

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 01/01/2017 To 12/31/2017	Worksheet S Parts I-III Date/Time Prepared: 5/29/2018 4:11 pm
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**PART I - COST REPORT STATUS**

Provider use only

1.  Electronically filed cost report  
 2.  Manually submitted cost report  
 3.  If this is an amended report enter the number of times the provider resubmitted this cost report  
 4.  Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5.  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.  Initial Report for this Provider CCN  
 9.  Final Report for this Provider CCN

10. NPR Date:  
 11. Contractor's Vendor Code: 4  
 12.  If line 5, column 1 is 4: Enter number of times reopened = 0-9.

Date: 5/29/2018 Time: 4:11 pm

**PART II - CERTIFICATION**

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by REHABILITATION HOSPITAL OF INDIANA ( 15-3028 ) for the cost reporting period beginning 01/01/2017 and ending 12/31/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) \_\_\_\_\_  
 Officer or Administrator of Provider(s)

\_\_\_\_\_  
 Title

\_\_\_\_\_  
 Date

Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	-25,726	40,374	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	-25,726	40,374	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-MEDI-CARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 15-3028		Period: From 01/01/2017 To 12/31/2017		Worksheet S-2 Part I Date/Time Prepared: 5/29/2018 4:06 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			
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
		1.00		2.00	3.00	4.00	5.00	V	XVIII	XIX	
								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
4.00	Subprovider - IPF										
5.00	Subprovider - IRF										
6.00	Subprovider - (Other)										
7.00	Swing Beds - SNF										
8.00	Swing Beds - NF										
9.00	Hospital-Based SNF										
10.00	Hospital-Based NF										
11.00	Hospital-Based OLTC										
12.00	Hospital-Based HHA										
13.00	Separately Certified ASC										
14.00	Hospital-Based Hospice										
15.00	Hospital-Based Health Clinic - RHC										
16.00	Hospital-Based Health Clinic - FQHC										
17.00	Hospital-Based (CMHC) I										
17.10	Hospital-Based (CORF) I										
18.00	Renal Dialysis										
19.00	Other										
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2017	12/31/2017		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		
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.			654	348	0	0	3,848	25.00		

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		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)(i) or (ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N				39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N				40.00
		V	XVIII	XIX			
		1.00	2.00	3.00			
<b>Prospective Payment System (PPS)-Capital</b>							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N			45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N			46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.	N	N	N			47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N			48.00
<b>Teaching Hospitals</b>							
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
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
		1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)	N					60.00
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03

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	Y/N	IME	Direct GME	IME	Direct GME			
	1.00	2.00	3.00	4.00	5.00			
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.04	
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05	
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06	
	Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count			
	1.00		2.00	3.00	4.00			
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.						61.10	0.00 0.00
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.						61.20	0.00 0.00
							1.00	
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 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)						62.00	0.00
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) Teaching Hospitals that Claim Residents in Nonprovider Settings						62.01	0.00
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)						63.00	N
	Program Name		Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
	1.00		2.00	3.00	4.00	5.00		
64.00	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. 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)						64.00	0.00 0.00 0.000000

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000		66.00
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		67.00
					1.00	2.00	3.00
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	71.00
75.00	Inpatient Rehabilitation Facility PPS 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 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			Y	N	0	76.00

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						1.00			
<b>Long Term Care Hospital PPS</b>									
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	
<b>TEFRA Providers</b>									
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.					N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.							86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.					N		87.00	
						V	XIX		
						1.00	2.00		
<b>Title V and XIX Services</b>									
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.					N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.					N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.						N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.					N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.					N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.					0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.					N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.					0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					N	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 1? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					N	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					N	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					N	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					N	Y	98.06	
<b>Rural Providers</b>									
105.00	Does this hospital qualify as a 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
						1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.						N		110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-3028	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 5/29/2018 4:06 pm		
		1.00	2.00			
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N				111.00
		1.00	2.00	3.00		
<b>Miscellaneous Cost Reporting Information</b>						
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:	78,701	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 healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N				122.00
<b>Transplant Center Information</b>						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N				125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00
<b>All Providers</b>						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		15H059		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-3028		Period: From 01/01/2017 To 12/31/2017		Worksheet S-2 Part I Date/Time Prepared: 5/29/2018 4:06 pm		
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.						N	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.							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		
Multi campus								
165.00	Is this hospital part of a Multi campus 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
						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)							168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)							168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00
						Beginning	Ending	
						1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)							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. 1, 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 01/01/2017 To 12/31/2017		Worksheet S-2 Part II Date/Time Prepared: 5/29/2018 4:06 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				
		1.00	2.00				
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				
		1.00	2.00				
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	04/05/2018			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	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					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	04/18/2018	Y	04/18/2018		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 01/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Prepared: 5/29/2018 4:06 pm	
		Description	Y/N	Y/N	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	0	1.00	3.00	20.00
			N	N	
		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	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relieved 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
<b>Interest Expense</b>					
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
<b>Purchased Services</b>					
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
<b>Provider-Based Physicians</b>					
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	
<b>Home Office Costs</b>					
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	
<b>Cost Report Preparer Contact Information</b>					
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 01/01/2017  
To 12/31/2017

Worksheet S-2  
Part II  
Date/Time Prepared:  
5/29/2018 4:06 pm

		3.00	
<b>Cost Report Preparer Contact Information</b>			
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 01/01/2017  
To 12/31/2017

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/29/2018 4:06 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits	Trips
	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	33,215	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	33,215	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	33,215	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
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-3028

Period:  
From 01/01/2017  
To 12/31/2017

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/29/2018 4:06 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	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)	6,770	654	19,719			1.00
2.00 HMO and other (see instructions)	1,777	4,196				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	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	6,770	654	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)	6,770	654	19,719	2.82	288.78	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)				2.82	288.78	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
33.01 LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-3028

Period:  
From 01/01/2017  
To 12/31/2017

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/29/2018 4:06 pm

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
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	463	34	1,298	1.00
2.00 HMO and other (see instructions)				130	249		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	463	34		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				0			33.00
33.01 LTCH site neutral days and discharges				0			33.01

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-3028

Period:  
From 01/01/2017  
To 12/31/2017

Worksheet A  
Date/Time Prepared:  
5/29/2018 4:06 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100		1,198,172	1,198,172	0	1,198,172	1.00
2.00	00200		1,010,571	1,010,571	0	1,010,571	2.00
3.00	00300		0	0	0	0	3.00
4.00	00400	156,098	5,564,154	5,720,252	-8,144	5,712,108	4.00
5.01	00591	2,871,319	1,940,767	4,812,086	-133,029	4,679,057	5.01
5.02	00590	732,334	222,841	955,175	-243	954,932	5.02
7.00	00700	290,852	1,229,588	1,520,440	-3,253	1,517,187	7.00
8.00	00800	0	99,954	99,954	0	99,954	8.00
9.00	00900	276,385	151,649	428,034	-363	427,671	9.00
10.00	01000	59,872	919,281	979,153	-315,341	663,812	10.00
11.00	01100	0	0	0	315,117	315,117	11.00
13.00	01300	1,312,809	244,341	1,557,150	116,856	1,674,006	13.00
14.00	01400	60,647	101,793	162,440	333,180	495,620	14.00
15.00	01500	474,685	154,493	629,178	6,336	635,514	15.00
16.00	01600	266,116	132,252	398,368	0	398,368	16.00
17.00	01700	290,351	42,508	332,859	0	332,859	17.00
22.00	02200	0	238,573	238,573	0	238,573	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	5,991,509	1,614,795	7,606,304	-312,677	7,293,627	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	0	0	0	0	50.00
54.00	05400	73,644	22,542	96,186	-2,525	93,661	54.00
60.00	06000	0	435,040	435,040	-1,064	433,976	60.00
65.00	06500	340,993	190,174	531,167	-100,499	430,668	65.00
66.00	06600	1,566,815	326,976	1,893,791	192,747	2,086,538	66.00
66.01	06601	221,210	104,023	325,233	-650	324,583	66.01
67.00	06700	1,377,581	148,411	1,525,992	271,133	1,797,125	67.00
68.00	06800	657,585	101,036	758,621	162,490	921,111	68.00
68.01	06801	157,153	26,597	183,750	-1,280	182,470	68.01
68.02	06802	1,080,287	315,650	1,395,937	-12,605	1,383,332	68.02
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	0	0	175,525	175,525	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	1,755,202	1,755,202	0	1,755,202	73.00
74.00	07400	0	0	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	191,030	60,819	251,849	-28,574	223,275	90.00
90.01	09001	0	0	0	0	0	90.01
91.00	09100	0	0	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.00	09900	0	0	0	0	0	99.00
99.10	09910	436,477	201,835	638,312	-638,313	-1	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00							
		18,885,752	18,554,037	37,439,789	14,824	37,454,613	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	647,303	587,035	1,234,338	-14,636	1,219,702	192.00
194.00	07950	95,347	14,401	109,748	-188	109,560	194.00
194.01	07951	151,087	248,425	399,512	0	399,512	194.01
194.02	07952	125,021	130,787	255,808	0	255,808	194.02
194.03	07953	103,867	18,384	122,251	0	122,251	194.03
194.04	07954	125,229	11,970	137,199	0	137,199	194.04
200.00		20,133,606	19,565,039	39,698,645	0	39,698,645	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-3028

Period:  
From 01/01/2017  
To 12/31/2017

Worksheet A  
Date/Time Prepared:  
5/29/2018 4:06 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT	84,478	1,282,650	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	62,494	1,073,065	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-3,139	5,708,969	4.00
5.01	00591	ADMINISTRATIVE AND GENERAL	1,667,226	6,346,283	5.01
5.02	00590	OTHER A&G - NON FOUNDATION	-53,760	901,172	5.02
7.00	00700	OPERATION OF PLANT	-38,939	1,478,248	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	99,954	8.00
9.00	00900	HOUSEKEEPING	0	427,671	9.00
10.00	01000	DIETARY	0	663,812	10.00
11.00	01100	CAFETERIA	-132,360	182,757	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,674,006	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-997	494,623	14.00
15.00	01500	PHARMACY	-26,757	608,757	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	398,368	16.00
17.00	01700	SOCIAL SERVICE	0	332,859	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	238,573	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	0	7,293,627	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	93,661	54.00
60.00	06000	LABORATORY	-92,734	341,242	60.00
65.00	06500	RESPIRATORY THERAPY	0	430,668	65.00
66.00	06600	PHYSICAL THERAPY	0	2,086,538	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0	324,583	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	1,797,125	67.00
68.00	06800	SPEECH PATHOLOGY	0	921,111	68.00
68.01	06801	VISION	-3,420	179,050	68.01
68.02	06802	FAC RESOURCE	-40,294	1,343,038	68.02
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	175,525	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,755,202	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0	223,275	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
<b>OTHER REIMBURSABLE COST CENTERS</b>					
99.00	09900	CMHC	0	0	99.00
99.10	09910	CORF	0	-1	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,421,798	38,876,411	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-1,900	1,217,802	192.00
194.00	07950	FOUNDATION	460,823	570,383	194.00
194.01	07951	PUBLIC RELATIONS	0	399,512	194.01
194.02	07952	ST. VINCENT - ARU	0	255,808	194.02
194.03	07953	MUNCIE - ARU	0	122,251	194.03
194.04	07954	RILEY - ARU	0	137,199	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	1,880,721	41,579,366	200.00



		Increases			
Cost Center		Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
<b>A - CAFETERIA</b>					
1.00	CAFETERIA	11.00	19,273	295,844	1.00
	0		19,273	295,844	
<b>B - NURSING ADMINISTRATION</b>					
1.00	NURSING ADMINISTRATION	13.00	132,915	0	1.00
	0		132,915	0	
<b>C - NCR (CORF)</b>					
1.00	PHYSICAL THERAPY	66.00	136,613	63,356	1.00
2.00	OCCUPATIONAL THERAPY	67.00	187,686	87,044	2.00
3.00	SPEECH PATHOLOGY	68.00	112,178	52,024	3.00
	0		436,477	202,424	
<b>D - MEDICAL SUPPLIES</b>					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	333,180	1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	175,525	2.00
3.00	PHARMACY	15.00	0	6,336	3.00
4.00	CORF	99.10	0	588	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	515,629	
500.00	Grand Total: Increases		588,665	1,013,897	500.00

RECLASSIFICATIONS

Provider CCN: 15-3028

Period:  
From 01/01/2017  
To 12/31/2017

Worksheet A-6  
Date/Time Prepared:  
5/29/2018 4:06 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
<b>A - CAFETERIA</b>							
1.00	DIETARY	10.00	19,273	295,844	0		1.00
	O		19,273	295,844			
<b>B - NURSING ADMINISTRATION</b>							
1.00	ADMINISTRATIVE AND GENERAL	5.01	132,915	0	0		1.00
	O		132,915	0			
<b>C - NCR (CORF)</b>							
1.00	CORF	99.10	436,477	202,424	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	O		436,477	202,424			
<b>D - MEDICAL SUPPLIES</b>							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	8,144	0		1.00
2.00	ADMINISTRATIVE AND GENERAL	5.01	0	114	0		2.00
3.00	OTHER A&G - NON FOUNDATION	5.02	0	243	0		3.00
4.00	OPERATION OF PLANT	7.00	0	3,253	0		4.00
5.00	HOUSEKEEPING	9.00	0	363	0		5.00
6.00	DIETARY	10.00	0	224	0		6.00
7.00	NURSING ADMINISTRATION	13.00	0	16,059	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	312,677	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,525	0		9.00
10.00	LABORATORY	60.00	0	1,064	0		10.00
11.00	RESPIRATORY THERAPY	65.00	0	100,499	0		11.00
12.00	PHYSICAL THERAPY	66.00	0	7,222	0		12.00
13.00	PHYSICAL THERAPY - CARMEL	66.01	0	650	0		13.00
14.00	OCCUPATIONAL THERAPY	67.00	0	3,597	0		14.00
15.00	SPEECH PATHOLOGY	68.00	0	1,712	0		15.00
16.00	VISION	68.01	0	1,280	0		16.00
17.00	FAC RESOURCE	68.02	0	12,605	0		17.00
18.00	CLINIC	90.00	0	28,574	0		18.00
19.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	14,636	0		19.00
20.00	FOUNDATION	194.00	0	188	0		20.00
	O		0	515,629			
500.00	Grand Total: Decreases		588,665	1,013,897			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-3028

Period:  
From 01/01/2017  
To 12/31/2017

Worksheet A-7  
Part I  
Date/Time Prepared:  
5/29/2018 4:06 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	2,506,638	0	0	0	1.00
2.00	Land Improvements	322,779	48,131	0	48,131	2.00
3.00	Buildings and Fixtures	15,162,022	292,294	0	292,294	3.00
4.00	Building Improvements	95,017	92,562	0	92,562	4.00
5.00	Fixed Equipment	2,046,848	81,323	0	81,323	5.00
6.00	Movable Equipment	12,862,654	527,062	0	527,062	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	32,995,958	1,041,372	0	1,041,372	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	32,995,958	1,041,372	0	1,041,372	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	2,506,638	0			1.00
2.00	Land Improvements	370,910	0			2.00
3.00	Buildings and Fixtures	15,454,316	0			3.00
4.00	Building Improvements	187,579	0			4.00
5.00	Fixed Equipment	2,128,171	0			5.00
6.00	Movable Equipment	13,389,716	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	34,037,330	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	34,037,330	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-3028

Period:  
From 01/01/2017  
To 12/31/2017

Worksheet A-7  
Part II  
Date/Time Prepared:  
5/29/2018 4:06 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	651,513	0	511,485	35,174	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	991,833	0	0	3,847	0	2.00
3.00	Total (sum of lines 1-2)	1,643,346	0	511,485	39,021	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	1,198,172				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	14,891	1,010,571				2.00
3.00	Total (sum of lines 1-2)	14,891	2,208,743				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-3028

Period:  
From 01/01/2017  
To 12/31/2017

Worksheet A-7  
Part III  
Date/Time Prepared:  
5/29/2018 4:06 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	34,037,330	0	34,037,330	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)	34,037,330	0	34,037,330	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	755,702	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,054,327	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,810,029	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	477,592	35,174	0	14,182	1,282,650	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,847	0	14,891	1,073,065	2.00
3.00	Total (sum of lines 1-2)	477,592	39,021	0	29,073	2,355,715	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-3028

Period:  
From 01/01/2017  
To 12/31/2017

Worksheet A-8

Date/Time Prepared:  
5/29/2018 4:06 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center		Line #	
			1.00	2.00	3.00	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-33,893	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	-11,708	OPERATION OF PLANT		7.00	0 7.00
8.00 Television and radio service (chapter 21)	A	-27,353	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	1,950,266				0 12.00
13.00 Laundry and linen service		0			0.00	0 13.00
14.00 Cafeteria-employees and guests	B	-132,360	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	-997	CENTRAL SERVICES & SUPPLY		14.00	0 16.00
17.00 Sale of drugs to other than patients	B	-26,757	PHARMACY		15.00	0 17.00
18.00 Sale of medical records and abstracts		0			0.00	0 18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)		0			0.00	0 19.00
20.00 Vending machines		0			0.00	0 20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00	0 21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00	0 22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY		65.00	23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY		66.00	24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***		114.00	25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT		0	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	-967	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-3028

Period:  
From 01/01/2017  
To 12/31/2017

Worksheet A-8

Date/Time Prepared:  
5/29/2018 4:06 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.		
			Cost Center	Line #			
			1.00	2.00		3.00	4.00
33.01	MI SCCELLANEOUS REVENUE	B	-206,569	ADMINISTRATIVE AND GENERAL	5.01	0	33.01
33.02	MI SCCELLANEOUS REVENUE	B	-53,760	OTHER A&G - NON FOUNDATION	5.02	0	33.02
33.03	MI SCCELLANEOUS REVENUE	B	-3,420	VISION	68.01	0	33.03
33.04	MI SCCELLANEOUS REVENUE	B	-40,069	FAC RESOURCE	68.02	0	33.04
33.05	MI SCCELLANEOUS REVENUE	B	-1,900	PHYSICIANS' PRIVATE OFFICES	192.00	0	33.05
33.06	RHI FOUNDATION	A	460,823	FOUNDATION	194.00	0	33.06
33.07	DONATIONS	A	528	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.07
33.08	DONATIONS	A	-2,400	ADMINISTRATIVE AND GENERAL	5.01	0	33.08
33.09	ADVERTISING	A	-2,700	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.09
33.10	ADVERTISING	A	-225	FAC RESOURCE	68.02	0	33.10
33.11	TAXES	A	122	OPERATION OF PLANT	7.00	0	33.11
33.12	TAXES	A	-122	ADMINISTRATIVE AND GENERAL	5.01	0	33.12
33.13	BOND ISSUANCE COST	A	14,182	CAP REL COSTS-BLDG & FIXT	1.00	14	33.13
50.00	AMORTIZATION CARR TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		1,880,721				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 01/01/2017 To 12/31/2017  
 Worksheet A-8-1  
 Date/Time Prepared: 5/29/2018 4:06 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	104,189	0
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	ALLOCATION FROM HO REPORT	62,494	0
3.00	5.01	ADMINISTRATIVE AND GENERAL	ALLOCATION FROM HO REPORT	2,210,036	333,719
4.00	60.00	LABORATORY	ALLOCATION FROM HO REPORT	340,890	433,624
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			2,717,609	767,343

\* 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.

Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office	
			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 01/01/2017  
To 12/31/2017

Worksheet A-8-1

Date/Time Prepared:  
5/29/2018 4:06 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>				
1.00	104,189	9		1.00
2.00	62,494	9		2.00
3.00	1,876,317	0		3.00
4.00	-92,734	0		4.00
5.00	1,950,266			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>B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:</b>			

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 requested 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 01/01/2017  
To 12/31/2017

Worksheet B  
Part I  
Date/Time Prepared:  
5/29/2018 4:06 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	1,282,650	1,282,650			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	1,073,065		1,073,065		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	5,708,969	21,707	18,160	5,748,836	4.00
5.01 00591	ADMINISTRATIVE AND GENERAL	6,346,283	40,725	34,071	788,017	7,209,096
5.02 00590	OTHER A&G - NON FOUNDATION	901,172	26,932	22,531	210,740	1,161,375
7.00 00700	OPERATION OF PLANT	1,478,248	16,622	13,906	83,697	1,592,473
8.00 00800	LAUNDRY & LINEN SERVICE	99,954	0	0	0	99,954
9.00 00900	HOUSEKEEPING	427,671	10,840	9,068	79,534	527,113
10.00 01000	DIETARY	663,812	44,947	37,603	11,683	758,045
11.00 01100	CAFETERIA	182,757	21,345	17,857	5,546	227,505
13.00 01300	NURSING ADMINISTRATION	1,674,006	8,833	7,390	416,029	2,106,258
14.00 01400	CENTRAL SERVICES & SUPPLY	494,623	11,049	9,243	17,452	532,367
15.00 01500	PHARMACY	608,757	5,462	4,569	136,598	755,386
16.00 01600	MEDICAL RECORDS & LIBRARY	398,368	14,574	12,192	76,579	501,713
17.00 01700	SOCIAL SERVICE	332,859	3,873	3,240	83,553	423,525
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	238,573	0	0	0	238,573
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	7,293,627	558,272	467,053	1,724,153	10,043,105
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	0	0	0	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	93,661	7,315	6,119	21,192	128,287
60.00 06000	LABORATORY	341,242	4,194	3,509	0	348,945
65.00 06500	RESPIRATORY THERAPY	430,668	16,636	13,917	98,126	559,347
66.00 06600	PHYSICAL THERAPY	2,086,538	204,519	171,101	490,187	2,952,345
66.01 06601	PHYSICAL THERAPY - CARMEL	324,583	0	0	63,656	388,239
67.00 06700	OCCUPATIONAL THERAPY	1,797,125	161,216	134,873	450,429	2,543,643
68.00 06800	SPEECH PATHOLOGY	921,111	31,627	26,459	221,511	1,200,708
68.01 06801	VISION	179,050	0	0	45,223	224,273
68.02 06802	FAC RESOURCE	1,343,038	7,774	6,504	310,869	1,668,185
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	175,525	0	0	0	175,525
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	1,755,202	0	0	0	1,755,202
74.00 07400	RENAL DIALYSIS	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	223,275	42,467	35,528	54,972	356,242
90.01 09001	SLEEP CENTER	0	0	0	0	0
91.00 09100	EMERGENCY	0	0	0	0	0
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.00 09900	CMHC	0	0	0	0	0
99.10 09910	CORF	-1	0	0	0	-1
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	38,876,411	1,260,929	1,054,893	5,389,746	38,477,428
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	1,217,802	19,492	16,307	186,271	1,439,872
194.00 07950	FOUNDATION	570,383	2,229	1,865	27,438	601,915
194.01 07951	PUBLIC RELATIONS	399,512	0	0	43,478	442,990
194.02 07952	ST. VINCENT - ARU	255,808	0	0	35,977	291,785
194.03 07953	MUNCIE - ARU	122,251	0	0	29,889	152,140
194.04 07954	RILEY - ARU	137,199	0	0	36,037	173,236
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118 through 201)	41,579,366	1,282,650	1,073,065	5,748,836	41,579,366

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-3028

Period:  
From 01/01/2017  
To 12/31/2017

Worksheet B  
Part I  
Date/Time Prepared:  
5/29/2018 4:06 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	
<b>GENERAL SERVICE COST CENTERS</b>								
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	7,209,096					5.01
5.02	00590	OTHER A&G - NON FOUNDATION	243,596	1,404,971	1,404,971			5.02
7.00	00700	OPERATION OF PLANT	334,018	1,926,491	67,373	1,993,864		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	20,965	120,919	4,229	0	125,148	8.00
9.00	00900	HOUSEKEEPING	110,561	637,674	22,301	18,368	0	9.00
10.00	01000	DIETARY	158,998	917,043	32,071	76,163	0	10.00
11.00	01100	CAFETERIA	47,719	275,224	9,625	36,169	0	11.00
13.00	01300	NURSING ADMINISTRATION	441,783	2,548,041	89,110	14,968	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	111,663	644,030	22,523	18,722	0	14.00
15.00	01500	PHARMACY	158,441	913,827	31,958	9,255	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	105,233	606,946	21,226	24,695	0	16.00
17.00	01700	SOCIAL SERVICE	88,834	512,359	17,918	6,563	0	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	50,040	288,613	10,093	0	0	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	2,106,524	12,149,629	424,890	945,996	123,034	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,908	155,195	5,427	12,395	0	54.00
60.00	06000	LABORATORY	73,191	422,136	14,763	7,106	0	60.00
65.00	06500	RESPIRATORY THERAPY	117,322	676,669	23,664	28,189	0	65.00
66.00	06600	PHYSICAL THERAPY	619,248	3,571,593	124,906	346,559	127	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	81,432	469,671	16,425	0	1,707	66.01
67.00	06700	OCCUPATIONAL THERAPY	533,524	3,077,167	107,615	273,182	175	67.00
68.00	06800	SPEECH PATHOLOGY	251,846	1,452,554	50,799	53,593	105	68.00
68.01	06801	VISION	47,041	271,314	9,488	0	0	68.01
68.02	06802	FAC RESOURCE	349,898	2,018,083	70,576	13,174	0	68.02
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	36,816	212,341	7,426	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	368,150	2,123,352	74,258	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	74,721	430,963	15,072	71,961	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
<b>OTHER REIMBURSABLE COST CENTERS</b>								
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	-1	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,558,472	37,826,804	1,273,736	1,957,058	125,148	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	302,010	1,741,882	60,917	33,029	0	192.00
194.00	07950	FOUNDATION	126,250	728,165	25,465	3,777	0	194.00
194.01	07951	PUBLIC RELATIONS	92,916	535,906	18,742	0	0	194.01
194.02	07952	ST. VINCENT - ARU	61,201	352,986	12,345	0	0	194.02
194.03	07953	MUNCIE - ARU	31,911	184,051	6,437	0	0	194.03
194.04	07954	RILEY - ARU	36,336	209,572	7,329	0	0	194.04
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	7,209,096	41,579,366	1,404,971	1,993,864	125,148	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-3028

Period:  
From 01/01/2017  
To 12/31/2017

Worksheet B  
Part I  
Date/Time Prepared:  
5/29/2018 4:06 pm

Cost Center Description		HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		9.00	10.00	11.00	13.00	14.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00591						5.01
5.02	00590						5.02
7.00	00700						7.00
8.00	00800						8.00
9.00	00900	678,343					9.00
10.00	01000	26,153	1,051,430				10.00
11.00	01100	12,420	0	333,438			11.00
13.00	01300	5,140	0	33,644	2,690,903		13.00
14.00	01400	6,429	0	2,528	0	694,232	14.00
15.00	01500	3,178	0	8,085	150,506	0	15.00
16.00	01600	8,480	0	7,647	142,354	0	16.00
17.00	01700	2,254	0	5,997	0	0	17.00
22.00	02200	0	0	0	0	0	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	324,831	1,051,430	120,732	2,247,524	242,601	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	0	0	0	0	50.00
54.00	05400	4,256	0	1,532	28,518	3,548	54.00
60.00	06000	2,440	0	5,017	0	1,504	60.00
65.00	06500	9,680	0	6,554	122,001	128,344	65.00
66.00	06600	119,001	0	33,598	0	7,960	66.00
66.01	06601	0	0	4,564	0	798	66.01
67.00	06700	93,805	0	32,523	0	4,064	67.00
68.00	06800	18,403	0	15,580	0	2,319	68.00
68.01	06801	0	0	2,983	0	1,595	68.01
68.02	06802	4,524	0	26,138	0	13,974	68.02
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	0	0	0	248,037	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	24,710	0	4,904	0	22,201	90.00
90.01	09001	0	0	0	0	0	90.01
91.00	09100	0	0	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.00	09900	0	0	0	0	0	99.00
99.10	09910	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		665,704	1,051,430	312,026	2,690,903	676,945	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	11,342	0	11,069	0	17,055	192.00
194.00	07950	1,297	0	7,389	0	232	194.00
194.01	07951	0	0	2,954	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		678,343	1,051,430	333,438	2,690,903	694,232	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-3028

Period:  
From 01/01/2017  
To 12/31/2017

Worksheet B  
Part I  
Date/Time Prepared:  
5/29/2018 4:06 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		
<b>GENERAL SERVICE COST CENTERS</b>							
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	1,116,809					15.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	0	811,348				16.00	
17.00 01700 SOCIAL SERVICE	0	0	545,091			17.00	
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	298,706		22.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000 ADULTS & PEDIATRICS	0	811,348	545,091	298,706	19,285,812	30.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	210,871	54.00	
60.00 06000 LABORATORY	0	0	0	0	452,966	60.00	
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	995,101	65.00	
66.00 06600 PHYSICAL THERAPY	0	0	0	0	4,203,744	66.00	
66.01 06601 PHYSICAL THERAPY - CARMEL	0	0	0	0	493,165	66.01	
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	3,588,531	67.00	
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	1,593,353	68.00	
68.01 06801 VISION	0	0	0	0	285,380	68.01	
68.02 06802 FAC RESOURCE	0	0	0	0	2,146,469	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	467,804	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	1,116,809	0	0	0	3,314,419	73.00	
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00	
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00 09000 CLINIC	0	0	0	0	569,811	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	
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.00 09900 CMHC	0	0	0	0	0	99.00	
99.10 09910 CORF	0	0	0	0	-1	99.10	
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	1,116,809	811,348	545,091	298,706	37,607,425	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
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	1,875,294	192.00	
194.00 07950 FOUNDATION	0	0	0	0	766,325	194.00	
194.01 07951 PUBLIC RELATIONS	0	0	0	0	557,602	194.01	
194.02 07952 ST. VINCENT - ARU	0	0	0	0	365,331	194.02	
194.03 07953 MUNCIE - ARU	0	0	0	0	190,488	194.03	
194.04 07954 RILEY - ARU	0	0	0	0	216,901	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 through 201)	1,116,809	811,348	545,091	298,706	41,579,366	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-3028	Period: From 01/01/2017 To 12/31/2017	Worksheet B Part I Date/Time Prepared: 5/29/2018 4:06 pm
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Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>				
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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000	ADULTS & PEDIATRICS	-298,706	18,987,106
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000	OPERATING ROOM	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	210,871
60.00	06000	LABORATORY	0	452,966
65.00	06500	RESPIRATORY THERAPY	0	995,101
66.00	06600	PHYSICAL THERAPY	0	4,203,744
66.01	06601	PHYSICAL THERAPY - CARMEL	0	493,165
67.00	06700	OCCUPATIONAL THERAPY	0	3,588,531
68.00	06800	SPEECH PATHOLOGY	0	1,593,353
68.01	06801	VISION	0	285,380
68.02	06802	FAC RESOURCE	0	2,146,469
69.00	06900	ELECTROCARDIOLOGY	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	467,804
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,314,419
74.00	07400	RENAL DIALYSIS	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000	CLINIC	0	569,811
90.01	09001	SLEEP CENTER	0	0
91.00	09100	EMERGENCY	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>				
99.00	09900	CMHC	0	0
99.10	09910	CORF	0	-1
<b>SPECIAL PURPOSE COST CENTERS</b>				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-298,706	37,308,719
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,875,294
194.00	07950	FOUNDATION	0	766,325
194.01	07951	PUBLIC RELATIONS	0	557,602
194.02	07952	ST. VINCENT - ARU	0	365,331
194.03	07953	MUNCIE - ARU	0	190,488
194.04	07954	RILEY - ARU	0	216,901
200.00		Cross Foot Adjustments	0	0
201.00		Negative Cost Centers	0	0
202.00		TOTAL (sum lines 118 through 201)	-298,706	41,280,660

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-3028	Period: From 01/01/2017 To 12/31/2017	Worksheet B Part II Date/Time Prepared: 5/29/2018 4:06 pm
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	2.00			
<b>GENERAL SERVICE COST CENTERS</b>						
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	21,707	18,160	39,867	39,867 4.00
5.01 00591	ADMINISTRATIVE AND GENERAL	0	40,725	34,071	74,796	5,466 5.01
5.02 00590	OTHER A&G - NON FOUNDATION	0	26,932	22,531	49,463	1,462 5.02
7.00 00700	OPERATION OF PLANT	0	16,622	13,906	30,528	581 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0 8.00
9.00 00900	HOUSEKEEPING	0	10,840	9,068	19,908	552 9.00
10.00 01000	DIETARY	0	44,947	37,603	82,550	81 10.00
11.00 01100	CAFETERIA	0	21,345	17,857	39,202	38 11.00
13.00 01300	NURSING ADMINISTRATION	0	8,833	7,390	16,223	2,886 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	11,049	9,243	20,292	121 14.00
15.00 01500	PHARMACY	0	5,462	4,569	10,031	947 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	14,574	12,192	26,766	531 16.00
17.00 01700	SOCIAL SERVICE	0	3,873	3,240	7,113	580 17.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0 22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	558,272	467,053	1,025,325	11,950 30.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	0	0	0	0 50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	7,315	6,119	13,434	147 54.00
60.00 06000	LABORATORY	0	4,194	3,509	7,703	0 60.00
65.00 06500	RESPIRATORY THERAPY	0	16,636	13,917	30,553	681 65.00
66.00 06600	PHYSICAL THERAPY	0	204,519	171,101	375,620	3,400 66.00
66.01 06601	PHYSICAL THERAPY - CARMEL	0	0	0	0	442 66.01
67.00 06700	OCCUPATIONAL THERAPY	0	161,216	134,873	296,089	3,124 67.00
68.00 06800	SPEECH PATHOLOGY	0	31,627	26,459	58,086	1,536 68.00
68.01 06801	VISION	0	0	0	0	314 68.01
68.02 06802	FAC RESOURCE	0	7,774	6,504	14,278	2,156 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
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	42,467	35,528	77,995	381 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
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.00 09900	CMHC	0	0	0	0	0 99.00
99.10 09910	CORF	0	0	0	0	0 99.10
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	1,260,929	1,054,893	2,315,822	37,376 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	19,492	16,307	35,799	1,292 192.00
194.00 07950	FOUNDATION	0	2,229	1,865	4,094	190 194.00
194.01 07951	PUBLIC RELATIONS	0	0	0	0	302 194.01
194.02 07952	ST. VINCENT - ARU	0	0	0	0	250 194.02
194.03 07953	MUNCIE - ARU	0	0	0	0	207 194.03
194.04 07954	RILEY - ARU	0	0	0	0	250 194.04
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 through 201)	0	1,282,650	1,073,065	2,355,715	39,867 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-3028

Period:  
From 01/01/2017  
To 12/31/2017

Worksheet B  
Part II  
Date/Time Prepared:  
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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	
<b>GENERAL SERVICE COST CENTERS</b>							
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	80,262				5.01
5.02	00590	OTHER A&G - NON FOUNDATION	2,712	53,637			5.02
7.00	00700	OPERATION OF PLANT	3,718	2,572	37,399		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	233	161	0	394	8.00
9.00	00900	HOUSEKEEPING	1,231	851	345	0	22,887
10.00	01000	DIETARY	1,770	1,224	1,429	0	882
11.00	01100	CAFETERIA	531	367	678	0	419
13.00	01300	NURSING ADMINISTRATION	4,918	3,402	281	0	173
14.00	01400	CENTRAL SERVICES & SUPPLY	1,243	860	351	0	217
15.00	01500	PHARMACY	1,764	1,220	174	0	107
16.00	01600	MEDICAL RECORDS & LIBRARY	1,171	810	463	0	286
17.00	01700	SOCIAL SERVICE	989	684	123	0	76
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	557	385	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	23,459	16,227	17,744	388	10,959
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	300	207	232	0	144
60.00	06000	LABORATORY	815	564	133	0	82
65.00	06500	RESPIRATORY THERAPY	1,306	903	529	0	327
66.00	06600	PHYSICAL THERAPY	6,894	4,768	6,500	0	4,015
66.01	06601	PHYSICAL THERAPY - CARMEL	907	627	0	5	0
67.00	06700	OCCUPATIONAL THERAPY	5,939	4,108	5,124	1	3,165
68.00	06800	SPEECH PATHOLOGY	2,804	1,939	1,005	0	621
68.01	06801	VISION	524	362	0	0	0
68.02	06802	FAC RESOURCE	3,895	2,694	247	0	153
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	410	283	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	4,098	2,835	0	0	0
74.00	07400	RENAL DIALYSIS	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	832	575	1,350	0	834
90.01	09001	SLEEP CENTER	0	0	0	0	0
91.00	09100	EMERGENCY	0	0	0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.00	09900	CMHC	0	0	0	0	0
99.10	09910	CORF	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	73,020	48,628	36,708	394	22,460
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,362	2,325	620	0	383
194.00	07950	FOUNDATION	1,405	972	71	0	44
194.01	07951	PUBLIC RELATIONS	1,034	715	0	0	0
194.02	07952	ST. VINCENT - ARU	681	471	0	0	0
194.03	07953	MUNCIE - ARU	355	246	0	0	0
194.04	07954	RILEY - ARU	405	280	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	80,262	53,637	37,399	394	22,887



ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-3028		Period: From 01/01/2017 To 12/31/2017		Worksheet B Part II Date/Time Prepared: 5/29/2018 4:06 pm	
Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00591						5.01
5.02	00590						5.02
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	87,936					10.00
11.00	01100	0	41,235				11.00
13.00	01300	0	4,161	32,044			13.00
14.00	01400	0	313	0	23,397		14.00
15.00	01500	0	1,000	1,792	0	17,035	15.00
16.00	01600	0	946	1,695	0	0	16.00
17.00	01700	0	742	0	0	0	17.00
22.00	02200	0	0	0	0	0	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	87,936	14,931	26,764	8,176	0	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	0	0	0	0	50.00
54.00	05400	0	189	340	120	0	54.00
60.00	06000	0	620	0	51	0	60.00
65.00	06500	0	810	1,453	4,325	0	65.00
66.00	06600	0	4,155	0	268	0	66.00
66.01	06601	0	564	0	27	0	66.01
67.00	06700	0	4,022	0	137	0	67.00
68.00	06800	0	1,927	0	78	0	68.00
68.01	06801	0	369	0	54	0	68.01
68.02	06802	0	3,232	0	471	0	68.02
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	0	0	8,359	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	17,035	73.00
74.00	07400	0	0	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	606	0	748	0	90.00
90.01	09001	0	0	0	0	0	90.01
91.00	09100	0	0	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.00	09900	0	0	0	0	0	99.00
99.10	09910	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		87,936	38,587	32,044	22,814	17,035	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	1,369	0	575	0	192.00
194.00	07950	0	914	0	8	0	194.00
194.01	07951	0	365	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		87,936	41,235	32,044	23,397	17,035	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-3028	Period: From 01/01/2017 To 12/31/2017	Worksheet B Part II Date/Time Prepared: 5/29/2018 4:06 pm
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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
<b>GENERAL SERVICE COST CENTERS</b>					
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	32,668			16.00
17.00 01700	SOCIAL SERVICE	0	10,307		17.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	942	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00 03000	ADULTS & PEDIATRICS	32,668	10,307	1,286,834	0 30.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 05000	OPERATING ROOM	0	0	0	0 50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	15,113	0 54.00
60.00 06000	LABORATORY	0	0	9,968	0 60.00
65.00 06500	RESPIRATORY THERAPY	0	0	40,887	0 65.00
66.00 06600	PHYSICAL THERAPY	0	0	405,620	0 66.00
66.01 06601	PHYSICAL THERAPY - CARMEL	0	0	2,572	0 66.01
67.00 06700	OCCUPATIONAL THERAPY	0	0	321,709	0 67.00
68.00 06800	SPEECH PATHOLOGY	0	0	67,996	0 68.00
68.01 06801	VISION	0	0	1,623	0 68.01
68.02 06802	FAC RESOURCE	0	0	27,126	0 68.02
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	9,052	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	23,968	0 73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0 74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00 09000	CLINIC	0	0	83,321	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	0	0	0 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
99.00 09900	CMHC	0	0	0	0 99.00
99.10 09910	CORF	0	0	0	0 99.10
<b>SPECIAL PURPOSE COST CENTERS</b>					
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	32,668	10,307	0	2,295,789 0 118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	45,725	0 192.00
194.00 07950	FOUNDATION	0	0	7,698	0 194.00
194.01 07951	PUBLIC RELATIONS	0	0	2,416	0 194.01
194.02 07952	ST. VINCENT - ARU	0	0	1,402	0 194.02
194.03 07953	MUNCIE - ARU	0	0	808	0 194.03
194.04 07954	RILEY - ARU	0	0	935	0 194.04
200.00	Cross Foot Adjustments			942	0 200.00
201.00	Negative Cost Centers	0	0	0	0 201.00
202.00	TOTAL (sum lines 118 through 201)	32,668	10,307	942	2,355,715 0 202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-3028	Period: From 01/01/2017 To 12/31/2017	Worksheet B Part II Date/Time Prepared: 5/29/2018 4:06 pm
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Cost Center Description		Total	
		26.00	
<b>GENERAL SERVICE COST CENTERS</b>			
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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000	ADULTS & PEDIATRICS	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00	05000	OPERATING ROOM	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	66.01
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
68.01	06801	VISION	68.01
68.02	06802	FAC RESOURCE	68.02
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
90.00	09000	CLINIC	90.00
90.01	09001	SLEEP CENTER	90.01
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>			
99.00	09900	CMHC	99.00
99.10	09910	CORF	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
194.00	07950	FOUNDATION	194.00
194.01	07951	PUBLIC RELATIONS	194.01
194.02	07952	ST. VINCENT - ARU	194.02
194.03	07953	MUNCIE - ARU	194.03
194.04	07954	RILEY - ARU	194.04
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-3028

Period:  
From 01/01/2017  
To 12/31/2017

Worksheet B-1  
Date/Time Prepared:  
5/29/2018 4:06 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
<b>GENERAL SERVICE COST CENTERS</b>						
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	19,977,508		4.00
5.01 00591	ADMINISTRATIVE AND GENERAL	2,923	2,923	2,738,404	-7,209,096	34,370,271
5.02 00590	OTHER A&G - NON FOUNDATION	1,933	1,933	732,334	0	1,161,375
7.00 00700	OPERATION OF PLANT	1,193	1,193	290,852	0	1,592,473
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	99,954
9.00 00900	HOUSEKEEPING	778	778	276,385	0	527,113
10.00 01000	DIETARY	3,226	3,226	40,599	0	758,045
11.00 01100	CAFETERIA	1,532	1,532	19,273	0	227,505
13.00 01300	NURSING ADMINISTRATION	634	634	1,445,724	0	2,106,258
14.00 01400	CENTRAL SERVICES & SUPPLY	793	793	60,647	0	532,367
15.00 01500	PHARMACY	392	392	474,685	0	755,386
16.00 01600	MEDICAL RECORDS & LIBRARY	1,046	1,046	266,116	0	501,713
17.00 01700	SOCIAL SERVICE	278	278	290,351	0	423,525
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	238,573
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	40,069	40,069	5,991,509	0	10,043,105
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	0	0	0	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	525	525	73,644	0	128,287
60.00 06000	LABORATORY	301	301	0	0	348,945
65.00 06500	RESPIRATORY THERAPY	1,194	1,194	340,993	0	559,347
66.00 06600	PHYSICAL THERAPY	14,679	14,679	1,703,428	0	2,952,345
66.01 06601	PHYSICAL THERAPY - CARMEL	0	0	221,210	0	388,239
67.00 06700	OCCUPATIONAL THERAPY	11,571	11,571	1,565,267	0	2,543,643
68.00 06800	SPEECH PATHOLOGY	2,270	2,270	769,763	0	1,200,708
68.01 06801	VISION	0	0	157,153	0	224,273
68.02 06802	FAC RESOURCE	558	558	1,080,287	0	1,668,185
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	175,525
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,755,202
74.00 07400	RENAL DIALYSIS	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	3,048	3,048	191,030	0	356,242
90.01 09001	SLEEP CENTER	0	0	0	0	0
91.00 09100	EMERGENCY	0	0	0	0	0
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.00 09900	CMHC	0	0	0	0	0
99.10 09910	CORF	0	0	0	1	0
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	90,501	90,501	18,729,654	-7,209,095	31,268,333
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	1,399	1,399	647,303	0	1,439,872
194.00 07950	FOUNDATION	160	160	95,347	0	601,915
194.01 07951	PUBLIC RELATIONS	0	0	151,087	0	442,990
194.02 07952	ST. VINCENT - ARU	0	0	125,021	0	291,785
194.03 07953	MUNCIE - ARU	0	0	103,867	0	152,140
194.04 07954	RILEY - ARU	0	0	125,229	0	173,236
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					
202.00	Cost to be allocated (per Wkst. B, Part I)	1,282,650	1,073,065	5,748,836		7,209,096
203.00	Unit cost multiplier (Wkst. B, Part I)	13.932761	11.656148	0.287765		0.209748
204.00	Cost to be allocated (per Wkst. B, Part II)			39,867		80,262
205.00	Unit cost multiplier (Wkst. B, Part II)			0.001996		0.002335
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)					
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)					

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-3028

Period:  
From 01/01/2017  
To 12/31/2017

Worksheet B-1

Date/Time Prepared:  
5/29/2018 4:06 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	
<b>GENERAL SERVICE COST CENTERS</b>							
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	-1,404,971	40,174,396			5.02
7.00	00700	OPERATION OF PLANT	0	1,926,491	84,453		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	120,919	0	189,853	8.00
9.00	00900	HOUSEKEEPING	0	637,674	778	0	83,675
10.00	01000	DIETARY	0	917,043	3,226	0	3,226
11.00	01100	CAFETERIA	0	275,224	1,532	0	1,532
13.00	01300	NURSING ADMINISTRATION	0	2,548,041	634	0	634
14.00	01400	CENTRAL SERVICES & SUPPLY	0	644,030	793	0	793
15.00	01500	PHARMACY	0	913,827	392	0	392
16.00	01600	MEDICAL RECORDS & LIBRARY	0	606,946	1,046	0	1,046
17.00	01700	SOCIAL SERVICE	0	512,359	278	0	278
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	288,613	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	0	12,149,629	40,069	186,646	40,069
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	155,195	525	0	525
60.00	06000	LABORATORY	0	422,136	301	0	301
65.00	06500	RESPIRATORY THERAPY	0	676,669	1,194	0	1,194
66.00	06600	PHYSICAL THERAPY	0	3,571,593	14,679	193	14,679
66.01	06601	PHYSICAL THERAPY - CARMEL	0	469,671	0	2,589	0
67.00	06700	OCCUPATIONAL THERAPY	0	3,077,167	11,571	266	11,571
68.00	06800	SPEECH PATHOLOGY	0	1,452,554	2,270	159	2,270
68.01	06801	VISION	0	271,314	0	0	0
68.02	06802	FAC RESOURCE	0	2,018,083	558	0	558
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	212,341	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,123,352	0	0	0
74.00	07400	RENAL DIALYSIS	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	430,963	3,048	0	3,048
90.01	09001	SLEEP CENTER	0	0	0	0	0
91.00	09100	EMERGENCY	0	0	0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.00	09900	CMHC	0	0	0	0	0
99.10	09910	CORF	1	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,404,970	36,421,834	82,894	189,853	82,116
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,741,882	1,399	0	1,399
194.00	07950	FOUNDATION	0	728,165	160	0	160
194.01	07951	PUBLIC RELATIONS	0	535,906	0	0	0
194.02	07952	ST. VINCENT - ARU	0	352,986	0	0	0
194.03	07953	MUNCIE - ARU	0	184,051	0	0	0
194.04	07954	RILEY - ARU	0	209,572	0	0	0
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)		1,404,971	1,993,864	125,148	678,343
203.00		Unit cost multiplier (Wkst. B, Part I)		0.034972	23.609155	0.659184	8.106878
204.00		Cost to be allocated (per Wkst. B, Part II)		53,637	37,399	394	22,887
205.00		Unit cost multiplier (Wkst. B, Part II)		0.001335	0.442838	0.002075	0.273523
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-3028

Period:  
From 01/01/2017  
To 12/31/2017

Worksheet B-1

Date/Time Prepared:  
5/29/2018 4:06 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	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00591						5.01
5.02	00590						5.02
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	59,157					10.00
11.00	01100	0	475,148				11.00
13.00	01300	0	47,942	205,985			13.00
14.00	01400	0	3,603	0	491,280		14.00
15.00	01500	0	11,521	11,521	0	100	15.00
16.00	01600	0	10,897	10,897	0	0	16.00
17.00	01700	0	8,545	0	0	0	17.00
22.00	02200	0	0	0	0	0	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	59,157	172,045	172,045	171,679	0	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	0	0	0	0	50.00
54.00	05400	0	2,183	2,183	2,511	0	54.00
60.00	06000	0	7,149	0	1,064	0	60.00
65.00	06500	0	9,339	9,339	90,824	0	65.00
66.00	06600	0	47,877	0	5,633	0	66.00
66.01	06601	0	6,503	0	565	0	66.01
67.00	06700	0	46,345	0	2,876	0	67.00
68.00	06800	0	22,201	0	1,641	0	68.00
68.01	06801	0	4,251	0	1,129	0	68.01
68.02	06802	0	37,247	0	9,889	0	68.02
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	0	0	175,525	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	100	73.00
74.00	07400	0	0	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	6,988	0	15,711	0	90.00
90.01	09001	0	0	0	0	0	90.01
91.00	09100	0	0	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.00	09900	0	0	0	0	0	99.00
99.10	09910	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		59,157	444,636	205,985	479,047	100	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	15,773	0	12,069	0	192.00
194.00	07950	0	10,530	0	164	0	194.00
194.01	07951	0	4,209	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
200.00							200.00
201.00							201.00
202.00		1,051,430	333,438	2,690,903	694,232	1,116,809	202.00
203.00		17.773552	0.701756	13.063587	1.413109	11,168.090000	203.00
204.00		87,936	41,235	32,044	23,397	17,035	204.00
205.00		1.486485	0.086783	0.155565	0.047625	170.350000	205.00
206.00							206.00
207.00							207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-3028

Period:  
From 01/01/2017  
To 12/31/2017

Worksheet B-1  
Date/Time Prepared:  
5/29/2018 4:06 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	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.01	00591				5.01
5.02	00590				5.02
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600	19,719			16.00
17.00	01700	0	19,719		17.00
22.00	02200	0	0	100	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	19,719	19,719	100	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	0	0	0	50.00
54.00	05400	0	0	0	54.00
60.00	06000	0	0	0	60.00
65.00	06500	0	0	0	65.00
66.00	06600	0	0	0	66.00
66.01	06601	0	0	0	66.01
67.00	06700	0	0	0	67.00
68.00	06800	0	0	0	68.00
68.01	06801	0	0	0	68.01
68.02	06802	0	0	0	68.02
69.00	06900	0	0	0	69.00
71.00	07100	0	0	0	71.00
72.00	07200	0	0	0	72.00
73.00	07300	0	0	0	73.00
74.00	07400	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	0	0	0	90.00
90.01	09001	0	0	0	90.01
91.00	09100	0	0	0	91.00
92.00	09200	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
99.00	09900	0	0	0	99.00
99.10	09910	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>					
118.00		19,719	19,719	100	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	0	0	0	190.00
192.00	19200	0	0	0	192.00
194.00	07950	0	0	0	194.00
194.01	07951	0	0	0	194.01
194.02	07952	0	0	0	194.02
194.03	07953	0	0	0	194.03
194.04	07954	0	0	0	194.04
200.00					200.00
201.00					201.00
202.00		811,348	545,091	298,706	202.00
203.00		41,145,494	27,642,933	2,987,060,000	203.00
204.00		32,668	10,307	942	204.00
205.00		1,656,676	0,522,694	9,420,000	205.00
206.00					206.00
207.00					207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-3028

Period:  
From 01/01/2017  
To 12/31/2017

Worksheet C  
Part I  
Date/Time Prepared:  
5/29/2018 4:06 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	Hospital		
					RCE Disallowance	Total Costs	
1.00	2.00	3.00	4.00	5.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	18,987,106		18,987,106	0	18,987,106	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0		0	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	210,871		210,871	0	210,871	54.00
60.00	06000 LABORATORY	452,966		452,966	0	452,966	60.00
65.00	06500 RESPIRATORY THERAPY	995,101	0	995,101	0	995,101	65.00
66.00	06600 PHYSICAL THERAPY	4,203,744	0	4,203,744	0	4,203,744	66.00
66.01	06601 PHYSICAL THERAPY - CARMEL	493,165	0	493,165	0	493,165	66.01
67.00	06700 OCCUPATIONAL THERAPY	3,588,531	0	3,588,531	0	3,588,531	67.00
68.00	06800 SPEECH PATHOLOGY	1,593,353	0	1,593,353	0	1,593,353	68.00
68.01	06801 VISION	285,380	0	285,380	0	285,380	68.01
68.02	06802 FAC RESOURCE	2,146,469	0	2,146,469	0	2,146,469	68.02
69.00	06900 ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	467,804		467,804	0	467,804	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3,314,419		3,314,419	0	3,314,419	73.00
74.00	07400 RENAL DIALYSIS	0		0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	569,811		569,811	0	569,811	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	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.00	09900 CMHC	0		0		0	99.00
99.10	09910 CORF	0		0		0	99.10
200.00	Subtotal (see instructions)	37,308,720	0	37,308,720	0	37,308,720	200.00
201.00	Less Observation Beds	0		0		0	201.00
202.00	Total (see instructions)	37,308,720	0	37,308,720	0	37,308,720	202.00



COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-3028

Period:  
From 01/01/2017  
To 12/31/2017

Worksheet C  
Part I  
Date/Time Prepared:  
5/29/2018 4:06 pm

		Title XVIII			Hospital	PPS	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	36,072,024		36,072,024			30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	0	0	0.000000	0.000000	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	951,074	0	951,074	0.221719	0.000000	54.00
60.00	06000 LABORATORY	1,619,169	0	1,619,169	0.279752	0.000000	60.00
65.00	06500 RESPIRATORY THERAPY	1,415,570	0	1,415,570	0.702968	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	10,490,708	5,336,581	15,827,289	0.265601	0.000000	66.00
66.01	06601 PHYSICAL THERAPY - CARMEL	0	1,464,362	1,464,362	0.336778	0.000000	66.01
67.00	06700 OCCUPATIONAL THERAPY	10,845,049	2,330,431	13,175,480	0.272364	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	9,283,589	1,346,979	10,630,568	0.149884	0.000000	68.00
68.01	06801 VISION	723,946	542,867	1,266,813	0.225274	0.000000	68.01
68.02	06802 FAC RESOURCE	0	1,321,941	1,321,941	1.623725	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	1,085,866	54,790	1,140,656	0.410118	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	5,890,146	4,385,727	10,275,873	0.322544	0.000000	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	3,140	2,276,010	2,279,150	0.250010	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
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.00	09900 CMHC	0	0	0			99.00
99.10	09910 CORF	0	0	0			99.10
200.00	Subtotal (see instructions)	78,380,281	19,059,688	97,439,969			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	78,380,281	19,059,688	97,439,969			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-3028	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Prepared: 5/29/2018 4:06 pm
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.000000		50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.221719		54.00
60.00	06000 LABORATORY	0.279752		60.00
65.00	06500 RESPIRATORY THERAPY	0.702968		65.00
66.00	06600 PHYSICAL THERAPY	0.265601		66.00
66.01	06601 PHYSICAL THERAPY - CARMEL	0.336778		66.01
67.00	06700 OCCUPATIONAL THERAPY	0.272364		67.00
68.00	06800 SPEECH PATHOLOGY	0.149884		68.00
68.01	06801 VISION	0.225274		68.01
68.02	06802 FAC RESOURCE	1.623725		68.02
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.410118		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.322544		73.00
74.00	07400 RENAL DIALYSIS	0.000000		74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0.250010		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
<b>OTHER REIMBURSABLE COST CENTERS</b>				
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 01/01/2017  
To 12/31/2017

Worksheet C  
Part I  
Date/Time Prepared:  
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Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	Hospital		
					RCE Disallowance	Total Costs	
1.00	2.00	3.00	4.00	5.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	18,987,106		18,987,106	0	18,987,106	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0		0	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	210,871		210,871	0	210,871	54.00
60.00	06000 LABORATORY	452,966		452,966	0	452,966	60.00
65.00	06500 RESPIRATORY THERAPY	995,101	0	995,101	0	995,101	65.00
66.00	06600 PHYSICAL THERAPY	4,203,744	0	4,203,744	0	4,203,744	66.00
66.01	06601 PHYSICAL THERAPY - CARMEL	493,165	0	493,165	0	493,165	66.01
67.00	06700 OCCUPATIONAL THERAPY	3,588,531	0	3,588,531	0	3,588,531	67.00
68.00	06800 SPEECH PATHOLOGY	1,593,353	0	1,593,353	0	1,593,353	68.00
68.01	06801 VISION	285,380	0	285,380	0	285,380	68.01
68.02	06802 FAC RESOURCE	2,146,469	0	2,146,469	0	2,146,469	68.02
69.00	06900 ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	467,804		467,804	0	467,804	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3,314,419		3,314,419	0	3,314,419	73.00
74.00	07400 RENAL DIALYSIS	0		0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	569,811		569,811	0	569,811	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	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.00	09900 CMHC	0		0	0	0	99.00
99.10	09910 CORF	0		0	0	0	99.10
200.00	Subtotal (see instructions)	37,308,720	0	37,308,720	0	37,308,720	200.00
201.00	Less Observation Beds	0		0	0	0	201.00
202.00	Total (see instructions)	37,308,720	0	37,308,720	0	37,308,720	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-3028

Period:  
From 01/01/2017  
To 12/31/2017

Worksheet C  
Part I  
Date/Time Prepared:  
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		Title XIX			Hospital	PPS	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00	9.00	10.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	36,072,024		36,072,024			30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	0	0	0.000000	0.000000	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	951,074	0	951,074	0.221719	0.000000	54.00
60.00	06000 LABORATORY	1,619,169	0	1,619,169	0.279752	0.000000	60.00
65.00	06500 RESPIRATORY THERAPY	1,415,570	0	1,415,570	0.702968	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	10,490,708	5,336,581	15,827,289	0.265601	0.000000	66.00
66.01	06601 PHYSICAL THERAPY - CARMEL	0	1,464,362	1,464,362	0.336778	0.000000	66.01
67.00	06700 OCCUPATIONAL THERAPY	10,845,049	2,330,431	13,175,480	0.272364	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	9,283,589	1,346,979	10,630,568	0.149884	0.000000	68.00
68.01	06801 VISION	723,946	542,867	1,266,813	0.225274	0.000000	68.01
68.02	06802 FAC RESOURCE	0	1,321,941	1,321,941	1.623725	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	1,085,866	54,790	1,140,656	0.410118	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	5,890,146	4,385,727	10,275,873	0.322544	0.000000	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	3,140	2,276,010	2,279,150	0.250010	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
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.00	09900 CMHC	0	0	0			99.00
99.10	09910 CORF	0	0	0			99.10
200.00	Subtotal (see instructions)	78,380,281	19,059,688	97,439,969			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	78,380,281	19,059,688	97,439,969			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-3028

Period:  
From 01/01/2017  
To 12/31/2017

Worksheet C  
Part I  
Date/Time Prepared:  
5/29/2018 4:06 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	PPS
		11.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS				30.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.000000			50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.221719			54.00
60.00	06000 LABORATORY	0.279752			60.00
65.00	06500 RESPIRATORY THERAPY	0.702968			65.00
66.00	06600 PHYSICAL THERAPY	0.265601			66.00
66.01	06601 PHYSICAL THERAPY - CARMEL	0.336778			66.01
67.00	06700 OCCUPATIONAL THERAPY	0.272364			67.00
68.00	06800 SPEECH PATHOLOGY	0.149884			68.00
68.01	06801 VISION	0.225274			68.01
68.02	06802 FAC RESOURCE	1.623725			68.02
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.410118			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.322544			73.00
74.00	07400 RENAL DIALYSIS	0.000000			74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	0.250010			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
<b>OTHER REIMBURSABLE COST CENTERS</b>					
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 01/01/2017  
To 12/31/2017

Worksheet C  
Part II  
Date/Time Prepared:  
5/29/2018 4:06 pm

Cost Center Description		Title XIX			Hospital		PPS
		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	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	210,871	15,113	195,758	0	54.00
60.00	06000	LABORATORY	452,966	9,968	442,998	0	60.00
65.00	06500	RESPIRATORY THERAPY	995,101	40,887	954,214	0	65.00
66.00	06600	PHYSICAL THERAPY	4,203,744	405,620	3,798,124	0	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	493,165	2,572	490,593	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	3,588,531	321,709	3,266,822	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,593,353	67,996	1,525,357	0	68.00
68.01	06801	VISION	285,380	1,623	283,757	0	68.01
68.02	06802	FAC RESOURCE	2,146,469	27,126	2,119,343	0	68.02
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	467,804	9,052	458,752	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,314,419	23,968	3,290,451	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	569,811	83,321	486,490	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	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.00	09900	CMHC	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	99.10
200.00		Subtotal (sum of lines 50 thru 199)	18,321,614	1,008,955	17,312,659	0	200.00
201.00		Less Observation Beds	0	0	0	0	201.00
202.00		Total (line 200 minus line 201)	18,321,614	1,008,955	17,312,659	0	202.00

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

Provider CCN: 15-3028

Period:  
From 01/01/2017  
To 12/31/2017

Worksheet C  
Part II  
Date/Time Prepared:  
5/29/2018 4:06 pm

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)	PPS
		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	210,871	951,074	0.221719	54.00
60.00	06000 LABORATORY	452,966	1,619,169	0.279752	60.00
65.00	06500 RESPIRATORY THERAPY	995,101	1,415,570	0.702968	65.00
66.00	06600 PHYSICAL THERAPY	4,203,744	15,827,289	0.265601	66.00
66.01	06601 PHYSICAL THERAPY - CARMEL	493,165	1,464,362	0.336778	66.01
67.00	06700 OCCUPATIONAL THERAPY	3,588,531	13,175,480	0.272364	67.00
68.00	06800 SPEECH PATHOLOGY	1,593,353	10,630,568	0.149884	68.00
68.01	06801 VISION	285,380	1,266,813	0.225274	68.01
68.02	06802 FAC RESOURCE	2,146,469	1,321,941	1.623725	68.02
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	467,804	1,140,656	0.410118	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3,314,419	10,275,873	0.322544	73.00
74.00	07400 RENAL DIALYSIS	0	0	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	569,811	2,279,150	0.250010	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)	18,321,614	61,367,945		200.00
201.00	Less Observation Beds	0	0		201.00
202.00	Total (line 200 minus line 201)	18,321,614	61,367,945		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-3028		Period: From 01/01/2017 To 12/31/2017		Worksheet D Part I Date/Time Prepared: 5/29/2018 4:06 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	1,286,834	0	1,286,834	19,719	65.26	30.00
200.00	Total (lines 30 through 199)	1,286,834		1,286,834	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	6,770	441,810				
200.00	Total (lines 30 through 199)	6,770	441,810				



APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 15-3028	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part II Date/Time Prepared: 5/29/2018 4:06 pm
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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	
Title XVIII Hospital PPS							
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0.000000	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	15,113	951,074	0.015890	362,978	5,768	54.00
60.00	06000 LABORATORY	9,968	1,619,169	0.006156	575,028	3,540	60.00
65.00	06500 RESPIRATORY THERAPY	40,887	1,415,570	0.028884	650,370	18,785	65.00
66.00	06600 PHYSICAL THERAPY	405,620	15,827,289	0.025628	3,620,937	92,797	66.00
66.01	06601 PHYSICAL THERAPY - CARMEL	2,572	1,464,362	0.001756	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	321,709	13,175,480	0.024417	3,948,875	96,420	67.00
68.00	06800 SPEECH PATHOLOGY	67,996	10,630,568	0.006396	3,309,769	21,169	68.00
68.01	06801 VISION	1,623	1,266,813	0.001281	0	0	68.01
68.02	06802 FAC RESOURCE	27,126	1,321,941	0.020520	0	0	68.02
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9,052	1,140,656	0.007936	361,966	2,873	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	23,968	10,275,873	0.002332	2,094,253	4,884	73.00
74.00	07400 RENAL DIALYSIS	0	0	0.000000	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	83,321	2,279,150	0.036558	2,004	73	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 through 199)	1,008,955	61,367,945		14,926,180	246,309	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 15-3028		Period: From 01/01/2017 To 12/31/2017		Worksheet D Part III Date/Time Prepared: 5/29/2018 4:06 pm		
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	PPS	
			1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 + col. 6)	Inpatient Program Days		
			4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	19,719	0.00	6,770	30.00	
200.00		Total (lines 30 through 199)	0	0	19,719		6,770	200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
			9.00						
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0						30.00
200.00		Total (lines 30 through 199)	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-3028	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 5/29/2018 4:06 pm
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Cost Center Description	Title XVIII		Hospital		PPS		
	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health		
	1.00	2A	2.00	3A	3.00		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000 OPERATING ROOM	0	0	0	0	0	0	50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
60.00 06000 LABORATORY	0	0	0	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	0	66.00
66.01 06601 PHYSICAL THERAPY - CARMEL	0	0	0	0	0	0	66.01
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
68.01 06801 VISION	0	0	0	0	0	0	68.01
68.02 06802 FAC RESOURCE	0	0	0	0	0	0	68.02
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00 09000 CLINIC	0	0	0	0	0	0	90.00
90.01 09001 SLEEP CENTER	0	0	0	0	0	0	90.01
91.00 09100 EMERGENCY	0	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
200.00 Total (lines 50 through 199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-3028	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 5/29/2018 4:06 pm
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Cost Center Description		Title XVIII			Hospital	PPS	
		All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
		4.00	5.00	6.00	7.00	8.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	951,074	54.00
60.00	06000	LABORATORY	0	0	0	1,619,169	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,415,570	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	15,827,289	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0	0	0	1,464,362	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	13,175,480	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	10,630,568	68.00
68.01	06801	VISION	0	0	0	1,266,813	68.01
68.02	06802	FAC RESOURCE	0	0	0	1,321,941	68.02
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,140,656	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	0	10,275,873	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	2,279,150	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	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	61,367,945	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-3028	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 5/29/2018 4:06 pm
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Cost Center Description		Title XVIII			Hospital		PPS
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.000000	0	0	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	362,978	0	0	0	54.00
60.00	06000 LABORATORY	0.000000	575,028	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.000000	650,370	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	3,620,937	0	2,097	0	66.00
66.01	06601 PHYSICAL THERAPY - CARMEL	0.000000	0	0	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	0.000000	3,948,875	0	3,495	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	3,309,769	0	0	0	68.00
68.01	06801 VISION	0.000000	0	0	0	0	68.01
68.02	06802 FAC RESOURCE	0.000000	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	0.000000	361,966	0	14,155	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	2,094,253	0	1,806,371	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0.000000	2,004	0	614,158	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	Total (lines 50 through 199)		14,926,180	0	2,440,276	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-3028	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Prepared: 5/29/2018 4:06 pm
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Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs			
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
								1.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.221719	0	0	0	0	54.00
60.00	06000	LABORATORY	0.279752	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.702968	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.265601	2,097	0	0	557	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0.336778	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.272364	3,495	0	0	952	67.00
68.00	06800	SPEECH PATHOLOGY	0.149884	0	0	0	0	68.00
68.01	06801	VISION	0.225274	0	0	0	0	68.01
68.02	06802	FAC RESOURCE	1.623725	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	0.410118	14,155	0	0	5,805	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	0.322544	1,806,371	0	0	582,634	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0.250010	614,158	0	0	153,546	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)		2,440,276	0	0	743,494	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		2,440,276	0	0	743,494	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-3028	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Prepared: 5/29/2018 4:06 pm
Title XVIII		Hospital	PPS

Cost Center Description	Costs				
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
<b>ANCILLARY SERVICE COST CENTERS</b>					
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
<b>OUTPATIENT SERVICE COST CENTERS</b>					
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 01/01/2017 To 12/31/2017		Worksheet D Part I Date/Time Prepared: 5/29/2018 4:06 pm	
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)	PPS
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	1,286,834	0	1,286,834	19,719	65.26	30.00
200.00	Total (lines 30 through 199)	1,286,834		1,286,834	19,719		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	654	42,680				
200.00	Total (lines 30 through 199)	654	42,680				



APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-3028	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part II Date/Time Prepared: 5/29/2018 4:06 pm
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Cost Center Description		Title XIX			Hospital	PPS
		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
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	0	0	0.000000	0	0 50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	15,113	951,074	0.015890	17,252	274 54.00
60.00	06000 LABORATORY	9,968	1,619,169	0.006156	41,985	258 60.00
65.00	06500 RESPIRATORY THERAPY	40,887	1,415,570	0.028884	39,950	1,154 65.00
66.00	06600 PHYSICAL THERAPY	405,620	15,827,289	0.025628	341,821	8,760 66.00
66.01	06601 PHYSICAL THERAPY - CARMEL	2,572	1,464,362	0.001756	0	0 66.01
67.00	06700 OCCUPATIONAL THERAPY	321,709	13,175,480	0.024417	355,571	8,682 67.00
68.00	06800 SPEECH PATHOLOGY	67,996	10,630,568	0.006396	256,397	1,640 68.00
68.01	06801 VISION	1,623	1,266,813	0.001281	18,522	24 68.01
68.02	06802 FAC RESOURCE	27,126	1,321,941	0.020520	0	0 68.02
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0	0 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9,052	1,140,656	0.007936	39,781	316 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	23,968	10,275,873	0.002332	177,204	413 73.00
74.00	07400 RENAL DIALYSIS	0	0	0.000000	0	0 74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC	83,321	2,279,150	0.036558	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 through 199)	1,008,955	61,367,945		1,288,483	21,521 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 15-3028		Period: From 01/01/2017 To 12/31/2017		Worksheet D Part III Date/Time Prepared: 5/29/2018 4:06 pm		
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
			1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 + col. 6)	Inpatient Program Days		
			4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	19,719	0.00	654	30.00	
200.00		Total (lines 30 through 199)	0	0	19,719	0.00	654	200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
			9.00						
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0						30.00
200.00		Total (lines 30 through 199)	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-3028	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 5/29/2018 4:06 pm
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Cost Center Description	Title XIX		Hospital		PPS	
	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
	1.00	2A	2.00	3A	3.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
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
<b>OUTPATIENT SERVICE COST CENTERS</b>						
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 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-3028	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 5/29/2018 4:06 pm
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Cost Center Description	Title XIX			Hospital	PPS			
	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	Total Outpatient Cost (sum of col 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)			
	4.00	5.00	6.00	7.00	8.00			
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	0.000000	50.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	951,074	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	1,619,169	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,415,570	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	15,827,289	0.000000	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0	0	0	1,464,362	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	13,175,480	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	10,630,568	0.000000	68.00
68.01	06801	VISION	0	0	0	1,266,813	0.000000	68.01
68.02	06802	FAC RESOURCE	0	0	0	1,321,941	0.000000	68.02
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,140,656	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,275,873	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	2,279,150	0.000000	90.00
90.01	09001	SLEEP CENTER	0	0	0	0	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	0	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	61,367,945		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-3028	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 5/29/2018 4:06 pm
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Cost Center Description		Title XIX			Hospital		PPS
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.000000	0	0	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	17,252	0	0	0	54.00
60.00	06000 LABORATORY	0.000000	41,985	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.000000	39,950	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	341,821	0	80,563	0	66.00
66.01	06601 PHYSICAL THERAPY - CARMEL	0.000000	0	0	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	0.000000	355,571	0	54,332	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	256,397	0	28,599	0	68.00
68.01	06801 VISION	0.000000	18,522	0	17,976	0	68.01
68.02	06802 FAC RESOURCE	0.000000	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	0.000000	39,781	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	177,204	0	436,509	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0.000000	0	0	118,780	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	Total (lines 50 through 199)		1,288,483	0	736,759	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-3028	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Prepared: 5/29/2018 4:06 pm
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		Title XIX		Hospital		PPS	
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.000000	0	0	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.221719	0	0	0	0	54.00
60.00	06000 LABORATORY	0.279752	0	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.702968	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.265601	80,563	0	0	21,398	66.00
66.01	06601 PHYSICAL THERAPY - CARMEL	0.336778	0	0	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	0.272364	54,332	0	0	14,798	67.00
68.00	06800 SPEECH PATHOLOGY	0.149884	28,599	0	0	4,287	68.00
68.01	06801 VISION	0.225274	17,976	0	0	4,050	68.01
68.02	06802 FAC RESOURCE	1.623725	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	0.410118	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.322544	436,509	0	0	140,793	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0.250010	118,780	0	0	29,696	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)		736,759	0	0	215,022	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00	Net Charges (line 200 - line 201)		736,759	0	0	215,022	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-3028	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Prepared: 5/29/2018 4:06 pm
	Title XIX	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
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
<b>OUTPATIENT SERVICE COST CENTERS</b>				
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

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-3028	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/29/2018 4:06 pm
Cost Center Description				PPS
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
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)		6,770	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
<b>SWING BED ADJUSTMENT</b>				
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)		18,987,106	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)		18,987,106	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		18,987,106	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		962.88	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		6,518,698	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)		6,518,698	41.00



COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-3028		Period: From 01/01/2017 To 12/31/2017		Worksheet D-1	
Title XVIII		Hospital		PPS		Date/Time Prepared: 5/29/2018 4:06 pm	
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)					4,056,308	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					10,575,006	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)					441,810	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					246,309	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					688,119	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					9,886,887	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 01/01/2017 To 12/31/2017		Worksheet D-1 Date/Time Prepared: 5/29/2018 4:06 pm	
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)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,286,834	18,987,106	0.067774	0	0	90.00
91.00	Nursing School cost	0	18,987,106	0.000000	0	0	91.00
92.00	Allied health cost	0	18,987,106	0.000000	0	0	92.00
93.00	All other Medical Education	0	18,987,106	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-3028	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/29/2018 4:06 pm
Cost Center Description				PPS
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
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)		654	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
<b>SWING BED ADJUSTMENT</b>				
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)		18,987,106	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)		18,987,106	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		18,987,106	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		962.88	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		629,724	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)		629,724	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-3028	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/29/2018 4:06 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)					347,361 48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					977,085 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)					42,680 50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					21,521 51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					64,201 52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					912,884 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 01/01/2017 To 12/31/2017		Worksheet D-1 Date/Time Prepared: 5/29/2018 4:06 pm	
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	1,286,834	18,987,106	0.067774	0	0	90.00
91.00	Nursing School cost	0	18,987,106	0.000000	0	0	91.00
92.00	Allied health cost	0	18,987,106	0.000000	0	0	92.00
93.00	All other Medical Education	0	18,987,106	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-3028	Period: From 01/01/2017 To 12/31/2017	Worksheet D-3 Date/Time Prepared: 5/29/2018 4:06 pm	
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		12,374,927		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.221719	362,978	80,479	54.00
60.00	06000 LABORATORY	0.279752	575,028	160,865	60.00
65.00	06500 RESPIRATORY THERAPY	0.702968	650,370	457,189	65.00
66.00	06600 PHYSICAL THERAPY	0.265601	3,620,937	961,724	66.00
66.01	06601 PHYSICAL THERAPY - CARMEL	0.336778	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	0.272364	3,948,875	1,075,531	67.00
68.00	06800 SPEECH PATHOLOGY	0.149884	3,309,769	496,081	68.00
68.01	06801 VISION	0.225274	0	0	68.01
68.02	06802 FAC RESOURCE	1.623725	0	0	68.02
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.410118	361,966	148,449	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.322544	2,094,253	675,489	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.250010	2,004	501	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 through 94 and 96 through 98)		14,926,180	4,056,308	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		14,926,180		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-3028	Period: From 01/01/2017 To 12/31/2017	Worksheet D-3 Date/Time Prepared: 5/29/2018 4:06 pm	
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		1,129,364		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.221719	17,252	3,825	54.00
60.00	06000 LABORATORY	0.279752	41,985	11,745	60.00
65.00	06500 RESPIRATORY THERAPY	0.702968	39,950	28,084	65.00
66.00	06600 PHYSICAL THERAPY	0.265601	341,821	90,788	66.00
66.01	06601 PHYSICAL THERAPY - CARMEL	0.336778	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	0.272364	355,571	96,845	67.00
68.00	06800 SPEECH PATHOLOGY	0.149884	256,397	38,430	68.00
68.01	06801 VISION	0.225274	18,522	4,173	68.01
68.02	06802 FAC RESOURCE	1.623725	0	0	68.02
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.410118	39,781	16,315	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.322544	177,204	57,156	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.250010	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 through 94 and 96 through 98)		1,288,483	347,361	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		1,288,483		202.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-3028

Period:  
From 01/01/2017  
To 12/31/2017

Worksheet E  
Part A Exhibit 4  
Date/Time Prepared:  
5/29/2018 4:06 pm

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0	0	0	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	0	0	0	0	0	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0	0	0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0	0	0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	0	0	0	0	0	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	2,087,899	587,036	2,674,935	4.00
<b>Indirect Medical Education Adjustment</b>								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
<b>Disproportionate Share Adjustment</b>								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000	0.0000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	0	11.00
11.01	Uncompensated care payments	36.00	0	0	0	0	0	11.01
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	0	0	0	0	0	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	0	0	0	0	0	15.00
16.00	Payment for inpatient program capital (From Wkst. L, Pt. I, if applicable)	50.00	0	0	0	0	0	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02



LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-3028

Period:  
From 01/01/2017  
To 12/31/2017

Worksheet E  
Part A Exhibit 4  
Date/Time Prepared:  
5/29/2018 4:06 pm

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	0	0	0	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	0	0	0	0	0	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	0	0	0	0	0	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	0	0	0	0	0	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		N					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 15-3028		Period: From 01/01/2017 To 12/31/2017		Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/29/2018 4:06 pm	
		Title XVIII		Hospital		PPS	
	Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (col s. 2 and 3)		
	0	1.00	2.00	3.00	4.00		
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0	0	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	0	0	0	0	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0	0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0	0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	0	0	0	0	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	2,087,899	587,036	2,674,935	4.00
<b>Indirect Medical Education Adjustment</b>							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
<b>Disproportionate Share Adjustment</b>							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	11.00
11.01	Uncompensated care payments	36.00	0	0	0	0	11.01
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	0	0	0	0	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	0	0	0	0	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	0	0	0	0	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			0	0	0	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 15-3028

Period:  
From 01/01/2017  
To 12/31/2017

Worksheet E  
Part A Exhibit 5  
Date/Time Prepared:  
5/29/2018 4:06 pm

		Title XVIII			Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)					
		0	1.00	2.00	3.00	4.00		
20.00	Capital DRG other than outlier	1.00	0	0	0	0	0	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	0	0	0	0	0	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	0	0	0	0	0	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)					
		0	1.00	2.00	3.00	4.00		
27.00								27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0			0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0		0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	0	0	0		0	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0		0	30.01
31.00	HRR adjustment (see instructions)	70.94	0	0	0		0	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0		0	31.01
							(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00		
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0		0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N					100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-3028	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 5/29/2018 4:06 pm
		Title XVIII	Hospital	PPS
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)			0 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			743,494 2.00
3.00	OPPS payments			636,164 3.00
4.00	Outlier payment (see instructions)			0 4.00
4.01	Outlier reconciliation amount (see instructions)			0 4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			0 11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
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
<b>Customary charges</b>				
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 charge basis had such payment been made in accordance with 42 CFR §413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (see instructions)			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, 4.01, 8 and 9)			636,164 24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
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)			132,401 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)			503,763 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			503,763 30.00
31.00	Primary payer payments			991 31.00
32.00	Subtotal (line 30 minus line 31)			502,772 32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			63,377 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			41,195 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			63,377 36.00
37.00	Subtotal (see instructions)			543,967 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 39.50
39.97	Demonstration payment adjustment amount before sequestration			0 39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (see instructions)			543,967 40.00
40.01	Sequestration adjustment (see instructions)			10,879 40.01
40.02	Demonstration payment adjustment amount after sequestration			0 40.02
41.00	Interim payments			492,714 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			40,374 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			7,389 44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
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 01/01/2017  
To 12/31/2017

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/29/2018 4:06 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		10,184,060		492,714	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)		10,184,060		492,714	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		0		40,374	6.01	
6.02	SETTLEMENT TO PROGRAM		25,726		0	6.02	
7.00	Total Medicare program liability (see instructions)		10,158,334		533,088	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 01/01/2017 To 12/31/2017	Worksheet E-3 Part III Date/Time Prepared: 5/29/2018 4:06 pm
		Title XVIII	Hospital	PPS
		1.00		
<b>PART III - MEDICARE PART A SERVICES - IRF PPS</b>				
1.00	Net Federal PPS Payment (see instructions)		9,515,320	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)		0.0325	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)		772,644	3.00
4.00	Outlier Payments		303,538	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)		2.82	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)		54.024658	10.00
11.00	Teaching Adjustment Factor (see instructions)		0.006396	11.00
12.00	Teaching Adjustment (see instructions)		60,860	12.00
13.00	Total PPS Payment (see instructions)		10,652,362	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)		10,652,362	17.00
18.00	Primary payer payments		8,283	18.00
19.00	Subtotal (line 17 less line 18).		10,644,079	19.00
20.00	Deductibles		44,716	20.00
21.00	Subtotal (line 19 minus line 20)		10,599,363	21.00
22.00	Coinsurance		267,463	22.00
23.00	Subtotal (line 21 minus line 22)		10,331,900	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		51,918	24.00
25.00	Adjusted reimbursable bad debts (see instructions)		33,747	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		51,918	26.00
27.00	Subtotal (sum of lines 23 and 25)		10,365,647	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)		0	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	Demonstration payment adjustment amount before sequestration		0	31.99
32.00	Total amount payable to the provider (see instructions)		10,365,647	32.00
32.01	Sequestration adjustment (see instructions)		207,313	32.01
32.02	Demonstration payment adjustment amount after sequestration		0	32.02
33.00	Interim payments		10,184,060	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, 32.02, 33, and 34)		-25,726	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		155,578	36.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4		303,538	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 01/01/2017 To 12/31/2017	Worksheet E-4 Date/Time Prepared: 5/29/2018 4:06 pm	
		Title XVIII	Hospital	PPS	
				1.00	
<b>COMPUTATION OF TOTAL DIRECT GME AMOUNT</b>					
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))			0.00	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)			0.00	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			2.82	6.00
7.00	Enter the lesser of line 5 or line 6			0.00	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	2.82	2.82	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	0.00	0.00	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	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	0.00		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	0.00		17.00
18.00	Per resident amount	83,072.45	83,072.45		18.00
19.00	Approved amount for resident costs	0	0	0	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)			2.82	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)			0	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
<b>COMPUTATION OF PROGRAM PATIENT LOAD</b>					
26.00	Inpatient Days (see instructions)	6,770	1,777		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	0.343324	0.090116		28.00
29.00	Program direct GME amount	0	0		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		0		30.00
31.00	Net Program direct GME amount			0	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 15-3028	Period: From 01/01/2017 To 12/31/2017	Worksheet E-4 Date/Time Prepared: 5/29/2018 4:06 pm
		Title XVIII	Hospital	PPS
				1.00
<b>DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)</b>				
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
<b>APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY</b>				
<b>Part A Reasonable Cost</b>				
37.00	Reasonable cost (see instructions)		10,575,006	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)		8,283	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		10,566,723	41.00
<b>Part B Reasonable Cost</b>				
42.00	Reasonable cost (see instructions)		743,494	42.00
43.00	Primary payer payments (see instructions)		991	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		742,503	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		11,309,226	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.934345	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.065655	47.00
<b>ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B</b>				
48.00	Total program GME payment (line 31)		0	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		0	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		0	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 01/01/2017  
To 12/31/2017

Worksheet G

Date/Time Prepared:  
5/29/2018 4:06 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	11,839,495	0	0	0	1.00
2.00	Temporary investments	270	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	20,838,964	0	0	0	4.00
5.00	Other receivable	329,628	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-14,675,035	0	0	0	6.00
7.00	Inventory	150,491	0	0	0	7.00
8.00	Prepaid expenses	620,775	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)	19,126,202	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	1,904,164	0	0	0	12.00
13.00	Land improvements	370,910	0	0	0	13.00
14.00	Accumulated depreciation	-241,824	0	0	0	14.00
15.00	Buildings	15,520,712	0	0	0	15.00
16.00	Accumulated depreciation	-12,390,818	0	0	0	16.00
17.00	Leasehold improvements	187,578	0	0	0	17.00
18.00	Accumulated depreciation	-113,185	0	0	0	18.00
19.00	Fixed equipment	2,770,636	0	0	0	19.00
20.00	Accumulated depreciation	-1,869,883	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	13,283,883	0	0	0	23.00
24.00	Accumulated depreciation	-9,686,725	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)	9,735,448	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	848,899	0	0	0	33.00
34.00	Other assets	602,474	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,451,373	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	30,313,023	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	2,107,572	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,748,052	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	740,000	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,363,669	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,959,293	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	12,260,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	250,765	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	12,510,765	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	18,470,058	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	11,842,965				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	11,842,965	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	30,313,023	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-3028

Period:  
From 01/01/2017  
To 12/31/2017

Worksheet G-1

Date/Time Prepared:  
5/29/2018 4:06 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		10,857,113		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		985,849			2.00
3.00	Total (sum of line 1 and line 2)		11,842,962		0	3.00
4.00	ROUNDING	3		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		3		0	10.00
11.00	Subtotal (line 3 plus line 10)		11,842,965		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		11,842,965		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	ROUNDING		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 15-3028

Period:  
From 01/01/2017  
To 12/31/2017

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
5/29/2018 4:06 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	36,072,024		36,072,024	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)	36,072,024		36,072,024	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)	36,072,024		36,072,024	17.00
18.00	Ancillary services	42,305,116	16,783,676	59,088,792	18.00
19.00	Outpatient services	144,968	3,056,048	3,201,016	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)	78,522,108	19,839,724	98,361,832	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		39,698,645		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)		39,698,645		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 15-3028

Period:  
From 01/01/2017  
To 12/31/2017

Worksheet G-3

Date/Time Prepared:  
5/29/2018 4:06 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	98,361,832	1.00
2.00	Less contractual allowances and discounts on patients' accounts	59,883,013	2.00
3.00	Net patient revenues (line 1 minus line 2)	38,478,819	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	39,698,645	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,219,826	5.00
<b>OTHER INCOME</b>			
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	2,205,675	24.00
25.00	Total other income (sum of lines 6-24)	2,205,675	25.00
26.00	Total (line 5 plus line 25)	985,849	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)	985,849	29.00