615	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	1,808	9,855	8,790	2,362	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
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	11,309	0	1,217	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	4,994	0	1,253	54.00
60.00	06000	LABORATORY	0	0	2,615	0	1,159	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	731	0	505	65.00
66.00	06600	PHYSICAL THERAPY	0	0	3,235	0	415	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	587	0	157	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	19	0	22	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	216	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	8,733	0	1,685	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	8,536	0	1,824	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	4,008	0	797	90.05
90.06	09006	INFUSION CLINIC	0	0	618	0	129	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	0	3,142	0	474	90.07
91.00	09100	EMERGENCY	0	0	4,770	0	1,513	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	0	0	1,571	0	229	93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,808	72,620	8,790	15,978	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	771	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,728	0	6,249	0	263	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	0	0	0	0	0	194.02
194.03	07953	JAY MERIDIAN URGENT CARE	0	0	1,605	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	246,320	868,325	879,882	551,163	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	136.238938	10.355695	100.100341	33.936519	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	26,431	33,217	108,850	78,961	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1320 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/27/2022 8:00 am

		Cost Center Description	OPERATION OF PLANT - WJ (SQUARE FEET-WJ)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	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	14.618916	0.396148	12.383390	4.861831	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 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/27/2022 8:00 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MOB						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT-POB						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT-WJ						1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT-INTEREST						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP - MOB						2.01
2.02	00202	CAP REL COSTS-MVBLE EQUIP - POB						2.02
2.03	00203	CAP REL COSTS-MVBLE EQUIP - WJ						2.03
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT - MOB						7.01
7.02	00702	OPERATION OF PLANT - POB						7.02
7.03	00703	OPERATION OF PLANT - WJ						7.03
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	4,973					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	562,612				14.00
15.00	01500	PHARMACY	0	4,884	1,945,487			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	82,370,503		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,591	127,014	15,177	8,694,626	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
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	837	89,632	5,758	5,945,200	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	18,014	5,828	13,285,351	0	54.00
60.00	06000	LABORATORY	0	11,579	0	8,257,662	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	24,527	0	1,596,976	0	65.00
66.00	06600	PHYSICAL THERAPY	0	3,625	0	1,507,265	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	126	0	415,028	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	27,700	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	973	25	1,164,005	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	93,761	0	233,958	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	21,599	0	276,140	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,868,075	13,539,911	0	73.00
76.00	03160	CARDIOPULMONARY	4	2,053	121	2,239,623	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	307	27,954	0	1,087,668	0	90.01
90.02	09002	JAY FAMILY MEDICINE	402	24,128	0	976,958	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	163	8,457	0	170,150	0	90.05
90.06	09006	INFUSION CLINIC	127	3,005	6,209	1,832,927	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	261	870	175	179,647	0	90.07
91.00	09100	EMERGENCY	1,281	98,567	44,119	20,634,194	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OUTPATIENT PSYCH	0	306	0	305,514	0	93.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,973	561,074	1,945,487	82,370,503	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	1,538	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	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						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,706,591	944,044	1,693,891	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	544.257189	1.677966	0.870677	0.000000	0.000000	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1320 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/27/2022 8:00 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	
			13.00	14.00	15.00	16.00	17.00	
204.00		Cost to be allocated (per Wkst. B, Part II)	79,676	9,790	60,974	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	16.021717	0.017401	0.031341	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 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/27/2022 8:00 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,500,233		6,500,233	0	0	30.00
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	40.00
43.00	04300	NURSERY	0		0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,107,214		3,107,214	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,354,018		2,354,018	0	0	54.00
60.00	06000	LABORATORY	2,913,214		2,913,214	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	886,881	0	886,881	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,317,536	0	1,317,536	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	218,314	0	218,314	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	31,982	0	31,982	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,857		2,857	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	281,283		281,283	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	64,796		64,796	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,096,138		4,096,138	0	0	73.00
76.00	03160	CARDIOPULMONARY	494,188		494,188	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	2,094,082		2,094,082	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	2,193,962		2,193,962	0	0	90.02
90.03	09003	WOUND CLINIC	0		0	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0		0	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	1,159,380		1,159,380	0	0	90.05
90.06	09006	INFUSION CLINIC	339,865		339,865	0	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	936,323		936,323	0	0	90.07
91.00	09100	EMERGENCY	3,965,470		3,965,470	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,241,619		1,241,619		0	92.00
93.00	04950	OUTPATIENT PSYCH	239,335		239,335	0	0	93.00
200.00		Subtotal (see instructions)	34,438,690	0	34,438,690	0	0	200.00
201.00		Less Observation Beds	1,241,619		1,241,619		0	201.00
202.00		Total (see instructions)	33,197,071	0	33,197,071	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1320 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/27/2022 8:00 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,600,547		5,600,547			30.00
40.00	04000	SUBPROVIDER - IPF	0		0			40.00
43.00	04300	NURSERY	0		0			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	24,306	5,920,894	5,945,200	0.522642	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	720,478	12,564,873	13,285,351	0.177189	0.000000	54.00
60.00	06000	LABORATORY	954,939	7,302,723	8,257,662	0.352789	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,040,508	556,468	1,596,976	0.555350	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	487,960	1,019,305	1,507,265	0.874124	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	310,754	104,274	415,028	0.526022	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	15,293	12,407	27,700	1.154585	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	59,506	1,104,499	1,164,005	0.002454	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	34,068	199,890	233,958	1.202280	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,186	269,954	276,140	0.234649	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,148,681	9,391,230	13,539,911	0.302523	0.000000	73.00
76.00	03160	CARDIOPULMONARY	223,812	2,015,811	2,239,623	0.220657	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	397	1,087,271	1,087,668	1.925295	0.000000	90.01
90.02	09002	JAY FAMILY MEDICINE	0	976,958	976,958	2.245708	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	170,150	170,150	6.813870	0.000000	90.05
90.06	09006	INFUSION CLINIC	0	1,832,927	1,832,927	0.185422	0.000000	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	60,592	119,055	179,647	5.212016	0.000000	90.07
91.00	09100	EMERGENCY	866,872	19,767,322	20,634,194	0.192180	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	3,094,079	3,094,079	0.401289	0.000000	92.00
93.00	04950	OUTPATIENT PSYCH	0	305,514	305,514	0.783385	0.000000	93.00
200.00		Subtotal (see instructions)	14,554,899	67,815,604	82,370,503			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	14,554,899	67,815,604	82,370,503			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1320 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/27/2022 8:00 am

Title XVIII | Hospital | Cost

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

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1320 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/27/2022 8:00 am

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	6,500,233		6,500,233	0	6,500,233	30.00
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	40.00
43.00	04300	NURSERY	0		0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,107,214		3,107,214	0	3,107,214	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,354,018		2,354,018	0	2,354,018	54.00
60.00	06000	LABORATORY	2,913,214		2,913,214	0	2,913,214	60.00
65.00	06500	RESPIRATORY THERAPY	886,881	0	886,881	0	886,881	65.00
66.00	06600	PHYSICAL THERAPY	1,317,536	0	1,317,536	0	1,317,536	66.00
67.00	06700	OCCUPATIONAL THERAPY	218,314	0	218,314	0	218,314	67.00
68.00	06800	SPEECH PATHOLOGY	31,982	0	31,982	0	31,982	68.00
69.00	06900	ELECTROCARDIOLOGY	2,857		2,857	0	2,857	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	281,283		281,283	0	281,283	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	64,796		64,796	0	64,796	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,096,138		4,096,138	0	4,096,138	73.00
76.00	03160	CARDIOPULMONARY	494,188		494,188	0	494,188	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	2,094,082		2,094,082	0	2,094,082	90.01
90.02	09002	JAY FAMILY MEDICINE	2,193,962		2,193,962	0	2,193,962	90.02
90.03	09003	WOUND CLINIC	0		0	0	0	90.03
90.04	09004	OP ORTHO CLINIC	0		0	0	0	90.04
90.05	09005	JAY FAMILY FIRST HEALTH CARE	1,159,380		1,159,380	0	1,159,380	90.05
90.06	09006	INFUSION CLINIC	339,865		339,865	0	339,865	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	936,323		936,323	0	936,323	90.07
91.00	09100	EMERGENCY	3,965,470		3,965,470	0	3,965,470	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,241,619		1,241,619		1,241,619	92.00
93.00	04950	OUTPATIENT PSYCH	239,335		239,335	0	239,335	93.00
200.00		Subtotal (see instructions)	34,438,690	0	34,438,690	0	34,438,690	200.00
201.00		Less Observation Beds	1,241,619		1,241,619		1,241,619	201.00
202.00		Total (see instructions)	33,197,071	0	33,197,071	0	33,197,071	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1320 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/27/2022 8:00 am

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,600,547		5,600,547			30.00
40.00	04000	SUBPROVIDER - IPF	0		0			40.00
43.00	04300	NURSERY	0		0			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	24,306	5,920,894	5,945,200	0.522642	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	720,478	12,564,873	13,285,351	0.177189	0.000000	54.00
60.00	06000	LABORATORY	954,939	7,302,723	8,257,662	0.352789	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,040,508	556,468	1,596,976	0.555350	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	487,960	1,019,305	1,507,265	0.874124	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	310,754	104,274	415,028	0.526022	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	15,293	12,407	27,700	1.154585	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	59,506	1,104,499	1,164,005	0.002454	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	34,068	199,890	233,958	1.202280	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,186	269,954	276,140	0.234649	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,148,681	9,391,230	13,539,911	0.302523	0.000000	73.00
76.00	03160	CARDIOPULMONARY	223,812	2,015,811	2,239,623	0.220657	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	397	1,087,271	1,087,668	1.925295	0.000000	90.01
90.02	09002	JAY FAMILY MEDICINE	0	976,958	976,958	2.245708	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	170,150	170,150	6.813870	0.000000	90.05
90.06	09006	INFUSION CLINIC	0	1,832,927	1,832,927	0.185422	0.000000	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	60,592	119,055	179,647	5.212016	0.000000	90.07
91.00	09100	EMERGENCY	866,872	19,767,322	20,634,194	0.192180	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	3,094,079	3,094,079	0.401289	0.000000	92.00
93.00	04950	OUTPATIENT PSYCH	0	305,514	305,514	0.783385	0.000000	93.00
200.00		Subtotal (see instructions)	14,554,899	67,815,604	82,370,503			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	14,554,899	67,815,604	82,370,503			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1320 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/27/2022 8:00 am

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.522642		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.177189		54.00
60.00	06000	LABORATORY	0.352789		60.00
65.00	06500	RESPIRATORY THERAPY	0.555350		65.00
66.00	06600	PHYSICAL THERAPY	0.874124		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.526022		67.00
68.00	06800	SPEECH PATHOLOGY	1.154585		68.00
69.00	06900	ELECTROCARDIOLOGY	0.002454		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.202280		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.234649		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.302523		73.00
76.00	03160	CARDIOPULMONARY	0.220657		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1.925295		90.01
90.02	09002	JAY FAMILY MEDICINE	2.245708		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	6.813870		90.05
90.06	09006	INFUSION CLINIC	0.185422		90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	5.212016		90.07
91.00	09100	EMERGENCY	0.192180		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.401289		92.00
93.00	04950	OUTPATIENT PSYCH	0.783385		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 01/01/2021 To 12/31/2021 | Worksheet C Part II Date/Time Prepared: 5/27/2022 8:00 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,107,214	267,295	2,839,919	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	2,354,018	232,565	2,121,453	0	0	54.00
60.00	06000	LABORATORY	2,913,214	141,257	2,771,957	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	886,881	41,193	845,688	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,317,536	146,604	1,170,932	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	218,314	26,754	191,560	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	31,982	1,207	30,775	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,857	30	2,827	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	281,283	2,917	278,366	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	64,796	672	64,124	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,096,138	84,158	4,011,980	0	0	73.00
76.00	03160	CARDIOPULMONARY	494,188	19,983	474,205	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	2,094,082	112,165	1,981,917	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	2,193,962	113,034	2,080,928	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	1,159,380	175,213	984,167	0	0	90.05
90.06	09006	INFUSION CLINIC	339,865	30,607	309,258	0	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	936,323	141,787	794,536	0	0	90.07
91.00	09100	EMERGENCY	3,965,470	255,651	3,709,819	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,241,619	118,022	1,123,597	0	0	92.00
93.00	04950	OUTPATIENT PSYCH	239,335	67,096	172,239	0	0	93.00
200.00		Subtotal (sum of lines 50 thru 199)	27,938,457	1,978,210	25,960,247	0	0	200.00
201.00		Less Observation Beds	1,241,619	118,022	1,123,597	0	0	201.00
202.00		Total (line 200 minus line 201)	26,696,838	1,860,188	24,836,650	0	0	202.00

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

Provider CCN: 15-1320 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part II | Date/Time Prepared: 5/27/2022 8:00 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	3,107,214	5,945,200	0.522642		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,354,018	13,285,351	0.177189		54.00
60.00	06000	LABORATORY	2,913,214	8,257,662	0.352789		60.00
65.00	06500	RESPIRATORY THERAPY	886,881	1,596,976	0.555350		65.00
66.00	06600	PHYSICAL THERAPY	1,317,536	1,507,265	0.874124		66.00
67.00	06700	OCCUPATIONAL THERAPY	218,314	415,028	0.526022		67.00
68.00	06800	SPEECH PATHOLOGY	31,982	27,700	1.154585		68.00
69.00	06900	ELECTROCARDIOLOGY	2,857	1,164,005	0.002454		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	281,283	233,958	1.202280		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	64,796	276,140	0.234649		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,096,138	13,539,911	0.302523		73.00
76.00	03160	CARDIOPULMONARY	494,188	2,239,623	0.220657		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0.000000		90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	2,094,082	1,087,668	1.925295		90.01
90.02	09002	JAY FAMILY MEDICINE	2,193,962	976,958	2.245708		90.02
90.03	09003	WOUND CLINIC	0	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	1,159,380	170,150	6.813870		90.05
90.06	09006	INFUSION CLINIC	339,865	1,832,927	0.185422		90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	936,323	179,647	5.212016		90.07
91.00	09100	EMERGENCY	3,965,470	20,634,194	0.192180		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,241,619	3,094,079	0.401289		92.00
93.00	04950	OUTPATIENT PSYCH	239,335	305,514	0.783385		93.00
200.00		Subtotal (sum of lines 50 thru 199)	27,938,457	76,769,956			200.00
201.00		Less Observation Beds	1,241,619	0			201.00
202.00		Total (line 200 minus line 201)	26,696,838	76,769,956			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1320 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part II Date/Time Prepared: 5/27/2022 8:00 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	267,295	5,945,200	0.044960	24,306	1,093	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	232,565	13,285,351	0.017505	212,499	3,720	54.00
60.00	06000	LABORATORY	141,257	8,257,662	0.017106	262,531	4,491	60.00
65.00	06500	RESPIRATORY THERAPY	41,193	1,596,976	0.025794	276,792	7,140	65.00
66.00	06600	PHYSICAL THERAPY	146,604	1,507,265	0.097265	64,207	6,245	66.00
67.00	06700	OCCUPATIONAL THERAPY	26,754	415,028	0.064463	32,084	2,068	67.00
68.00	06800	SPEECH PATHOLOGY	1,207	27,700	0.043574	6,068	264	68.00
69.00	06900	ELECTROCARDIOLOGY	30	1,164,005	0.000026	12,371	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,917	233,958	0.012468	9,150	114	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	672	276,140	0.002434	6,186	15	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	84,158	13,539,911	0.006216	984,513	6,120	73.00
76.00	03160	CARDIOPULMONARY	19,983	2,239,623	0.008922	66,208	591	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	112,165	1,087,668	0.103124	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	113,034	976,958	0.115700	0	0	90.02
90.03	09003	WOUND CLINIC	0	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	175,213	170,150	1.029756	0	0	90.05
90.06	09006	INFUSION CLINIC	30,607	1,832,927	0.016698	0	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	141,787	179,647	0.789253	0	0	90.07
91.00	09100	EMERGENCY	255,651	20,634,194	0.012390	34,448	427	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	118,022	3,094,079	0.038144	0	0	92.00
93.00	04950	OUTPATIENT PSYCH	67,096	305,514	0.219617	0	0	93.00
200.00		Total (lines 50 through 199)	1,978,210	76,769,956		1,991,363	32,288	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1320 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV Date/Time Prepared: 5/27/2022 8:00 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	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 01/01/2021 To 12/31/2021 | Worksheet D Part IV Date/Time Prepared: 5/27/2022 8:00 am

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	5,945,200	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	13,285,351	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	8,257,662	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,596,976	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,507,265	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	415,028	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	27,700	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,164,005	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	233,958	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	276,140	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	13,539,911	0.000000	73.00
76.00	03160	CARDIOPULMONARY	0	0	0	2,239,623	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	1,087,668	0.000000	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	0	976,958	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	170,150	0.000000	90.05
90.06	09006	INFUSION CLINIC	0	0	0	1,832,927	0.000000	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	0	0	179,647	0.000000	90.07
91.00	09100	EMERGENCY	0	0	0	20,634,194	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,094,079	0.000000	92.00
93.00	04950	OUTPATIENT PSYCH	0	0	0	305,514	0.000000	93.00
200.00		Total (lines 50 through 199)	0	0	0	76,769,956		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1320 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV Date/Time Prepared: 5/27/2022 8:00 am

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	24,306	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	212,499	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	262,531	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	276,792	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	64,207	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	32,084	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	6,068	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	12,371	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	9,150	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	6,186	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	984,513	0	0	0	73.00
76.00	03160	CARDIOPULMONARY	0.000000	66,208	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	34,448	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)		1,991,363	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1320 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part V Date/Time Prepared: 5/27/2022 8:00 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.522642	0	1,095,012	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	0.177189	0	2,561,904	0	0	54.00
60.00	06000	LABORATORY	0.352789	0	1,551,431	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.555350	0	110,007	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.874124	0	293,711	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.526022	0	29,196	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.154585	0	484	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.002454	0	228,836	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.202280	0	24,369	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.234649	0	40,591	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.302523	0	1,681,290	95,481	0	73.00
76.00	03160	CARDIOPULMONARY	0.220657	0	642,076	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1.925295	0	269,077	52,265	0	90.01
90.02	09002	JAY FAMILY MEDICINE	2.245708	0	403,485	95,465	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	6.813870	0	56,190	15,043	0	90.05
90.06	09006	INFUSION CLINIC	0.185422	0	742,574	359	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	5.212016	0	18,593	0	0	90.07
91.00	09100	EMERGENCY	0.192180	0	3,421,011	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.401289	0	730,811	898	0	92.00
93.00	04950	OUTPATIENT PSYCH	0.783385	0	32,707	0	0	93.00
200.00		Subtotal (see instructions)		0	13,933,355	259,511	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	13,933,355	259,511	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1320 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part V Date/Time Prepared: 5/27/2022 8:00 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	572,299	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	453,941	0		54.00
60.00	06000	LABORATORY	547,328	0		60.00
65.00	06500	RESPIRATORY THERAPY	61,092	0		65.00
66.00	06600	PHYSICAL THERAPY	256,740	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	15,358	0		67.00
68.00	06800	SPEECH PATHOLOGY	559	0		68.00
69.00	06900	ELECTROCARDIOLOGY	562	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	29,298	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,525	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	508,629	28,885		73.00
76.00	03160	CARDIOPULMONARY	141,679	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	518,053	100,626		90.01
90.02	09002	JAY FAMILY MEDICINE	906,109	214,387		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	382,871	102,501		90.05
90.06	09006	INFUSION CLINIC	137,690	67		90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	96,907	0		90.07
91.00	09100	EMERGENCY	657,450	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	293,266	360		92.00
93.00	04950	OUTPATIENT PSYCH	25,622	0		93.00
200.00		Subtotal (see instructions)	5,614,978	446,826		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	5,614,978	446,826		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-1320 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part I Date/Time Prepared: 5/27/2022 8:00 am

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	617,878	130,682	487,196	2,386	204.19	30.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00
43.00	NURSERY	0		0	0	0.00	43.00
200.00	Total (lines 30 through 199)	617,878		487,196	2,386		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	40	8,168	30.00
40.00	SUBPROVIDER - IPF	0	0	40.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30 through 199)	40	8,168	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1320 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part II Date/Time Prepared: 5/27/2022 8:00 am

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	267,295	5,945,200	0.044960	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	232,565	13,285,351	0.017505	11,253	197	54.00
60.00	06000	LABORATORY	141,257	8,257,662	0.017106	19,425	332	60.00
65.00	06500	RESPIRATORY THERAPY	41,193	1,596,976	0.025794	4,212	109	65.00
66.00	06600	PHYSICAL THERAPY	146,604	1,507,265	0.097265	5,801	564	66.00
67.00	06700	OCCUPATIONAL THERAPY	26,754	415,028	0.064463	5,667	365	67.00
68.00	06800	SPEECH PATHOLOGY	1,207	27,700	0.043574	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	30	1,164,005	0.000026	1,652	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,917	233,958	0.012468	6,202	77	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	672	276,140	0.002434	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	84,158	13,539,911	0.006216	36,433	226	73.00
76.00	03160	CARDIOPULMONARY	19,983	2,239,623	0.008922	3,842	34	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	112,165	1,087,668	0.103124	384	40	90.01
90.02	09002	JAY FAMILY MEDICINE	113,034	976,958	0.115700	0	0	90.02
90.03	09003	WOUND CLINIC	0	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	175,213	170,150	1.029756	0	0	90.05
90.06	09006	INFUSION CLINIC	30,607	1,832,927	0.016698	0	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	141,787	179,647	0.789253	0	0	90.07
91.00	09100	EMERGENCY	255,651	20,634,194	0.012390	30,560	379	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	118,022	3,094,079	0.038144	0	0	92.00
93.00	04950	OUTPATIENT PSYCH	67,096	305,514	0.219617	0	0	93.00
200.00		Total (lines 50 through 199)	1,978,210	76,769,956		125,431	2,323	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1320 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part III Date/Time Prepared: 5/27/2022 8:00 am

Title XIX | Hospital | PPS

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

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	2,386	0.00	40	30.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0.00	0	40.00
43.00	04300	NURSERY		0	0	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	2,386		40	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 01/01/2021 To 12/31/2021 | Worksheet D Part IV Date/Time Prepared: 5/27/2022 8:00 am

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	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 01/01/2021 To 12/31/2021 | Worksheet D Part IV Date/Time Prepared: 5/27/2022 8:00 am

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	5,945,200	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	13,285,351	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	8,257,662	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,596,976	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,507,265	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	415,028	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	27,700	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,164,005	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	233,958	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	276,140	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	13,539,911	0.000000	73.00
76.00	03160	CARDIOPULMONARY	0	0	0	2,239,623	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	1,087,668	0.000000	90.01
90.02	09002	JAY FAMILY MEDICINE	0	0	0	976,958	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	170,150	0.000000	90.05
90.06	09006	INFUSION CLINIC	0	0	0	1,832,927	0.000000	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	0	0	0	179,647	0.000000	90.07
91.00	09100	EMERGENCY	0	0	0	20,634,194	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,094,079	0.000000	92.00
93.00	04950	OUTPATIENT PSYCH	0	0	0	305,514	0.000000	93.00
200.00		Total (lines 50 through 199)	0	0	0	76,769,956		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1320 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV Date/Time Prepared: 5/27/2022 8:00 am

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	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	11,253	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	19,425	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	4,212	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	5,801	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	5,667	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	1,652	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	6,202	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	36,433	0	0	0	73.00
76.00	03160	CARDIOPULMONARY	0.000000	3,842	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	384	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	30,560	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)		125,431	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1320 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/27/2022 8:00 am

Title XVIII | Hospital

	Cost Center Description	Cost	
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,589	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,386	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)	1,808	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	640	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	562	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)	652	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)	640	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	6,500,233	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)	1,374,803	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,125,430	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)	5,125,430	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)	2,148.13	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,400,581	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)	1,400,581	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1320 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/27/2022 8:00 am

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	708,247	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,108,828	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)	1,374,803	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)	1,374,803	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)	578	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,148.13	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,241,619	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1320 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/27/2022 8:00 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	617,878	6,500,233	0.095055	1,241,619	118,022	90.00
91.00	Nursing Program cost	0	6,500,233	0.000000	1,241,619	0	91.00
92.00	Allied health cost	0	6,500,233	0.000000	1,241,619	0	92.00
93.00	All other Medical Education	0	6,500,233	0.000000	1,241,619	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1320 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/27/2022 8:00 am

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,589	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,386	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)	1,808	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	640	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	563	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)	40	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	6,500,233	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)	1,374,803	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,125,430	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)	5,125,430	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)	2,148.13	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	85,925	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)	85,925	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1320 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/27/2022 8:00 am

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	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)	45,181	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	131,106	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)	8,168	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	2,323	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	10,491	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	120,615	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)	578	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,148.13	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,241,619	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1320 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/27/2022 8:00 am

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	617,878	6,500,233	0.095055	1,241,619	118,022	90.00
91.00	Nursing Program cost	0	6,500,233	0.000000	1,241,619	0	91.00
92.00	Allied health cost	0	6,500,233	0.000000	1,241,619	0	92.00
93.00	All other Medical Education	0	6,500,233	0.000000	1,241,619	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1320 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-3 | Date/Time Prepared: 5/27/2022 8:00 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,512,442		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	0.522642	24,306	12,703	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.177189	212,499	37,652	54.00
60.00	06000	LABORATORY	0.352789	262,531	92,618	60.00
65.00	06500	RESPIRATORY THERAPY	0.555350	276,792	153,716	65.00
66.00	06600	PHYSICAL THERAPY	0.874124	64,207	56,125	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.526022	32,084	16,877	67.00
68.00	06800	SPEECH PATHOLOGY	1.154585	6,068	7,006	68.00
69.00	06900	ELECTROCARDIOLOGY	0.002454	12,371	30	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.202280	9,150	11,001	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.234649	6,186	1,452	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.302523	984,513	297,838	73.00
76.00	03160	CARDIOPULMONARY	0.220657	66,208	14,609	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1.925295	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	2.245708	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	6.813870	0	0	90.05
90.06	09006	INFUSION CLINIC	0.185422	0	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	5.212016	0	0	90.07
91.00	09100	EMERGENCY	0.192180	34,448	6,620	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.401289	0	0	92.00
93.00	04950	OUTPATIENT PSYCH	0.783385	0	0	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,991,363	708,247	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)		1,991,363		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1320 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-3

Component CCN: 15-Z320 | Date/Time Prepared: 5/27/2022 8:00 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
40.00	04000	SUBPROVIDER - IPF				40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.522642	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.177189	48,825	8,651	54.00
60.00	06000	LABORATORY	0.352789	63,741	22,487	60.00
65.00	06500	RESPIRATORY THERAPY	0.555350	105,928	58,827	65.00
66.00	06600	PHYSICAL THERAPY	0.874124	191,406	167,313	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.526022	123,681	65,059	67.00
68.00	06800	SPEECH PATHOLOGY	1.154585	2,522	2,912	68.00
69.00	06900	ELECTROCARDIOLOGY	0.002454	2,832	7	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.202280	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.234649	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.302523	300,356	90,865	73.00
76.00	03160	CARDIOPULMONARY	0.220657	5,766	1,272	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1.925295	0	0	90.01
90.02	09002	JAY FAMILY MEDICINE	2.245708	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	6.813870	0	0	90.05
90.06	09006	INFUSION CLINIC	0.185422	0	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	5.212016	0	0	90.07
91.00	09100	EMERGENCY	0.192180	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.401289	0	0	92.00
93.00	04950	OUTPATIENT PSYCH	0.783385	0	0	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		845,057	417,393	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)		845,057		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1320 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-3 | Date/Time Prepared: 5/27/2022 8:00 am

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		95,151		30.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.522642	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.177189	11,253	1,994	54.00
60.00	06000	LABORATORY	0.352789	19,425	6,853	60.00
65.00	06500	RESPIRATORY THERAPY	0.555350	4,212	2,339	65.00
66.00	06600	PHYSICAL THERAPY	0.874124	5,801	5,071	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.526022	5,667	2,981	67.00
68.00	06800	SPEECH PATHOLOGY	1.154585	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.002454	1,652	4	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.202280	6,202	7,457	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.234649	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.302523	36,433	11,022	73.00
76.00	03160	CARDIOPULMONARY	0.220657	3,842	848	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	FAMILY PRACTICE OF JAY COUNTY	1.925295	384	739	90.01
90.02	09002	JAY FAMILY MEDICINE	2.245708	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	6.813870	0	0	90.05
90.06	09006	INFUSION CLINIC	0.185422	0	0	90.06
90.07	09007	HEALTH BEGINNINGS PROGRAM	5.212016	0	0	90.07
91.00	09100	EMERGENCY	0.192180	30,560	5,873	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.401289	0	0	92.00
93.00	04950	OUTPATIENT PSYCH	0.783385	0	0	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		125,431	45,181	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)		125,431		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1320 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E Part B Date/Time Prepared: 5/27/2022 8:00 am

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,061,804	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)	6,061,804	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)	6,122,422	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)	101,034	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	2,307,545	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	3,713,843	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	3,713,843	30.00
31.00	Primary payer payments	1,208	31.00
32.00	Subtotal (line 30 minus line 31)	3,712,635	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)	482,689	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	313,748	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	296,838	36.00
37.00	Subtotal (see instructions)	4,026,383	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)	4,026,383	40.00
40.01	Sequestration adjustment (see instructions)	0	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	4,467,527	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)	-441,144	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	491,563	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 01/01/2021 To 12/31/2021 | Worksheet E-1 Part I Date/Time Prepared: 5/27/2022 8:00 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,922,524		3,121,827	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	11/16/2021	541,500	11/16/2021	1,345,700	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)		541,500		1,345,700	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,464,024		4,467,527	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		534,505		441,144	6.02
7.00	Total Medicare program liability (see instructions)		1,929,519		4,026,383	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 01/01/2021 To 12/31/2021 | Worksheet E-1 Part I | Date/Time Prepared: 5/27/2022 8:00 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,745,841		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	11/16/2021	425,700		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)		425,700		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,171,541		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		374,578		0	6.02
7.00	Total Medicare program liability (see instructions)		1,796,963		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 01/01/2021 To 12/31/2021	Worksheet E-1 Part II Date/Time Prepared: 5/27/2022 8:00 am
	Title XVIII	Hospital	Cost

			1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS			
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION			
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)			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 01/01/2021 To 12/31/2021 | Worksheet E-2 | Date/Time Prepared: 5/27/2022 8:00 am

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,388,551	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)	421,567	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	640	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)	1,810,118	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,810,118	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)	1,810,118	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	13,727	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	1,796,391	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)	880	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	572	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	880	0	18.00
19.00	Total (see instructions)	1,796,963	0	19.00
19.01	Sequestration adjustment (see instructions)	0	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	2,171,541	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, 19.02, 19.25, 20, and 21)	-374,578	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	140,814	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 01/01/2021 To 12/31/2021	Worksheet E-3 Part V Date/Time Prepared: 5/27/2022 8:00 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	2,108,828	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)	2,108,828	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,129,916	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)	2,129,916	19.00
20.00	Deductibles (exclude professional component)	215,104	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,914,812	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,914,812	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	22,626	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	14,707	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	7,420	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,929,519	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.98	Recovery of accelerated depreciation.	0	29.98
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	1,929,519	30.00
30.01	Sequestration adjustment (see instructions)	0	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	2,464,024	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)	-534,505	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	166,555	34.00

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 01/01/2021 To 12/31/2021 | Worksheet G | Date/Time Prepared: 5/27/2022 8:00 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	-3,250,998	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	5,227,469	0	0	0	4.00
5.00	Other receivable	500,564	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	638,564	0	0	0	7.00
8.00	Prepaid expenses	154,898	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)	3,270,497	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	-4,883,151	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	-18,439	0	0	0	22.00
23.00	Major movable equipment	9,816,480	0	0	0	23.00
24.00	Accumulated depreciation	-5,984,935	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)	18,939,101	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	1,905,223	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,905,223	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	24,114,821	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,967,942	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,050,039	0	0	0	38.00
39.00	Payroll taxes payable	60,278	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	1,109,535				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	9,187,336	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	13,375,130	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)	13,375,130	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	10,739,691				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)	10,739,691	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	24,114,821	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1320 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G-1 | Date/Time Prepared: 5/27/2022 8:00 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		11,377,869		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-638,178				2.00
3.00	Total (sum of line 1 and line 2)		10,739,691		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)		10,739,691		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)		10,739,691		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 01/01/2021 To 12/31/2021 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/27/2022 8:00 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	4,511,424		4,511,424	1.00
2.00	SUBPROVIDER - IPF	0		0	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	1,084,297		1,084,297	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)	5,595,721		5,595,721	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)	5,595,721		5,595,721	17.00
18.00	Ancillary services	8,026,491	40,462,328	48,488,819	18.00
19.00	Outpatient services	932,469	27,353,494	28,285,963	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)	14,554,681	67,815,822	82,370,503	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		39,701,916		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)		39,701,916		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-1320	Period: From 01/01/2021 To 12/31/2021	Worksheet G-3 Date/Time Prepared: 5/27/2022 8:00 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	82,370,503	1.00
2.00	Less contractual allowances and discounts on patients' accounts	43,665,767	2.00
3.00	Net patient revenues (line 1 minus line 2)	38,704,736	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	39,701,916	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-997,180	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	-1,148,087	24.00
24.50	COVID-19 PHE Funding	1,507,089	24.50
25.00	Total other income (sum of lines 6-24)	359,002	25.00
26.00	Total (line 5 plus line 25)	-638,178	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)	-638,178	29.00