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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-3028	Period: From 01/01/2016 To 12/31/2016	Worksheet S Parts I-III Date/Time Prepared: 5/25/2017 11:36 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/25/2017 Time: 11:36 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by REHABILITATION HOSPITAL OF INDIANA (15-3028) for the cost reporting period beginning 01/01/2016 and ending 12/31/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed) _____
Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER
Title

05/25/2017
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	168,328	34,037	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	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	168,328	34,037	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/23/2017 1:15 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 4141 SHORE DRIVE	PO Box:			1.00
2.00	City: INDIANAPOLIS	State: IN	Zip Code: 46254	County: MARION	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	REHABILITATION HOSPITAL OF INDIANA	153028	26900	5	01/07/1992	N	P	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									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
17.10	Hospital-Based (CORF) I									17.10
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2016	12/31/2016	20.00
21.00	Type of Control (see instructions)	4		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	474	482	0	0	3,460		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/23/2017 1:15 pm

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		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.	1		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)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	Y			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.	N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/23/2017 1:15 pm

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/23/2017 1:15 pm

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

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			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.	Y			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	Y	N	0	76.00

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I | Date/Time Prepared: 5/23/2017 1:15 pm

		V	XIX	
		1.00	2.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a critical access hospital (CAH)?	N		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)			106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

		1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo)for the current cost reporting period? Enter "Y" for yes or "N" for no.	N	110.00

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	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.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	72,163	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		121.00
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/23/2017 1:15 pm

		1.00	2.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	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: IU HEALTH	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 340 W 10TH STREET	PO Box:		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46202	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	N	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.	Y		145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

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

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00
161.10	CORF		N	N	N	161.10

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-3028	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Prepared: 5/23/2017 1:15 pm

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part II | Date/Time Prepared: 5/23/2017 1:15 pm

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	04/17/2017	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	04/03/2017	Y	04/03/2017	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part II Date/Time Prepared: 5/23/2017 1:15 pm

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

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	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.	N	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.		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.	IU 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: 15-3028	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part II Date/Time Prepared: 5/23/2017 1:15 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I Date/Time Prepared: 5/23/2017 1:15 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	91	33,306	0.00	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)		91	33,306	0.00	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						13.00
14.00	Total (see instructions)		91	33,306	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						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	99.00				0	25.00
25.10	CMHC - CORF	99.10				0	25.10
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)		91				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I | Date/Time Prepared: 5/23/2017 1:15 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	6,597	474	19,719			1.00
2.00	HMO and other (see instructions)	1,644	3,942				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	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	6,597	474	19,719			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)	6,597	474	19,719	0.00	291.15	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						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)	0	0	0			24.10
25.00	CMHC - CMHC	0	0	0	0.00	0.00	25.00
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
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	291.15	27.00
28.00	Observation Bed Days		0	0			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I Date/Time Prepared: 5/23/2017 1:15 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	466	26	1,298	1.00
2.00	HMO and other (see instructions)			114	243		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	466	26	1,298	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						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	0.00					25.00
25.10	CMHC - CORF	0.00					25.10
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						33.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A | Date/Time Prepared: 5/23/2017 1:15 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		977,586	977,586	0	977,586	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,176,632	1,176,632	0	1,176,632	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	162,702	5,509,169	5,671,871	-9,807	5,662,064	4.00
5.01	00591	ADMINISTRATIVE AND GENERAL	2,731,238	2,396,303	5,127,541	-167,892	4,959,649	5.01
5.02	00590	OTHER A&G - NON FOUNDATION	667,406	246,239	913,645	172	913,817	5.02
7.00	00700	OPERATION OF PLANT	277,493	1,183,443	1,460,936	-472	1,460,464	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	99,479	99,479	0	99,479	8.00
9.00	00900	HOUSEKEEPING	281,144	193,599	474,743	-561	474,182	9.00
10.00	01000	DIETARY	60,845	993,063	1,053,908	-339,365	714,543	10.00
11.00	01100	CAFETERIA	0	0	0	339,200	339,200	11.00
13.00	01300	NURSING ADMINISTRATION	1,133,562	263,129	1,396,691	148,210	1,544,901	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	51,906	27,758	79,664	362,526	442,190	14.00
15.00	01500	PHARMACY	453,596	135,146	588,742	5,195	593,937	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	286,530	109,105	395,635	-71	395,564	16.00
17.00	01700	SOCIAL SERVICE	276,241	31,807	308,048	0	308,048	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	234,406	234,406	0	234,406	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,452,345	1,480,980	7,933,325	-336,676	7,596,649	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	70,187	17,840	88,027	-3,352	84,675	54.00
60.00	06000	LABORATORY	0	430,629	430,629	-592	430,037	60.00
65.00	06500	RESPIRATORY THERAPY	304,969	186,480	491,449	-102,186	389,263	65.00
66.00	06600	PHYSICAL THERAPY	1,622,949	345,887	1,968,836	210,663	2,179,499	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	261,619	115,222	376,841	-4,215	372,626	66.01
67.00	06700	OCCUPATIONAL THERAPY	1,263,707	145,578	1,409,285	303,647	1,712,932	67.00
68.00	06800	SPEECH PATHOLOGY	596,814	86,704	683,518	189,646	873,164	68.00
68.01	06801	VISION	154,354	14,360	168,714	-1,286	167,428	68.01
68.02	06802	FAC RESOURCE	955,544	264,977	1,220,521	-13,703	1,206,818	68.02
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	172,078	172,078	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,526,939	1,526,939	0	1,526,939	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	528,391	108,502	636,893	-16,679	620,214	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	150,032	43,886	193,918	-15,784	178,134	90.00
90.01	09001	SLEEP CENTER	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	488,188	230,508	718,696	-718,696	0	99.10
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	19,231,762	18,575,356	37,807,118	0	37,807,118	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	583,659	583,659	0	583,659	192.00
194.00	07950	FOUNDATION	95,369	18,078	113,447	0	113,447	194.00
194.01	07951	PUBLIC RELATIONS	155,370	335,695	491,065	0	491,065	194.01
194.02	07952	ST. VINCENT - ARU	166,071	153,524	319,595	0	319,595	194.02
194.03	07953	MUNCIE - ARU	100,044	19,756	119,800	0	119,800	194.03
194.04	07954	RILEY - ARU	125,123	11,429	136,552	0	136,552	194.04
200.00		TOTAL (SUM OF LINES 118-199)	19,873,739	19,697,497	39,571,236	0	39,571,236	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A | Date/Time Prepared: 5/23/2017 1:15 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-104,392	873,194		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	75,948	1,252,580		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-40,240	5,621,824		4.00
5.01	00591	ADMINISTRATIVE AND GENERAL	2,314,019	7,273,668		5.01
5.02	00590	OTHER A&G - NON FOUNDATION	-53,760	860,057		5.02
7.00	00700	OPERATION OF PLANT	-44,041	1,416,423		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	99,479		8.00
9.00	00900	HOUSEKEEPING	-2	474,180		9.00
10.00	01000	DIETARY	0	714,543		10.00
11.00	01100	CAFETERIA	-131,066	208,134		11.00
13.00	01300	NURSING ADMINISTRATION	0	1,544,901		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-2,518	439,672		14.00
15.00	01500	PHARMACY	-10,056	583,881		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	395,564		16.00
17.00	01700	SOCIAL SERVICE	0	308,048		17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	234,406		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	7,596,649		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	84,675		54.00
60.00	06000	LABORATORY	-80,160	349,877		60.00
65.00	06500	RESPIRATORY THERAPY	0	389,263		65.00
66.00	06600	PHYSICAL THERAPY	0	2,179,499		66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	-132	372,494		66.01
67.00	06700	OCCUPATIONAL THERAPY	0	1,712,932		67.00
68.00	06800	SPEECH PATHOLOGY	0	873,164		68.00
68.01	06801	VISION	-3,420	164,008		68.01
68.02	06802	FAC RESOURCE	-2,770	1,204,048		68.02
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	172,078		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,526,939		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	-32,698	587,516		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	178,134		90.00
90.01	09001	SLEEP CENTER	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
99.00	09900	CMHC	0	0		99.00
99.10	09910	CORF	0	0		99.10
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,884,712	39,691,830		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	583,659		192.00
194.00	07950	FOUNDATION	696,322	809,769		194.00
194.01	07951	PUBLIC RELATIONS	0	491,065		194.01
194.02	07952	ST. VINCENT - ARU	0	319,595		194.02
194.03	07953	MUNCIE - ARU	0	119,800		194.03
194.04	07954	RILEY - ARU	0	136,552		194.04
200.00		TOTAL (SUM OF LINES 118-199)	2,581,034	42,152,270		200.00

RECLASSIFICATIONS | Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-6 | Date/Time Prepared: 5/23/2017 1:15 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA				
1.00	CAFETERIA	11.00	19,586	319,614	1.00
	0		19,586	319,614	
	B - NURSING ADMINISTRATION				
1.00	NURSING ADMINISTRATION	13.00	164,290	0	1.00
	0		164,290	0	
	C - NCR (CORF)				
1.00	PHYSICAL THERAPY	66.00	148,097	69,279	1.00
2.00	OCCUPATIONAL THERAPY	67.00	209,698	98,098	2.00
3.00	SPEECH PATHOLOGY	68.00	130,393	60,997	3.00
	0		488,188	228,374	
	D - MEDICAL SUPPLIES				
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	362,526	1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	172,078	2.00
3.00	OTHER A&G - NON FOUNDATION	5.02	0	172	3.00
4.00	PHARMACY	15.00	0	5,195	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
	0		0	539,971	
500.00	Grand Total: Increases		672,064	1,087,959	500.00

RECLASSIFICATIONS | Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-6 | Date/Time Prepared: 5/23/2017 1:15 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA						
1.00	DIETARY	10.00	19,586	319,614	0		1.00
	0		19,586	319,614			
	B - NURSING ADMINISTRATION						
1.00	ADMINISTRATIVE AND GENERAL	5.01	164,290	0	0		1.00
	0		164,290	0			
	C - NCR (CORF)						
1.00	CORF	99.10	488,188	228,374	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	0		488,188	228,374			
	D - MEDICAL SUPPLIES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	9,807	0		1.00
2.00	ADMINISTRATIVE AND GENERAL	5.01	0	3,602	0		2.00
3.00	OPERATION OF PLANT	7.00	0	472	0		3.00
4.00	HOUSEKEEPING	9.00	0	561	0		4.00
5.00	DIETARY	10.00	0	165	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	16,080	0		6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	71	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	336,676	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,352	0		9.00
10.00	LABORATORY	60.00	0	592	0		10.00
11.00	RESPIRATORY THERAPY	65.00	0	102,186	0		11.00
12.00	PHYSICAL THERAPY	66.00	0	6,713	0		12.00
13.00	PHYSICAL THERAPY - CARMEL	66.01	0	4,215	0		13.00
14.00	OCCUPATIONAL THERAPY	67.00	0	4,149	0		14.00
15.00	SPEECH PATHOLOGY	68.00	0	1,744	0		15.00
16.00	VISION	68.01	0	1,286	0		16.00
17.00	FAC RESOURCE	68.02	0	13,703	0		17.00
18.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00	0	16,679	0		18.00
19.00	CLINIC	90.00	0	15,784	0		19.00
20.00	CORF	99.10	0	2,134	0		20.00
	0		0	539,971			
500.00	Grand Total: Decreases		672,064	1,087,959			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part I | Date/Time Prepared: 5/23/2017 1:15 pm

		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	2,506,638	0	0	0	0	1.00
2.00	Land Improvements	306,681	16,098	0	16,098	0	2.00
3.00	Buildings and Fixtures	15,000,854	161,168	0	161,168	0	3.00
4.00	Building Improvements	95,017	0	0	0	0	4.00
5.00	Fixed Equipment	2,046,848	0	0	0	0	5.00
6.00	Movable Equipment	12,205,641	657,013	0	657,013	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	32,161,679	834,279	0	834,279	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	32,161,679	834,279	0	834,279	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	2,506,638	0	1.00
2.00	Land Improvements	322,779	0	2.00
3.00	Buildings and Fixtures	15,162,022	0	3.00
4.00	Building Improvements	95,017	0	4.00
5.00	Fixed Equipment	2,046,848	0	5.00
6.00	Movable Equipment	12,862,654	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	32,995,958	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	32,995,958	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part II | Date/Time Prepared: 5/23/2017 1:15 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	605,376	0	342,600	29,610	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	958,839	0	0	3,888	0	2.00
3.00	Total (sum of lines 1-2)	1,564,215	0	342,600	33,498	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	977,586	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	213,905	1,176,632	2.00
3.00	Total (sum of lines 1-2)	213,905	2,154,218	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part III Date/Time Prepared: 5/23/2017 1:15 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	32,995,958	0	32,995,958	1.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	32,995,958	0	32,995,958	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	745,098	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,034,787	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,779,885	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	310,027	29,610	0	-211,541	873,194	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,888	0	213,905	1,252,580	2.00
3.00	Total (sum of lines 1-2)	310,027	33,498	0	2,364	2,125,774	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8 | Date/Time Prepared: 5/23/2017 1:15 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-32,573	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-14,116	OPERATION OF PLANT	7.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-23,764	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	0			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	2,467,098			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-131,066	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	B	-2,518	CENTRAL SERVICES & SUPPLY	14.00	0	16.00
17.00	Sale of drugs to other than patients	B	-10,056	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
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	MISCELLANEOUS REVENUE	B	-989	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
33.01	MISCELLANEOUS REVENUE	B	-17,119	ADMINISTRATIVE AND GENERAL	5.01	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8 | Date/Time Prepared: 5/23/2017 1:15 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.02	MISCELLANEOUS REVENUE	B	-53,760	OTHER A&G - NON FOUNDATION	5.02	0	33.02
33.03	MISCELLANEOUS REVENUE	B	-5,910	OPERATION OF PLANT	7.00	0	33.03
33.04	MISCELLANEOUS REVENUE	B	-2	HOUSEKEEPING	9.00	0	33.04
33.05	MISCELLANEOUS REVENUE	B	-132	PHYSICAL THERAPY - CARMEL	66.01	0	33.05
33.06	MISCELLANEOUS REVENUE	B	-3,420	VISION	68.01	0	33.06
33.07	MISCELLANEOUS REVENUE	B	-2,720	FAC RESOURCE	68.02	0	33.07
33.08	MISCELLANEOUS REVENUE	B	-32,698	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00	0	33.08
33.09	RHI FOUNDATION	A	696,322	FOUNDATION	194.00	0	33.09
33.10	DONATIONS	A	-450	ADMINISTRATIVE AND GENERAL	5.01	0	33.10
33.11	ADVERTISING	A	-39,251	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.11
33.12	ADVERTISING	A	-50	FAC RESOURCE	68.02	0	33.12
33.13	TAXES	A	-251	OPERATION OF PLANT	7.00	0	33.13
33.14	BOND ISSUANCE COST OFFSET	A	-213,905	CAP REL COSTS-BLDG & FIXT	1.00	14	33.14
33.15	BOND ISSUANCE COST AMORTIZATION CARR	A	2,364	CAP REL COSTS-BLDG & FIXT	1.00	14	33.15
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		2,581,034				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: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8-1 | Date/Time Prepared: 5/23/2017 1:15 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	ALLOCATION FROM HO REPORT	139,722	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	ALLOCATION FROM HO REPORT	75,948	0	2.00
3.00	5.01	ADMINISTRATIVE AND GENERAL	ALLOCATION FROM HO REPORT	2,552,940	221,352	3.00
4.00	60.00	LABORATORY	ALLOCATION FROM HO REPORT	349,428	429,588	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			3,118,038	650,940	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		51.00	IU HEALTH	51.00	6.00
7.00	B		49.00	ST. VINCENT	49.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-3028	Period: From 01/01/2016 To 12/31/2016	Worksheet A-8-1 Date/Time Prepared: 5/23/2017 1:15 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	139,722	9		1.00
2.00	75,948	9		2.00
3.00	2,331,588	0		3.00
4.00	-80,160	0		4.00
5.00	2,467,098			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	HOME OFFICE		6.00
7.00	MGMT COMPANY		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.

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 5/23/2017 1:15 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	873,194	873,194				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,252,580		1,252,580			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,621,824	14,778	21,198	5,657,800		4.00
5.01	00591	ADMINISTRATIVE AND GENERAL	7,273,668	27,725	39,771	736,809	8,077,973	5.01
5.02	00590	OTHER A&G - NON FOUNDATION	860,057	18,335	26,301	191,570	1,096,263	5.02
7.00	00700	OPERATION OF PLANT	1,416,423	11,316	16,232	79,651	1,523,622	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	99,479	0	0	0	99,479	8.00
9.00	00900	HOUSEKEEPING	474,180	7,379	10,586	80,699	572,844	9.00
10.00	01000	DIETARY	714,543	30,599	43,893	11,843	800,878	10.00
11.00	01100	CAFETERIA	208,134	14,531	20,845	5,622	249,132	11.00
13.00	01300	NURSING ADMINISTRATION	1,544,901	6,014	8,626	372,532	1,932,073	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	439,672	7,522	10,790	14,899	472,883	14.00
15.00	01500	PHARMACY	583,881	3,718	5,334	130,199	723,132	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	395,564	9,921	14,232	82,245	501,962	16.00
17.00	01700	SOCIAL SERVICE	308,048	2,637	3,783	79,291	393,759	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	234,406	0	0	0	234,406	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,596,649	380,056	545,183	1,852,065	10,373,953	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	84,675	4,980	7,143	20,146	116,944	54.00
60.00	06000	LABORATORY	349,877	2,855	4,095	0	356,827	60.00
65.00	06500	RESPIRATORY THERAPY	389,263	11,325	16,246	87,537	504,371	65.00
66.00	06600	PHYSICAL THERAPY	2,179,499	136,044	195,153	508,356	3,019,052	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	372,494	0	0	75,094	447,588	66.01
67.00	06700	OCCUPATIONAL THERAPY	1,712,932	109,827	157,545	422,922	2,403,226	67.00
68.00	06800	SPEECH PATHOLOGY	873,164	24,642	35,349	208,735	1,141,890	68.00
68.01	06801	VISION	164,008	0	0	44,305	208,313	68.01
68.02	06802	FAC RESOURCE	1,204,048	5,293	7,592	274,276	1,491,209	68.02
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	172,078	0	0	0	172,078	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,526,939	0	0	0	1,526,939	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	587,516	5,947	8,531	151,668	753,662	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	178,134	28,910	41,471	43,065	291,580	90.00
90.01	09001	SLEEP CENTER	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	39,691,830	864,354	1,239,899	5,473,529	39,486,038	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	583,659	7,322	10,504	0	601,485	192.00
194.00	07950	FOUNDATION	809,769	1,518	2,177	27,374	840,838	194.00
194.01	07951	PUBLIC RELATIONS	491,065	0	0	44,597	535,662	194.01
194.02	07952	ST. VINCENT - ARU	319,595	0	0	47,669	367,264	194.02
194.03	07953	MUNCIE - ARU	119,800	0	0	28,716	148,516	194.03
194.04	07954	RILEY - ARU	136,552	0	0	35,915	172,467	194.04
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	42,152,270	873,194	1,252,580	5,657,800	42,152,270	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I | Date/Time Prepared: 5/23/2017 1:15 pm

		Cost Center Description	ADMINISTRATIVE AND GENERAL	Subtotal	OTHER A&G - NON FOUNDATION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.01	5A.01	5.02	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00591	ADMINISTRATIVE AND GENERAL	8,077,973					5.01
5.02	00590	OTHER A&G - NON FOUNDATION	259,890	1,356,153	1,356,153			5.02
7.00	00700	OPERATION OF PLANT	361,204	1,884,826	62,655	1,947,481		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	23,583	123,062	4,091	0	127,153	8.00
9.00	00900	HOUSEKEEPING	135,804	708,648	23,557	17,941	0	9.00
10.00	01000	DIETARY	189,863	990,741	32,934	74,391	0	10.00
11.00	01100	CAFETERIA	59,061	308,193	10,245	35,328	0	11.00
13.00	01300	NURSING ADMINISTRATION	458,035	2,390,108	79,452	14,620	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	112,106	584,989	19,446	18,287	0	14.00
15.00	01500	PHARMACY	171,432	894,564	29,737	9,039	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	119,000	620,962	20,642	24,121	0	16.00
17.00	01700	SOCIAL SERVICE	93,348	487,107	16,192	6,411	0	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	55,570	289,976	9,639	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,459,354	12,833,307	426,615	923,987	124,215	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,724	144,668	4,809	12,106	0	54.00
60.00	06000	LABORATORY	84,593	441,420	14,674	6,941	0	60.00
65.00	06500	RESPIRATORY THERAPY	119,571	623,942	20,741	27,534	0	65.00
66.00	06600	PHYSICAL THERAPY	715,724	3,734,776	124,151	330,749	165	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	106,109	553,697	18,406	0	2,395	66.01
67.00	06700	OCCUPATIONAL THERAPY	569,730	2,972,956	98,827	267,011	233	67.00
68.00	06800	SPEECH PATHOLOGY	270,707	1,412,597	46,958	59,910	145	68.00
68.01	06801	VISION	49,385	257,698	8,566	0	0	68.01
68.02	06802	FAC RESOURCE	353,519	1,844,728	61,322	12,867	0	68.02
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	40,794	212,872	7,076	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	361,990	1,888,929	62,792	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	178,670	932,332	30,993	14,459	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	69,125	360,705	11,991	70,287	0	90.00
90.01	09001	SLEEP CENTER	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,445,891	38,853,956	1,246,511	1,925,989	127,153	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	142,593	744,078	24,735	17,802	0	192.00
194.00	07950	FOUNDATION	199,337	1,040,175	34,577	3,690	0	194.00
194.01	07951	PUBLIC RELATIONS	126,989	662,651	22,028	0	0	194.01
194.02	07952	ST. VINCENT - ARU	87,067	454,331	15,103	0	0	194.02
194.03	07953	MUNCIE - ARU	35,209	183,725	6,107	0	0	194.03
194.04	07954	RILEY - ARU	40,887	213,354	7,092	0	0	194.04
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	8,077,973	42,152,270	1,356,153	1,947,481	127,153	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I | Date/Time Prepared: 5/23/2017 1:15 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00591	ADMINISTRATIVE AND GENERAL						5.01
5.02	00590	OTHER A&G - NON FOUNDATION						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	750,146					9.00
10.00	01000	DIETARY	28,921	1,126,987				10.00
11.00	01100	CAFETERIA	13,734	0	367,500			11.00
13.00	01300	NURSING ADMINISTRATION	5,684	0	27,607	2,517,471		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,109	0	2,360	0	632,191	14.00
15.00	01500	PHARMACY	3,514	0	8,890	124,632	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,377	0	8,743	122,572	0	16.00
17.00	01700	SOCIAL SERVICE	2,492	0	6,297	0	0	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	359,221	1,126,987	153,446	2,151,299	229,523	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,707	0	1,696	23,772	4,134	54.00
60.00	06000	LABORATORY	2,698	0	0	0	730	60.00
65.00	06500	RESPIRATORY THERAPY	10,704	0	6,790	95,196	113,141	65.00
66.00	06600	PHYSICAL THERAPY	128,585	0	39,442	0	8,938	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0	0	5,557	0	4,922	66.01
67.00	06700	OCCUPATIONAL THERAPY	103,806	0	34,423	0	5,539	67.00
68.00	06800	SPEECH PATHOLOGY	23,291	0	16,714	0	2,121	68.00
68.01	06801	VISION	0	0	3,149	0	1,823	68.01
68.02	06802	FAC RESOURCE	5,002	0	26,700	0	16,900	68.02
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	212,227	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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	5,621	0	10,568	0	20,570	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	27,325	0	4,348	0	11,623	90.00
90.01	09001	SLEEP CENTER	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	741,791	1,126,987	356,730	2,517,471	632,191	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	6,921	0	0	0	0	192.00
194.00	07950	FOUNDATION	1,434	0	7,422	0	0	194.00
194.01	07951	PUBLIC RELATIONS	0	0	3,348	0	0	194.01
194.02	07952	ST. VINCENT - ARU	0	0	0	0	0	194.02
194.03	07953	MUNCIE - ARU	0	0	0	0	0	194.03
194.04	07954	RILEY - ARU	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	750,146	1,126,987	367,500	2,517,471	632,191	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I | Date/Time Prepared: 5/23/2017 1:15 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS	Subtotal	
			15.00	16.00	17.00	22.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00591	ADMINISTRATIVE AND GENERAL						5.01
5.02	00590	OTHER A&G - NON FOUNDATION						5.02
7.00	00700	OPERATION OF PLANT						7.00
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	1,070,376					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	806,417				16.00
17.00	01700	SOCIAL SERVICE	0	0	518,499			17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	299,615		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	806,417	518,499	299,615	19,953,131	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	195,892	54.00
60.00	06000	LABORATORY	0	0	0	0	466,463	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	898,048	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	4,366,806	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0	0	0	0	584,977	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	3,482,795	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	1,561,736	68.00
68.01	06801	VISION	0	0	0	0	271,236	68.01
68.02	06802	FAC RESOURCE	0	0	0	0	1,967,519	68.02
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	432,175	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,070,376	0	0	0	3,022,097	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	1,014,543	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	486,279	90.00
90.01	09001	SLEEP CENTER	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,070,376	806,417	518,499	299,615	38,703,697	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	793,536	192.00
194.00	07950	FOUNDATION	0	0	0	0	1,087,298	194.00
194.01	07951	PUBLIC RELATIONS	0	0	0	0	688,027	194.01
194.02	07952	ST. VINCENT - ARU	0	0	0	0	469,434	194.02
194.03	07953	MUNCIE - ARU	0	0	0	0	189,832	194.03
194.04	07954	RILEY - ARU	0	0	0	0	220,446	194.04
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,070,376	806,417	518,499	299,615	42,152,270	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 5/23/2017 1:15 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00591	ADMINISTRATIVE AND GENERAL				5.01
5.02	00590	OTHER A&G - NON FOUNDATION				5.02
7.00	00700	OPERATION OF PLANT				7.00
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				17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD				22.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-299,615	19,653,516		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	195,892		54.00
60.00	06000	LABORATORY	0	466,463		60.00
65.00	06500	RESPIRATORY THERAPY	0	898,048		65.00
66.00	06600	PHYSICAL THERAPY	0	4,366,806		66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0	584,977		66.01
67.00	06700	OCCUPATIONAL THERAPY	0	3,482,795		67.00
68.00	06800	SPEECH PATHOLOGY	0	1,561,736		68.00
68.01	06801	VISION	0	271,236		68.01
68.02	06802	FAC RESOURCE	0	1,967,519		68.02
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	432,175		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,022,097		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	1,014,543		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	486,279		90.00
90.01	09001	SLEEP CENTER	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
99.00	09900	CMHC	0	0		99.00
99.10	09910	CORF	0	0		99.10
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-299,615	38,404,082		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	793,536		192.00
194.00	07950	FOUNDATION	0	1,087,298		194.00
194.01	07951	PUBLIC RELATIONS	0	688,027		194.01
194.02	07952	ST. VINCENT - ARU	0	469,434		194.02
194.03	07953	MUNCIE - ARU	0	189,832		194.03
194.04	07954	RILEY - ARU	0	220,446		194.04
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	-299,615	41,852,655		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/23/2017 1:15 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	14,778	21,198	35,976	35,976	4.00
5.01	00591	ADMINISTRATIVE AND GENERAL	0	27,725	39,771	67,496	4,685	5.01
5.02	00590	OTHER A&G - NON FOUNDATION	0	18,335	26,301	44,636	1,218	5.02
7.00	00700	OPERATION OF PLANT	0	11,316	16,232	27,548	506	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	7,379	10,586	17,965	513	9.00
10.00	01000	DIETARY	0	30,599	43,893	74,492	75	10.00
11.00	01100	CAFETERIA	0	14,531	20,845	35,376	36	11.00
13.00	01300	NURSING ADMINISTRATION	0	6,014	8,626	14,640	2,369	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	7,522	10,790	18,312	95	14.00
15.00	01500	PHARMACY	0	3,718	5,334	9,052	828	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	9,921	14,232	24,153	523	16.00
17.00	01700	SOCIAL SERVICE	0	2,637	3,783	6,420	504	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	380,056	545,183	925,239	11,778	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,980	7,143	12,123	128	54.00
60.00	06000	LABORATORY	0	2,855	4,095	6,950	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	11,325	16,246	27,571	557	65.00
66.00	06600	PHYSICAL THERAPY	0	136,044	195,153	331,197	3,232	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0	0	0	0	477	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	109,827	157,545	267,372	2,689	67.00
68.00	06800	SPEECH PATHOLOGY	0	24,642	35,349	59,991	1,327	68.00
68.01	06801	VISION	0	0	0	0	282	68.01
68.02	06802	FAC RESOURCE	0	5,293	7,592	12,885	1,744	68.02
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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	5,947	8,531	14,478	964	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	28,910	41,471	70,381	274	90.00
90.01	09001	SLEEP CENTER	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	864,354	1,239,899	2,104,253	34,804	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	7,322	10,504	17,826	0	192.00
194.00	07950	FOUNDATION	0	1,518	2,177	3,695	174	194.00
194.01	07951	PUBLIC RELATIONS	0	0	0	0	284	194.01
194.02	07952	ST. VINCENT - ARU	0	0	0	0	303	194.02
194.03	07953	MUNCIE - ARU	0	0	0	0	183	194.03
194.04	07954	RILEY - ARU	0	0	0	0	228	194.04
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	873,194	1,252,580	2,125,774	35,976	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II | Date/Time Prepared: 5/23/2017 1:15 pm

		Cost Center Description	ADMINISTRATIVE AND GENERAL	OTHER A&G - NON FOUNDATION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.01	5.02	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00591	ADMINISTRATIVE AND GENERAL	72,181					5.01
5.02	00590	OTHER A&G - NON FOUNDATION	2,322	48,176				5.02
7.00	00700	OPERATION OF PLANT	3,227	2,226	33,507			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	211	145	0	356		8.00
9.00	00900	HOUSEKEEPING	1,213	837	309	0	20,837	9.00
10.00	01000	DIETARY	1,696	1,170	1,280	0	803	10.00
11.00	01100	CAFETERIA	528	364	608	0	382	11.00
13.00	01300	NURSING ADMINISTRATION	4,092	2,823	252	0	158	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,002	691	315	0	197	14.00
15.00	01500	PHARMACY	1,532	1,056	156	0	98	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,063	733	415	0	260	16.00
17.00	01700	SOCIAL SERVICE	834	575	110	0	69	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	496	342	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,983	15,153	15,897	348	9,979	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	248	171	208	0	131	54.00
60.00	06000	LABORATORY	756	521	119	0	75	60.00
65.00	06500	RESPIRATORY THERAPY	1,068	737	474	0	297	65.00
66.00	06600	PHYSICAL THERAPY	6,394	4,411	5,691	0	3,572	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	948	654	0	7	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	5,090	3,511	4,594	1	2,883	67.00
68.00	06800	SPEECH PATHOLOGY	2,419	1,668	1,031	0	647	68.00
68.01	06801	VISION	441	304	0	0	0	68.01
68.02	06802	FAC RESOURCE	3,158	2,179	221	0	139	68.02
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	364	251	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	3,234	2,231	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,596	1,101	249	0	156	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	618	426	1,209	0	759	90.00
90.01	09001	SLEEP CENTER	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	66,533	44,280	33,138	356	20,605	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	1,274	879	306	0	192	192.00
194.00	07950	FOUNDATION	1,781	1,228	63	0	40	194.00
194.01	07951	PUBLIC RELATIONS	1,135	783	0	0	0	194.01
194.02	07952	ST. VINCENT - ARU	778	537	0	0	0	194.02
194.03	07953	MUNCIE - ARU	315	217	0	0	0	194.03
194.04	07954	RILEY - ARU	365	252	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	72,181	48,176	33,507	356	20,837	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II | Date/Time Prepared: 5/23/2017 1:15 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00591	ADMINISTRATIVE AND GENERAL						5.01
5.02	00590	OTHER A&G - NON FOUNDATION						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	79,516					10.00
11.00	01100	CAFETERIA	0	37,294				11.00
13.00	01300	NURSING ADMINISTRATION	0	2,802	27,136			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	239	0	20,851		14.00
15.00	01500	PHARMACY	0	902	1,343	0	14,967	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	887	1,321	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	639	0	0	0	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	79,516	15,572	23,190	7,571	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	172	256	136	0	54.00
60.00	06000	LABORATORY	0	0	0	24	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	689	1,026	3,732	0	65.00
66.00	06600	PHYSICAL THERAPY	0	4,003	0	295	0	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0	564	0	162	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	3,493	0	183	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,696	0	70	0	68.00
68.01	06801	VISION	0	320	0	60	0	68.01
68.02	06802	FAC RESOURCE	0	2,710	0	557	0	68.02
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	7,000	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	14,967	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	1,072	0	678	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	441	0	383	0	90.00
90.01	09001	SLEEP CENTER	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	79,516	36,201	27,136	20,851	14,967	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	FOUNDATION	0	753	0	0	0	194.00
194.01	07951	PUBLIC RELATIONS	0	340	0	0	0	194.01
194.02	07952	ST. VINCENT - ARU	0	0	0	0	0	194.02
194.03	07953	MUNCIE - ARU	0	0	0	0	0	194.03
194.04	07954	RILEY - ARU	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	79,516	37,294	27,136	20,851	14,967	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/23/2017 1:15 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	22.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00591	ADMINISTRATIVE AND GENERAL						5.01
5.02	00590	OTHER A&G - NON FOUNDATION						5.02
7.00	00700	OPERATION OF PLANT						7.00
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	29,355					16.00
17.00	01700	SOCIAL SERVICE	0	9,151				17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	838			22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,355	9,151		1,164,732	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0		0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		13,573	0	54.00
60.00	06000	LABORATORY	0	0		8,445	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0		36,151	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0		358,795	0	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0	0		2,812	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0		289,816	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68,849	0	68.00
68.01	06801	VISION	0	0		1,407	0	68.01
68.02	06802	FAC RESOURCE	0	0		23,593	0	68.02
69.00	06900	ELECTROCARDIOLOGY	0	0		0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		7,615	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		20,432	0	73.00
74.00	07400	RENAL DIALYSIS	0	0		0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		20,294	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0		74,491	0	90.00
90.01	09001	SLEEP CENTER	0	0		0	0	90.01
91.00	09100	EMERGENCY	0	0		0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0		0	0	99.00
99.10	09910	CORF	0	0		0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	29,355	9,151	0	2,091,005	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		20,477	0	192.00
194.00	07950	FOUNDATION	0	0		7,734	0	194.00
194.01	07951	PUBLIC RELATIONS	0	0		2,542	0	194.01
194.02	07952	ST. VINCENT - ARU	0	0		1,618	0	194.02
194.03	07953	MUNCIE - ARU	0	0		715	0	194.03
194.04	07954	RILEY - ARU	0	0		845	0	194.04
200.00		Cross Foot Adjustments			838	838	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	29,355	9,151	838	2,125,774	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/23/2017 1:15 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00591	ADMINISTRATIVE AND GENERAL			5.01
5.02	00590	OTHER A&G - NON FOUNDATION			5.02
7.00	00700	OPERATION OF PLANT			7.00
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			17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD			22.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	1,164,732		30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,573		54.00
60.00	06000	LABORATORY	8,445		60.00
65.00	06500	RESPIRATORY THERAPY	36,151		65.00
66.00	06600	PHYSICAL THERAPY	358,795		66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	2,812		66.01
67.00	06700	OCCUPATIONAL THERAPY	289,816		67.00
68.00	06800	SPEECH PATHOLOGY	68,849		68.00
68.01	06801	VISION	1,407		68.01
68.02	06802	FAC RESOURCE	23,593		68.02
69.00	06900	ELECTROCARDIOLOGY	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,615		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,432		73.00
74.00	07400	RENAL DIALYSIS	0		74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	20,294		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	74,491		90.00
90.01	09001	SLEEP CENTER	0		90.01
91.00	09100	EMERGENCY	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
99.00	09900	CMHC	0		99.00
99.10	09910	CORF	0		99.10
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,091,005		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	20,477		192.00
194.00	07950	FOUNDATION	7,734		194.00
194.01	07951	PUBLIC RELATIONS	2,542		194.01
194.02	07952	ST. VINCENT - ARU	1,618		194.02
194.03	07953	MUNCIE - ARU	715		194.03
194.04	07954	RILEY - ARU	845		194.04
200.00		Cross Foot Adjustments	838		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	2,125,774		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/23/2017 1:15 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A.01	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	92,060					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		92,060				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,558	1,558	19,711,037			4.00
5.01	00591	ADMINISTRATIVE AND GENERAL	2,923	2,923	2,566,948	-8,077,973	34,074,297	5.01
5.02	00590	OTHER A&G - NON FOUNDATION	1,933	1,933	667,406	0	1,096,263	5.02
7.00	00700	OPERATION OF PLANT	1,193	1,193	277,493	0	1,523,622	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	99,479	8.00
9.00	00900	HOUSEKEEPING	778	778	281,144	0	572,844	9.00
10.00	01000	DIETARY	3,226	3,226	41,259	0	800,878	10.00
11.00	01100	CAFETERIA	1,532	1,532	19,586	0	249,132	11.00
13.00	01300	NURSING ADMINISTRATION	634	634	1,297,852	0	1,932,073	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	793	793	51,906	0	472,883	14.00
15.00	01500	PHARMACY	392	392	453,596	0	723,132	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,046	1,046	286,530	0	501,962	16.00
17.00	01700	SOCIAL SERVICE	278	278	276,241	0	393,759	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	234,406	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	40,069	40,069	6,452,345	0	10,373,953	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	525	525	70,187	0	116,944	54.00
60.00	06000	LABORATORY	301	301	0	0	356,827	60.00
65.00	06500	RESPIRATORY THERAPY	1,194	1,194	304,969	0	504,371	65.00
66.00	06600	PHYSICAL THERAPY	14,343	14,343	1,771,046	0	3,019,052	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0	0	261,619	0	447,588	66.01
67.00	06700	OCCUPATIONAL THERAPY	11,579	11,579	1,473,405	0	2,403,226	67.00
68.00	06800	SPEECH PATHOLOGY	2,598	2,598	727,207	0	1,141,890	68.00
68.01	06801	VISION	0	0	154,354	0	208,313	68.01
68.02	06802	FAC RESOURCE	558	558	955,544	0	1,491,209	68.02
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	172,078	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	1,526,939	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	627	627	528,391	0	753,662	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,048	3,048	150,032	0	291,580	90.00
90.01	09001	SLEEP CENTER	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	91,128	91,128	19,069,060	-8,077,973	31,408,065	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	772	772	0	0	601,485	192.00
194.00	07950	FOUNDATION	160	160	95,369	0	840,838	194.00
194.01	07951	PUBLIC RELATIONS	0	0	155,370	0	535,662	194.01
194.02	07952	ST. VINCENT - ARU	0	0	166,071	0	367,264	194.02
194.03	07953	MUNCIE - ARU	0	0	100,044	0	148,516	194.03
194.04	07954	RILEY - ARU	0	0	125,123	0	172,467	194.04
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)	873,194	1,252,580	5,657,800		8,077,973	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.485053	13.606126	0.287037		0.237069	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			35,976		72,181	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001825		0.002118	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/23/2017 1:15 pm

		Cost Center Description	Reconciliation	OTHER A&G - NON FOUNDATION (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
			5A.02	5.02	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00591	ADMINISTRATIVE AND GENERAL						5.01
5.02	00590	OTHER A&G - NON FOUNDATION	-1,356,153	40,796,117				5.02
7.00	00700	OPERATION OF PLANT	0	1,884,826	84,453			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	123,062	0	200,413		8.00
9.00	00900	HOUSEKEEPING	0	708,648	778	0	83,675	9.00
10.00	01000	DIETARY	0	990,741	3,226	0	3,226	10.00
11.00	01100	CAFETERIA	0	308,193	1,532	0	1,532	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,390,108	634	0	634	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	584,989	793	0	793	14.00
15.00	01500	PHARMACY	0	894,564	392	0	392	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	620,962	1,046	0	1,046	16.00
17.00	01700	SOCIAL SERVICE	0	487,107	278	0	278	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	289,976	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	12,833,307	40,069	195,781	40,069	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	144,668	525	0	525	54.00
60.00	06000	LABORATORY	0	441,420	301	0	301	60.00
65.00	06500	RESPIRATORY THERAPY	0	623,942	1,194	0	1,194	65.00
66.00	06600	PHYSICAL THERAPY	0	3,734,776	14,343	260	14,343	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0	553,697	0	3,775	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	2,972,956	11,579	368	11,579	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,412,597	2,598	229	2,598	68.00
68.01	06801	VISION	0	257,698	0	0	0	68.01
68.02	06802	FAC RESOURCE	0	1,844,728	558	0	558	68.02
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	212,872	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,888,929	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	932,332	627	0	627	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	360,705	3,048	0	3,048	90.00
90.01	09001	SLEEP CENTER	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,356,153	37,497,803	83,521	200,413	82,743	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	744,078	772	0	772	192.00
194.00	07950	FOUNDATION	0	1,040,175	160	0	160	194.00
194.01	07951	PUBLIC RELATIONS	0	662,651	0	0	0	194.01
194.02	07952	ST. VINCENT - ARU	0	454,331	0	0	0	194.02
194.03	07953	MUNCIE - ARU	0	183,725	0	0	0	194.03
194.04	07954	RILEY - ARU	0	213,354	0	0	0	194.04
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)		1,356,153	1,947,481	127,153	750,146	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.033242	23.059939	0.634455	8.964996	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		48,176	33,507	356	20,837	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.001181	0.396753	0.001776	0.249023	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/23/2017 1:15 pm

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (HOURS PAID)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00591	ADMINISTRATIVE AND GENERAL						5.01
5.02	00590	OTHER A&G - NON FOUNDATION						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	59,157					10.00
11.00	01100	CAFETERIA	0	480,294				11.00
13.00	01300	NURSING ADMINISTRATION	0	36,080	234,675			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,084	0	512,594		14.00
15.00	01500	PHARMACY	0	11,618	11,618	0	100	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	11,426	11,426	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	8,230	0	0	0	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	59,157	200,541	200,541	186,102	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,216	2,216	3,352	0	54.00
60.00	06000	LABORATORY	0	0	0	592	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	8,874	8,874	91,737	0	65.00
66.00	06600	PHYSICAL THERAPY	0	51,548	0	7,247	0	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0	7,263	0	3,991	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	44,988	0	4,491	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	21,844	0	1,720	0	68.00
68.01	06801	VISION	0	4,116	0	1,478	0	68.01
68.02	06802	FAC RESOURCE	0	34,895	0	13,703	0	68.02
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	172,078	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	100	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	13,812	0	16,679	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	5,683	0	9,424	0	90.00
90.01	09001	SLEEP CENTER	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	59,157	466,218	234,675	512,594	100	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	FOUNDATION	0	9,700	0	0	0	194.00
194.01	07951	PUBLIC RELATIONS	0	4,376	0	0	0	194.01
194.02	07952	ST. VINCENT - ARU	0	0	0	0	0	194.02
194.03	07953	MUNCIE - ARU	0	0	0	0	0	194.03
194.04	07954	RILEY - ARU	0	0	0	0	0	194.04
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)	1,126,987	367,500	2,517,471	632,191	1,070,376	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	19.050780	0.765156	10.727478	1.233317	10,703.760000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	79,516	37,294	27,136	20,851	14,967	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.344152	0.077648	0.115632	0.040677	149.670000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/23/2017 1:15 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (PATIENT DAYS)	SOCIAL SERVICE (PATIENT DAYS)	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)		
			16.00	17.00	22.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00591	ADMINISTRATIVE AND GENERAL					5.01
5.02	00590	OTHER A&G - NON FOUNDATION					5.02
7.00	00700	OPERATION OF PLANT					7.00
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	19,719				16.00
17.00	01700	SOCIAL SERVICE	0	19,719			17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	100		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	19,719	19,719	100		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0	0	0		66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
68.01	06801	VISION	0	0	0		68.01
68.02	06802	FAC RESOURCE	0	0	0		68.02
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	SLEEP CENTER	0	0	0		90.01
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
		OTHER REIMBURSABLE COST CENTERS					
99.00	09900	CMHC	0	0	0		99.00
99.10	09910	CORF	0	0	0		99.10
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	19,719	19,719	100		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
194.00	07950	FOUNDATION	0	0	0		194.00
194.01	07951	PUBLIC RELATIONS	0	0	0		194.01
194.02	07952	ST. VINCENT - ARU	0	0	0		194.02
194.03	07953	MUNCIE - ARU	0	0	0		194.03
194.04	07954	RILEY - ARU	0	0	0		194.04
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)	806,417	518,499	299,615		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	40.895431	26.294386	2,996.150000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	29,355	9,151	838		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.488666	0.464070	8.380000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/23/2017 1:15 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,653,516		19,653,516	0	19,653,516	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0		0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	195,892		195,892	0	195,892	54.00
60.00	06000	LABORATORY	466,463		466,463	0	466,463	60.00
65.00	06500	RESPIRATORY THERAPY	898,048	0	898,048	0	898,048	65.00
66.00	06600	PHYSICAL THERAPY	4,366,806	0	4,366,806	0	4,366,806	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	584,977	0	584,977	0	584,977	66.01
67.00	06700	OCCUPATIONAL THERAPY	3,482,795	0	3,482,795	0	3,482,795	67.00
68.00	06800	SPEECH PATHOLOGY	1,561,736	0	1,561,736	0	1,561,736	68.00
68.01	06801	VISION	271,236	0	271,236	0	271,236	68.01
68.02	06802	FAC RESOURCE	1,967,519	0	1,967,519	0	1,967,519	68.02
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	432,175		432,175	0	432,175	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,022,097		3,022,097	0	3,022,097	73.00
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,014,543		1,014,543	0	1,014,543	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	486,279		486,279	0	486,279	90.00
90.01	09001	SLEEP CENTER	0		0	0	0	90.01
91.00	09100	EMERGENCY	0		0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0		0		0	99.00
99.10	09910	CORF	0		0		0	99.10
200.00		Subtotal (see instructions)	38,404,082	0	38,404,082	0	38,404,082	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	38,404,082	0	38,404,082	0	38,404,082	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/23/2017 1:15 pm

Title XVIII | 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	34,757,801		34,757,801			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0.000000	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	898,575	0	898,575	0.218003	0.000000	54.00
60.00	06000	LABORATORY	1,369,488	0	1,369,488	0.340611	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,289,530	0	1,289,530	0.696415	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	10,531,209	4,897,425	15,428,634	0.283033	0.000000	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0	1,883,071	1,883,071	0.310651	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	10,008,999	2,283,311	12,292,310	0.283331	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	8,262,885	1,322,831	9,585,716	0.162923	0.000000	68.00
68.01	06801	VISION	571,271	548,782	1,120,053	0.242164	0.000000	68.01
68.02	06802	FAC RESOURCE	0	1,248,077	1,248,077	1.576440	0.000000	68.02
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	964,477	37,026	1,001,503	0.431526	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,517,078	3,450,391	8,967,469	0.337007	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	135,564	780,222	915,786	1.107839	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,759	1,247,259	1,249,018	0.389329	0.000000	90.00
90.01	09001	SLEEP CENTER	0	0	0	0.000000	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0			99.00
99.10	09910	CORF	0	0	0			99.10
200.00		Subtotal (see instructions)	74,308,636	17,698,395	92,007,031			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	74,308,636	17,698,395	92,007,031			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/23/2017 1:15 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.218003	54.00
60.00	06000	LABORATORY	0.340611	60.00
65.00	06500	RESPIRATORY THERAPY	0.696415	65.00
66.00	06600	PHYSICAL THERAPY	0.283033	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0.310651	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.283331	67.00
68.00	06800	SPEECH PATHOLOGY	0.162923	68.00
68.01	06801	VISION	0.242164	68.01
68.02	06802	FAC RESOURCE	1.576440	68.02
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.431526	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.337007	73.00
74.00	07400	RENAL DIALYSIS	0.000000	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.107839	76.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.389329	90.00
90.01	09001	SLEEP CENTER	0.000000	90.01
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
99.00	09900	CMHC		99.00
99.10	09910	CORF		99.10
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: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/23/2017 1:15 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,653,516		19,653,516	0	19,653,516	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0		0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	195,892		195,892	0	195,892	54.00
60.00	06000	LABORATORY	466,463		466,463	0	466,463	60.00
65.00	06500	RESPIRATORY THERAPY	898,048	0	898,048	0	898,048	65.00
66.00	06600	PHYSICAL THERAPY	4,366,806	0	4,366,806	0	4,366,806	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	584,977	0	584,977	0	584,977	66.01
67.00	06700	OCCUPATIONAL THERAPY	3,482,795	0	3,482,795	0	3,482,795	67.00
68.00	06800	SPEECH PATHOLOGY	1,561,736	0	1,561,736	0	1,561,736	68.00
68.01	06801	VISION	271,236	0	271,236	0	271,236	68.01
68.02	06802	FAC RESOURCE	1,967,519	0	1,967,519	0	1,967,519	68.02
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	432,175		432,175	0	432,175	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,022,097		3,022,097	0	3,022,097	73.00
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,014,543		1,014,543	0	1,014,543	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	486,279		486,279	0	486,279	90.00
90.01	09001	SLEEP CENTER	0		0	0	0	90.01
91.00	09100	EMERGENCY	0		0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0		0		0	99.00
99.10	09910	CORF	0		0		0	99.10
200.00		Subtotal (see instructions)	38,404,082	0	38,404,082	0	38,404,082	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	38,404,082	0	38,404,082	0	38,404,082	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/23/2017 1:15 pm

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	34,757,801		34,757,801			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0.000000	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	898,575	0	898,575	0.218003	0.000000	54.00
60.00	06000	LABORATORY	1,369,488	0	1,369,488	0.340611	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,289,530	0	1,289,530	0.696415	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	10,531,209	4,897,425	15,428,634	0.283033	0.000000	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0	1,883,071	1,883,071	0.310651	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	10,008,999	2,283,311	12,292,310	0.283331	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	8,262,885	1,322,831	9,585,716	0.162923	0.000000	68.00
68.01	06801	VISION	571,271	548,782	1,120,053	0.242164	0.000000	68.01
68.02	06802	FAC RESOURCE	0	1,248,077	1,248,077	1.576440	0.000000	68.02
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	964,477	37,026	1,001,503	0.431526	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,517,078	3,450,391	8,967,469	0.337007	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	135,564	780,222	915,786	1.107839	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,759	1,247,259	1,249,018	0.389329	0.000000	90.00
90.01	09001	SLEEP CENTER	0	0	0	0.000000	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0			99.00
99.10	09910	CORF	0	0	0			99.10
200.00		Subtotal (see instructions)	74,308,636	17,698,395	92,007,031			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	74,308,636	17,698,395	92,007,031			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/23/2017 1:15 pm

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.218003	54.00
60.00	06000	LABORATORY	0.340611	60.00
65.00	06500	RESPIRATORY THERAPY	0.696415	65.00
66.00	06600	PHYSICAL THERAPY	0.283033	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0.310651	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.283331	67.00
68.00	06800	SPEECH PATHOLOGY	0.162923	68.00
68.01	06801	VISION	0.242164	68.01
68.02	06802	FAC RESOURCE	1.576440	68.02
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.431526	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.337007	73.00
74.00	07400	RENAL DIALYSIS	0.000000	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.107839	76.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.389329	90.00
90.01	09001	SLEEP CENTER	0.000000	90.01
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
99.00	09900	CMHC		99.00
99.10	09910	CORF		99.10
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: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part II | Date/Time Prepared: 5/23/2017 1:15 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	195,892	13,573	182,319	0	0	54.00
60.00	06000	LABORATORY	466,463	8,445	458,018	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	898,048	36,151	861,897	0	0	65.00
66.00	06600	PHYSICAL THERAPY	4,366,806	358,795	4,008,011	0	0	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	584,977	2,812	582,165	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	3,482,795	289,816	3,192,979	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,561,736	68,849	1,492,887	0	0	68.00
68.01	06801	VISION	271,236	1,407	269,829	0	0	68.01
68.02	06802	FAC RESOURCE	1,967,519	23,593	1,943,926	0	0	68.02
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	432,175	7,615	424,560	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	3,022,097	20,432	3,001,665	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,014,543	20,294	994,249	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	486,279	74,491	411,788	0	0	90.00
90.01	09001	SLEEP CENTER	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
200.00		Subtotal (sum of lines 50 thru 199)	18,750,566	926,273	17,824,293	0	0	200.00
201.00		Less Observation Beds	0	0	0	0	0	201.00
202.00		Total (line 200 minus line 201)	18,750,566	926,273	17,824,293	0	0	202.00

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

Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part II Date/Time Prepared: 5/23/2017 1:15 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0.000000		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	195,892	898,575	0.218003		54.00
60.00	06000	LABORATORY	466,463	1,369,488	0.340611		60.00
65.00	06500	RESPIRATORY THERAPY	898,048	1,289,530	0.696415		65.00
66.00	06600	PHYSICAL THERAPY	4,366,806	15,428,634	0.283033		66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	584,977	1,883,071	0.310651		66.01
67.00	06700	OCCUPATIONAL THERAPY	3,482,795	12,292,310	0.283331		67.00
68.00	06800	SPEECH PATHOLOGY	1,561,736	9,585,716	0.162923		68.00
68.01	06801	VISION	271,236	1,120,053	0.242164		68.01
68.02	06802	FAC RESOURCE	1,967,519	1,248,077	1.576440		68.02
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	432,175	1,001,503	0.431526		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,022,097	8,967,469	0.337007		73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000		74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,014,543	915,786	1.107839		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	486,279	1,249,018	0.389329		90.00
90.01	09001	SLEEP CENTER	0	0	0.000000		90.01
91.00	09100	EMERGENCY	0	0	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS					
99.00	09900	CMHC	0	0	0.000000		99.00
99.10	09910	CORF	0	0	0.000000		99.10
200.00		Subtotal (sum of lines 50 thru 199)	18,750,566	57,249,230			200.00
201.00		Less Observation Beds	0	0			201.00
202.00		Total (line 200 minus line 201)	18,750,566	57,249,230			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part I Date/Time Prepared: 5/23/2017 1:15 pm

Title XVIII | 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	1,164,732	0	1,164,732	19,719	59.07	30.00
200.00	Total (lines 30-199)	1,164,732		1,164,732	19,719		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	6,597	389,685				30.00
200.00	Total (lines 30-199)	6,597	389,685				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part II Date/Time Prepared: 5/23/2017 1:15 pm

Title XVIII | 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	0	0	0.000000	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,573	898,575	0.015105	288,944	4,364	54.00
60.00	06000	LABORATORY	8,445	1,369,488	0.006167	497,138	3,066	60.00
65.00	06500	RESPIRATORY THERAPY	36,151	1,289,530	0.028034	597,478	16,750	65.00
66.00	06600	PHYSICAL THERAPY	358,795	15,428,634	0.023255	3,597,824	83,667	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	2,812	1,883,071	0.001493	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	289,816	12,292,310	0.023577	3,465,580	81,708	67.00
68.00	06800	SPEECH PATHOLOGY	68,849	9,585,716	0.007182	2,566,658	18,434	68.00
68.01	06801	VISION	1,407	1,120,053	0.001256	0	0	68.01
68.02	06802	FAC RESOURCE	23,593	1,248,077	0.018903	0	0	68.02
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,615	1,001,503	0.007604	345,965	2,631	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,432	8,967,469	0.002278	1,952,252	4,447	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	20,294	915,786	0.022160	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	74,491	1,249,018	0.059640	0	0	90.00
90.01	09001	SLEEP CENTER	0	0	0.000000	0	0	90.01
91.00	09100	EMERGENCY	0	0	0.000000	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.000000	0	0	92.00
200.00		Total (lines 50-199)	926,273	57,249,230		13,311,839	215,067	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part III Date/Time Prepared: 5/23/2017 1:15 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,719	0.00	6,597	0		30.00
200.00		Total (lines 30-199)	19,719		6,597	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 5/23/2017 1:15 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
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
66.01	06601	PHYSICAL THERAPY - CARMEL	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	VISION	0	0	0	0	0	68.01
68.02	06802	FAC RESOURCE	0	0	0	0	0	68.02
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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	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	SLEEP CENTER	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/23/2017 1:15 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0.000000	0.000000	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	898,575	0.000000	0.000000	288,944	54.00
60.00	06000	LABORATORY	0	1,369,488	0.000000	0.000000	497,138	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,289,530	0.000000	0.000000	597,478	65.00
66.00	06600	PHYSICAL THERAPY	0	15,428,634	0.000000	0.000000	3,597,824	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0	1,883,071	0.000000	0.000000	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	12,292,310	0.000000	0.000000	3,465,580	67.00
68.00	06800	SPEECH PATHOLOGY	0	9,585,716	0.000000	0.000000	2,566,658	68.00
68.01	06801	VISION	0	1,120,053	0.000000	0.000000	0	68.01
68.02	06802	FAC RESOURCE	0	1,248,077	0.000000	0.000000	0	68.02
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,001,503	0.000000	0.000000	345,965	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,967,469	0.000000	0.000000	1,952,252	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	915,786	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,249,018	0.000000	0.000000	0	90.00
90.01	09001	SLEEP CENTER	0	0	0.000000	0.000000	0	90.01
91.00	09100	EMERGENCY	0	0	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	57,249,230			13,311,839	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/23/2017 1:15 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	2,881	0		66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0	0	0		66.01
67.00	06700	OCCUPATIONAL THERAPY	0	222	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
68.01	06801	VISION	0	0	0		68.01
68.02	06802	FAC RESOURCE	0	0	0		68.02
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	11,648	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,125,607	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	403,768	0		90.00
90.01	09001	SLEEP CENTER	0	0	0		90.01
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	0	1,544,126	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/23/2017 1:15 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.218003	0	0	0	0	54.00
60.00	06000	LABORATORY	0.340611	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.696415	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.283033	2,881	0	0	815	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0.310651	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.283331	222	0	0	63	67.00
68.00	06800	SPEECH PATHOLOGY	0.162923	0	0	0	0	68.00
68.01	06801	VISION	0.242164	0	0	0	0	68.01
68.02	06802	FAC RESOURCE	1.576440	0	0	0	0	68.02
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.431526	11,648	0	0	5,026	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	0.337007	1,125,607	0	0	379,337	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.107839	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.389329	403,768	0	0	157,199	90.00
90.01	09001	SLEEP CENTER	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Subtotal (see instructions)		1,544,126	0	0	542,440	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		1,544,126	0	0	542,440	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/23/2017 1:15 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
68.01	06801	VISION	0	0	68.01
68.02	06802	FAC RESOURCE	0	0	68.02
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
90.01	09001	SLEEP CENTER	0	0	90.01
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part I | Date/Time Prepared: 5/23/2017 1:15 pm

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,164,732	0	1,164,732	19,719	59.07	30.00
200.00	Total (lines 30-199)	1,164,732		1,164,732	19,719		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	474	27,999				30.00
200.00	Total (lines 30-199)	474	27,999				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part II Date/Time Prepared: 5/23/2017 1:15 pm

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0.000000	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,573	898,575	0.015105	34,840	526	54.00
60.00	06000	LABORATORY	8,445	1,369,488	0.006167	45,696	282	60.00
65.00	06500	RESPIRATORY THERAPY	36,151	1,289,530	0.028034	56,474	1,583	65.00
66.00	06600	PHYSICAL THERAPY	358,795	15,428,634	0.023255	399,110	9,281	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	2,812	1,883,071	0.001493	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	289,816	12,292,310	0.023577	369,243	8,706	67.00
68.00	06800	SPEECH PATHOLOGY	68,849	9,585,716	0.007182	279,529	2,008	68.00
68.01	06801	VISION	1,407	1,120,053	0.001256	34,133	43	68.01
68.02	06802	FAC RESOURCE	23,593	1,248,077	0.018903	0	0	68.02
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,615	1,001,503	0.007604	45,368	345	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,432	8,967,469	0.002278	263,964	601	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	20,294	915,786	0.022160	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	74,491	1,249,018	0.059640	-578	-34	90.00
90.01	09001	SLEEP CENTER	0	0	0.000000	0	0	90.01
91.00	09100	EMERGENCY	0	0	0.000000	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.000000	0	0	92.00
200.00		Total (lines 50-199)	926,273	57,249,230		1,527,779	23,341	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part III Date/Time Prepared: 5/23/2017 1:15 pm

Title XIX | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,719	0.00	474	0		30.00
200.00		Total (lines 30-199)	19,719		474	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 5/23/2017 1:15 pm

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
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
66.01	06601	PHYSICAL THERAPY - CARMEL	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	VISION	0	0	0	0	0	68.01
68.02	06802	FAC RESOURCE	0	0	0	0	0	68.02
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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	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	SLEEP CENTER	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 5/23/2017 1:15 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0.000000	0.000000	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	898,575	0.000000	0.000000	34,840	54.00
60.00	06000	LABORATORY	0	1,369,488	0.000000	0.000000	45,696	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,289,530	0.000000	0.000000	56,474	65.00
66.00	06600	PHYSICAL THERAPY	0	15,428,634	0.000000	0.000000	399,110	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0	1,883,071	0.000000	0.000000	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	12,292,310	0.000000	0.000000	369,243	67.00
68.00	06800	SPEECH PATHOLOGY	0	9,585,716	0.000000	0.000000	279,529	68.00
68.01	06801	VISION	0	1,120,053	0.000000	0.000000	34,133	68.01
68.02	06802	FAC RESOURCE	0	1,248,077	0.000000	0.000000	0	68.02
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,001,503	0.000000	0.000000	45,368	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,967,469	0.000000	0.000000	263,964	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	915,786	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,249,018	0.000000	0.000000	-578	90.00
90.01	09001	SLEEP CENTER	0	0	0.000000	0.000000	0	90.01
91.00	09100	EMERGENCY	0	0	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	57,249,230			1,527,779	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/23/2017 1:15 pm

Title XIX | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0	0	0		66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
68.01	06801	VISION	0	0	0		68.01
68.02	06802	FAC RESOURCE	0	0	0		68.02
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	SLEEP CENTER	0	0	0		90.01
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/23/2017 1:15 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.218003	0	0	0	0	54.00
60.00	06000	LABORATORY	0.340611	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.696415	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.283033	0	98,401	0	0	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0.310651	0	3,563	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.283331	0	62,357	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.162923	0	38,747	0	0	68.00
68.01	06801	VISION	0.242164	0	16,916	0	0	68.01
68.02	06802	FAC RESOURCE	1.576440	0	0	0	0	68.02
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.431526	0	2,003	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	0.337007	0	239,852	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.107839	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.389329	0	64,542	0	0	90.00
90.01	09001	SLEEP CENTER	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	526,381	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	526,381	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/23/2017 1:15 pm

Title XIX | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	27,851	0		66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	1,107	0		66.01
67.00	06700	OCCUPATIONAL THERAPY	17,668	0		67.00
68.00	06800	SPEECH PATHOLOGY	6,313	0		68.00
68.01	06801	VISION	4,096	0		68.01
68.02	06802	FAC RESOURCE	0	0		68.02
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	864	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	80,832	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	25,128	0		90.00
90.01	09001	SLEEP CENTER	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	163,859	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	163,859	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/23/2017 1:15 pm

Title XVIII | 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)	19,719	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	19,719	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)	19,719	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	6,597	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	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	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)	19,653,516	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	19,653,516	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)	19,653,516	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)	996.68	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	6,575,098	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)	6,575,098	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/23/2017 1:15 pm

Title XVIII | 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)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	3,874,008	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	10,449,106	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)	389,685	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	215,067	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	604,752	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	9,844,354	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/23/2017 1:15 pm

Title XVIII | 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	1,164,732	19,653,516	0.059263	0	0	90.00
91.00	Nursing School cost	0	19,653,516	0.000000	0	0	91.00
92.00	Allied health cost	0	19,653,516	0.000000	0	0	92.00
93.00	All other Medical Education	0	19,653,516	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/23/2017 1:15 pm

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	19,719	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	19,719	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)	19,719	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	474	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	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	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)	19,653,516	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	19,653,516	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)	19,653,516	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)	996.68	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	472,426	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)	472,426	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/23/2017 1:15 pm

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						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)	442,186	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	914,612	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)	27,999	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	23,341	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	51,340	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	863,272	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/23/2017 1:15 pm

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,164,732	19,653,516	0.059263	0	0	90.00
91.00	Nursing School cost	0	19,653,516	0.000000	0	0	91.00
92.00	Allied health cost	0	19,653,516	0.000000	0	0	92.00
93.00	All other Medical Education	0	19,653,516	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/23/2017 1:15 pm

Title XVIII | 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		11,493,484		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.000000	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.218003	288,944	62,991	54.00
60.00	06000	LABORATORY	0.340611	497,138	169,331	60.00
65.00	06500	RESPIRATORY THERAPY	0.696415	597,478	416,093	65.00
66.00	06600	PHYSICAL THERAPY	0.283033	3,597,824	1,018,303	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0.310651	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.283331	3,465,580	981,906	67.00
68.00	06800	SPEECH PATHOLOGY	0.162923	2,566,658	418,168	68.00
68.01	06801	VISION	0.242164	0	0	68.01
68.02	06802	FAC RESOURCE	1.576440	0	0	68.02
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.431526	345,965	149,293	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.337007	1,952,252	657,923	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.107839	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.389329	0	0	90.00
90.01	09001	SLEEP CENTER	0.000000	0	0	90.01
91.00	09100	EMERGENCY	0.000000	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		13,311,839	3,874,008	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)		13,311,839		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/23/2017 1:15 pm

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,299,495		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.000000	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.218003	34,840	7,595	54.00
60.00	06000	LABORATORY	0.340611	45,696	15,565	60.00
65.00	06500	RESPIRATORY THERAPY	0.696415	56,474	39,329	65.00
66.00	06600	PHYSICAL THERAPY	0.283033	399,110	112,961	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0.310651	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.283331	369,243	104,618	67.00
68.00	06800	SPEECH PATHOLOGY	0.162923	279,529	45,542	68.00
68.01	06801	VISION	0.242164	34,133	8,266	68.01
68.02	06802	FAC RESOURCE	1.576440	0	0	68.02
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.431526	45,368	19,577	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.337007	263,964	88,958	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.107839	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.389329	-578	-225	90.00
90.01	09001	SLEEP CENTER	0.000000	0	0	90.01
91.00	09100	EMERGENCY	0.000000	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,527,779	442,186	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)		1,527,779		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-3028	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part B Date/Time Prepared: 5/23/2017 1:15 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	542,440	2.00
3.00	PPS payments	436,336	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	0	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	436,336	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	90,201	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)	346,135	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	5,433	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)	351,568	30.00
31.00	Primary payer payments	78	31.00
32.00	Subtotal (line 30 minus line 31)	351,490	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)	45,076	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	29,299	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	45,076	36.00
37.00	Subtotal (see instructions)	380,789	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	380,789	40.00
40.01	Sequestration adjustment (see instructions)	7,616	40.01
41.00	Interim payments	339,136	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	34,037	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E-1 Part I | Date/Time Prepared: 5/23/2017 1:15 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		9,652,700		339,136	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		9,652,700		339,136	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		168,328		34,037	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		9,821,028		373,173	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	Provider CCN: 15-3028	Period: From 01/01/2016 To 12/31/2016	Worksheet E-3 Part III Date/Time Prepared: 5/23/2017 1:15 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	9,063,486	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0321	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	680,668	3.00
4.00	Outlier Payments	310,366	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.34	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	2.92	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.34	9.00
10.00	Average Daily Census (see instructions)	53.877049	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.006414	11.00
12.00	Teaching Adjustment (see instructions)	58,133	12.00
13.00	Total PPS Payment (see instructions)	10,112,653	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	10,112,653	17.00
18.00	Primary payer payments	27,071	18.00
19.00	Subtotal (line 17 less line 18).	10,085,582	19.00
20.00	Deductibles	72,016	20.00
21.00	Subtotal (line 19 minus line 20)	10,013,566	21.00
22.00	Coinsurance	137,858	22.00
23.00	Subtotal (line 21 minus line 22)	9,875,708	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	63,617	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	41,351	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	43,030	26.00
27.00	Subtotal (sum of lines 23 and 25)	9,917,059	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	104,398	28.00
29.00	Other pass through costs (see instructions)	0	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.99	Recovery of Accelerated Depreciation	0	31.99
32.00	Total amount payable to the provider (see instructions)	10,021,457	32.00
32.01	Sequestration adjustment (see instructions)	200,429	32.01
33.00	Interim payments	9,652,700	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 33, and 34)	168,328	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	35,348	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	310,366	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E-4 | Date/Time Prepared: 5/23/2017 1:15 pm

Title XVIII | Hospital | PPS

				1.00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			0.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			3.13	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts			3.13	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			2.92	6.00
7.00	Enter the lesser of line 5 or line 6			2.92	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.00	2.92	2.92	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	0.00	2.92	2.92	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	0.00	2.92		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	3.92		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	3.08		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	3.31		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	0.00	3.31		17.00
18.00	Per resident amount	81,699.89	81,699.89		18.00
19.00	Approved amount for resident costs	0	270,427	270,427	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locally adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			270,427	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD				
26.00	Inpatient Days (see instructions)	6,597	1,644		26.00
27.00	Total Inpatient Days (see instructions)	19,719	19,719		27.00
28.00	Ratio of inpatient days to total inpatient days	0.334550	0.083371		28.00
29.00	Program direct GME amount	90,471	22,546		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		3,186		30.00
31.00	Net Program direct GME amount			109,831	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E-4 | Date/Time Prepared: 5/23/2017 1:15 pm

Title XVIII | Hospital | PPS

		1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)		
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)	0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)	0	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)	0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)	0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)	0	36.00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY		
	Part A Reasonable Cost		
37.00	Reasonable cost (see instructions)	10,449,106	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)	0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)	0	39.00
40.00	Primary payer payments (see instructions)	27,071	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)	10,422,035	41.00
	Part B Reasonable Cost		
42.00	Reasonable cost (see instructions)	542,440	42.00
43.00	Primary payer payments (see instructions)	78	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)	542,362	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)	10,964,397	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)	0.950534	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)	0.049466	47.00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B		
48.00	Total program GME payment (line 31)	109,831	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)	104,398	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)	5,433	50.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G | Date/Time Prepared: 5/23/2017 1:15 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	9,901,104	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	19,886,478	0	0	0	4.00
5.00	Other receivable	395,440	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-13,524,158	0	0	0	6.00
7.00	Inventory	254,854	0	0	0	7.00
8.00	Prepaid expenses	494,806	0	0	0	8.00
9.00	Other current assets	21,614	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)	17,430,138	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	2,506,638	0	0	0	12.00
13.00	Land improvements	322,779	0	0	0	13.00
14.00	Accumulated depreciation	-208,910	0	0	0	14.00
15.00	Buildings	15,162,022	0	0	0	15.00
16.00	Accumulated depreciation	-11,795,242	0	0	0	16.00
17.00	Leasehold improvements	95,017	0	0	0	17.00
18.00	Accumulated depreciation	-90,162	0	0	0	18.00
19.00	Fixed equipment	2,046,848	0	0	0	19.00
20.00	Accumulated depreciation	-1,832,523	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	12,756,822	0	0	0	23.00
24.00	Accumulated depreciation	-8,747,285	0	0	0	24.00
25.00	Minor equipment depreciable	105,832	0	0	0	25.00
26.00	Accumulated depreciation	-105,832	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)	10,216,004	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	3,009,179	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	740,508	0	0	0	33.00
34.00	Other assets	526,389	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	4,276,076	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	31,922,218	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,883,653	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,711,494	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	3,698,654	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	332,465	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	7,626,266	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	13,000,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	438,839	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	13,438,839	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	21,065,105	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	10,857,113				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)	10,857,113	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	31,922,218	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G-1 | Date/Time Prepared: 5/23/2017 1:15 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		9,324,252		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,532,860				2.00
3.00	Total (sum of line 1 and line 2)		10,857,112		0		3.00
4.00	ROUNDING	1		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)		1		0		10.00
11.00	Subtotal (line 3 plus line 10)		10,857,113		0		11.00
12.00		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)		10,857,113		0		19.00

		Endowment Fund	Plant Fund			
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	ROUNDING		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00			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: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/23/2017 1:15 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	34,757,801		34,757,801	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	34,757,801		34,757,801	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)	34,757,801		34,757,801	17.00
18.00	Ancillary services	39,550,835	17,698,395	57,249,230	18.00
19.00	Outpatient services	0	59,062	59,062	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		0	0	24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	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)	74,308,636	17,757,457	92,066,093	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		39,571,236		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)		39,571,236		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-3028 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G-3 | Date/Time Prepared: 5/23/2017 1:15 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	92,066,093	1.00
2.00	Less contractual allowances and discounts on patients' accounts	53,018,996	2.00
3.00	Net patient revenues (line 1 minus line 2)	39,047,097	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	39,571,236	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-524,139	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	2,056,999	24.00
25.00	Total other income (sum of lines 6-24)	2,056,999	25.00
26.00	Total (line 5 plus line 25)	1,532,860	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,532,860	29.00