

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT
CERTIFICATION AND SETTLEMENT SUMMARY

WORKSHEET S
PARTS I, II & III

PART I - COST REPORT STATUS

PROVIDER USE ONLY 1. [X] ELECTRONICALLY FILED COST REPORT DATE: 02/25/2013 TIME: 11:31_____
2. [X] MANUALLY SUBMITTED COST REPORT
3. [] IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THIS COST REPORT
4. [F] MEDICARE UTILIZATION. ENTER "F" FOR FULL OR "L" FOR LOW.

CONTRACTOR 5. [] COST REPORT STATUS 6. DATE RECEIVED: _____ 10. NPR DATE: _____
USE ONLY 1 - AS SUBMITTED 7. CONTRACTOR NO: _____ 11. CONTRACTOR'S VENDOR CODE: _____
2 - SETTLED WITHOUT AUDIT 8. [] INITIAL REPORT FOR THIS PROVIDER CCN 12. [] IF LINE 5, COLUMN 1 IS 4: ENTER
3 - SETTLED WITH AUDIT 9. [] FINAL REPORT FOR THIS PROVIDER CCN NUMBER OF TIMES REOPENED - 0-9.
4 - REOPENED
5 - AMENDED

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 WHERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE 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 CENTRAL INDIANA-AMG SPECIALTY HOSPITAL (15-2025) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 06/01/2012 AND ENDING 08/31/2012, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT 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.

ECR Encryption: 02/25/2013 11:31
9IPDZIAFPLBFh3qlHPdqZornajLMP0
FV8ni0nUSI8yB7.IKcAOBaLvJv.VVS
:uPg0rnzFT0RvLy0

(SIGNED) _____
OFFICER OR ADMINISTRATOR OF PROVIDER(S)

PI Encryption: 02/25/2013 11:31
BOgMjw2nbKF5s50V.cNoDkh0ONSdY0
8E.680y4OwQjrd:NM3wtzgoUif8xnv
wbiJ0SFZAA0LfXbd

TITLE

DATE

PART III - SETTLEMENT SUMMARY

	TITLE V	TITLE XVIII		HIT	TITLE XIX	
	1	PART A	PART B	4	5	
1	HOSPITAL					1
2	SUBPROVIDER - IPF					2
3	SUBPROVIDER - IRF					3
4	SUBPROVIDER (OTHER)					4
5	SWING BED - SNF					5
6	SWING BED - NF					6
7	SKILLED NURSING FACILITY					7
8	NURSING FACILITY					8
9	HOME HEALTH AGENCY					9
10	HEALTH CLINIC - RHC					10
11	HEALTH CLINIC - FQHC					11
12	OUTPATIENT REHABILITATION PROVIDER					12
200	TOTAL					200

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 THIS 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 THIS FORM, PLEASE WRITE TO: CMS, 7500 SECURITY BOULEVARD, ATTN: PRA REPORT CLEARANCE OFFICER, MAIL STOP C4-26-05, BALTIMORE, MARYLAND 21244-1850.

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1 STREET: 2401 W. UNIVERSITY AVE, 8TH FLOOR N
 2 CITY: MUNCIE STATE: IN

P.O. BOX: 1
 ZIP CODE: 47303 COUNTY: DELAWARE 2

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

COMPONENT 0	COMPONENT NAME 1	CCN NUMBER 2	CBSA NUMBER 3	PROV TYPE 4	DATE CERTIFIED 5	PAYMENT SYSTEM (P, T, O, OR N)			3	
						V 6	XVIII 7	XIX 8		
3	HOSPITAL	CENTRAL INDIANA-AMG SPECIALTY	15-2025	34620	2	02/16/2005	N	P	P	3
4	SUBPROVIDER - IPF									4
5	SUBPROVIDER - IRF									5
6	SUBPROVIDER - (OTHER)									6
7	SWING BEDS - SNF									7
8	SWING BEDS - NF									8
9	HOSPITAL-BASED SNF									9
10	HOSPITAL-BASED NF									10
11	HOSPITAL-BASED OLTC									11
12	HOSPITAL-BASED HHA									12
13	SEPARATELY CERTIFIED ASC									13
14	HOSPITAL-BASED HOSPICE									14
15	HOSPITAL-BASED HEALTH CLINIC - RHC									15
16	HOSPITAL-BASED HEALTH CLINIC - FQHC									16
17	HOSPITAL-BASED (CMHC)									17
18	RENAL DIALYSIS									18
19	OTHER									19
20	COST REPORTING PERIOD (MM/DD/YYYY)	FROM: 06/01/2012			TO: 08/31/2012					20
21	TYPE OF CONTROL									21

INPATIENT PPS INFORMATION

22	DOES THIS FACILITY QUALIFY FOR AND RECEIVE DISPROPORTIONATE SHARE HOSPITAL PAYMENT IN ACCORDANCE WITH 42 CFR §412.106 IN COLUMN 1, ENTER 'Y' FOR YES AND 'N' FOR NO. IS THIS FACILITY SUBJECT TO 42 CFR §412.06(c)(2)(PICKLE AMENDMENT HOSPITAL)? IN COLUMN 2, ENTER 'Y', FOR YES OR 'N' FOR NO.									1	2
23	WHICH METHOD IS USED TO DETERMINE MEDICAID DAYS ON LINES 24 AND/OR 25 BELOW? IN COLUMN 1, ENTER 1 IF DATE OF ADMISSION, 2 IF CENSUS DAYS, OR 3 IF DATE OF DISCHARGE. IS THE METHOD OF IDENTIFYING THE DAYS IN THIS COST REPORTING PERIOD DIFFERENT FROM THE METHOD USED IN THE PRIOR COST REPORTING PERIOD? IN COLUMN 2, ENTER 'Y' FOR YES OR 'N' FOR NO.									3	N 23

		IN-STATE		OUT-OF-STATE		OUT-OF-STATE		MEDICAID HMO 5	OTHER MEDICAID 6	24
		MEDICAID PAID DAYS 1	ELIGIBLE UNPAID DAYS 2	MEDICAID PAID DAYS 3	ELIGIBLE UNPAID DAYS 4	MEDICAID UNPAID DAYS 5	MEDICAID UNPAID DAYS 6			
24	IF THIS PROVIDER IS AN IPHS HOSPITAL, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.									24
25	IF THIS PROVIDER IS AN IRF, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.									25
26	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.					1				26
27	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
35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.									35
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.					BEGINNING:		ENDING:		36
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.									37
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.					BEGINNING:		ENDING:		38

PROSPECTIVE PAYMENT SYSTEM(PPS)-CAPITAL

		V 1	XVIII 2	XIX 3	
45	DOES THIS FACILITY QUALIFY AND RECEIVE CAPITAL PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR §412.320?	N	N	N	45
46	IS THIS FACILITY ELIGIBLE FOR ADDITIONAL PAYMENT EXCEPTION FOR EXTRAORDINARY CIRCUMSTANCES PURSUANT TO 42 CFR §412.348(f)? IF YES, COMPLETE WORKSHEET L, PART III AND L-1, PARTS I THROUGH III.	N	N	N	46
47	IS THIS A NEW HOSPITAL UNDER 42 CFR §412.300 PPS CAPITAL? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N	47
48	IS THE FACILITY ELECTING FULL FEDERAL CAPITAL PAYMENT? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N	48

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

TEACHING HOSPITALS		1	2	3	
56	IS THIS A HOSPITAL INVOLVED IN TRAINING RESIDENTS IN APPROVED GME PROGRAMS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N			56
57	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 WORKSHEET D, PART III & IV AND D-2, PART II, IF APPLICABLE.	N	N		57
58	IF LINE 56 IS YES, DID THIS FACILITY ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB 15-1, SECTION 2148? IF YES, COMPLETE WORKSHEET D-5.	N			58
59	ARE COSTS CLAIMED ON LINE 100 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N			59
60	ARE YOU CLAIMING NURSING SCHOOL AND/OR ALLIED HEALTH COSTS FOR A PROGRAM THAT MEETS THE PROVIDER-OPERATED CRITERIA UNDER §413.85? ENTER 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)	N			60
61	DID YOUR FACILITY RECEIVE ADDITIONAL FTE SLOTS UNDER ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF 'Y', EFFECTIVE FOR PORTIONS OF COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2011 ENTER THE AVERAGE NUMBER OF PRIMARY CARE FTE RESIDENTS FOR IME IN COLUMN 2 AND DIRECT GME IN COLUMN 3 FROM THE HOSPITAL'S THREE MOST RECENT COST REPORTS ENDING AND SUBMITTED BEFORE MARCH 23, 2010. (SEE INSTRUCTIONS)	Y/N N	IME AVERAGE	DIRECT GME AVERAGE	61
ACA PROVISIONS AFFECTING THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)					
62	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
62.01	ENTER THE NUMBER OF FTE RESIDENTS THAT ROTATED FROM A TEACHING HEALTH CENTER (THC) INTO YOUR HOSPITAL IN THIS COST REPORTING PERIOD OF HRSA THC PROGRAM. (SEE INSTRUCTIONS)				62.01
TEACHING HOSPITALS THAT CLAIM RESIDENTS IN NON-PROVIDER SETTINGS					
63	HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, COMPLETE LINES 64-67. (SEE INSTRUCTIONS)	N			63
SECTION 5504 OF THE ACA BASE YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS					
THIS BASE YEAR IS YOUR COST REPORTING PERIOD THAT BEGINS ON OR AFTER JULY 1, 2009 AND BEFORE JUNE 30, 2010.					
64	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 NON-PROVIDER 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)		UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))
	ENTER IN LINES 65-65.49 IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE PROGRAM NAME. 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)		UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.3+COL.4))
	PROGRAM NAME	PROGRAM CODE			
	1	2	3	4	5
SECTION 5504 OF THE ACA CURRENT YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS					
EFFECTIVE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2010					
66	ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER 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)		UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

ENTER IN LINES 67-67.49, COLUMN 1 THE PROGRAM NAME. 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)

PROGRAM NAME 1	PROGRAM CODE 2	UNWEIGHTED FTES NONPROVIDER SITE 3	UNWEIGHTED FTES IN HOSPITAL 4	RATIO (COL.1/ (COL.3+COL.4)) 5				
INPATIENT PSYCHIATRIC FACILITY PPS								
70	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		
71	IF LINE 70 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORT FILED 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 AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.					71		
INPATIENT REHABILITATION FACILITY PPS								
75	IS THIS FACILITY AN INPATIENT REHABILITATION FACILITY (IRF), OR DOES IT CONTAIN AN IRF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.			N		75		
76	IF LINE 75 YES: COLUMN 1: DID THE FACILITY HAVE A 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 AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.					76		
LONG TERM CARE HOSPITAL PPS								
80	IS THIS A LONG TERM CARE HOSPITAL (LTCH)? ENTER 'Y' FOR YES OR 'N' FOR NO.			Y		80		
TEFRA PROVIDERS								
85	IS THIS A NEW HOSPITAL UNDER 42 CFR §413.40(f)(1)(i) TEFRA?. ENTER 'Y' FOR YES OR 'N' FOR NO.			N		85		
86	DID THIS FACILITY ESTABLISH A NEW OTHER SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR §413.40(f)(1)(ii)? ENTER 'Y' FOR YES, OR 'N' FOR NO.			N		86		
TITLE V AND XIX INPATIENT SERVICES								
90	DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.			N	N	90		
91	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		
92	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.				N	92		
93	DOES THIS FACILITY OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE V AND XIX? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N	N	93		
94	DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N	N	94		
95	IF LINE 94 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.					95		
96	DOES TITLE V OR TITLE XIX REDUCE OPERATING COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N	N	96		
97	IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.					97		
RURAL PROVIDERS								
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?			N	1	2 105		
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.					106		
107	COLUMN 1: IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES, COMPLETE WORKSHEET D-2, PART II, COLUMN 2: IF THIS FACILITY IS A CAH, DO I&Rs IN AN APPROVED MEDICAL EDUCATION PROGRAM TRAIN IN THE CAH'S EXCLUDED IPF AND/OR IRF UNIT? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2.					107		
108	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR §412.113(c). ENTER 'Y' FOR YES OR 'N' FOR NO.			N		108		
109	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 EACH THERAPY.				PHY- SICAL N	OCCUP- ATIONAL N	RESPI- RATORY N	109

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

MISCELLANEOUS COST REPORTING INFORMATION

115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF 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 15-18 2208.1.	N		115
116	IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		116
117	IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		117
118	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.			118
118.01	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES: PREMIUMS: PAID LOSSES: SELF INSURANCE:			118.01
118.02	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN A COST CENTER OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.	N		118.02
120	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
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		121

TRANSPLANT CENTER INFORMATION

125	DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, ENTER CERTIFICATION DATE(S) (MM/DD/YYYY) BELOW.	N		125
126	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
127	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
128	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
129	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
130	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
131	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
132	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
133	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
134	IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			134

ALL PROVIDERS

140	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.	1 Y	2 PPLIED	140
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	NAME: NAME: ACADIANA MANAGEMENT GRO CONTRACTOR'S NAME: NOVITAS	CONTRACTOR'S NUMBER: 0000		141
142	STREET: STREET: 101 LA RUE FRANCE, P.O. BOX:			142
143	CITY: LAFAYETTE STATE: LA	ZIP CODE: 70508		143
144	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	Y		144
145	IF COSTS FOR RENAL SERVICES ARE CLAIMED ON WORKSHEET A, LINE 74 ARE THEY COSTS FOR INPATIENT SERVICES ONLY? ENTER 'Y' FOR YES, OR 'N' FOR NO.	Y		145
146	HAS THE COST ALLOCATION METHODOLOGY CHANGED FROM THE PREVIOUSLY FILED COST REPORT? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. (SEE CMS PUB. 15-2, SECTION 4020). IF YES, ENTER THE APPROVAL DATE (MM/DD/YYYY) IN COLUMN 2.	N		146
147	WAS THERE A CHANGE IN THE STATISTICAL BASIS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		147
148	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		148
149	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		149

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)

	TITLE XVIII		TITLE	TITLE
	PART A	PART B	V	XIX
	1	2	3	4
155	HOSPITAL	N	N	N 155
156	SUBPROVIDER - IPF	N	N	156
157	SUBPROVIDER - IRF	N	N	157
158	SUBPROVIDER - (OTHER)	N	N	158
159	SNF	N	N	159
160	HHA	N	N	160
161	CMHC		N	161

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I (CONT)

MULTICAMPUS

165 IS THIS HOSPITAL PART OF A MULTICAMPUS HOSPITAL THAT HAS ONE OR MORE CAMPUSES IN DIFFERENT CBSAs? N 165
ENTER 'Y' FOR YES OR 'N' FOR NO.

166 IF LINE 165 IS YES, FOR EACH CAMPUS, ENTER THE NAME IN COLUMN 0, COUNTY IN COLUMN 1, STATE IN
COLUMN 2, ZIP IN COLUMN 3, CBSA IN COLUMN 4, FTE/CAMPUS IN COLUMN 5.

NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
0	1	2	3	4	5

HEALTH INFORMATION TECHNOLOGY (HIT) INCENTIVE IN THE AMERICAN RECOVERY AND REINVESTMENT ACT

167 IS THIS PROVIDER A MEANINGFUL USER UNDER §1886(n)? ENTER 'Y' FOR YES OR 'N' FOR NO. N 167

168 IF THIS PROVIDER IS A CAH (LINE 105 IS 'Y') AND A MEANINGFUL USER (LINE 167 IS 'Y'),
ENTER THE REASONABLE COST INCURRED FOR THE HIT ASSETS. 168

169 IF THIS PROVIDER IS A MEANINGFUL USER (LINE 167 IS 'Y') AND IS NOT A CAH
(LINE 105 IS 'N'), ENTER THE TRANSITIONAL FACTOR. 169

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
 PART II

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

		Y/N	DATE		
PROVIDER ORGANIZATION AND OPERATION					
1	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)	1 N	2	1	
		Y/N	DATE	V/I	
2	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.	1 N	2	3 2	
3	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	
FINANCIAL DATA AND REPORTS					
		Y/N	TYPE	DATE	
4	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.	1 N	2	3 4	
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	N		5	
APPROVED EDUCATIONAL ACTIVITIES					
		Y/N		Y/N	
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	1 N		2 6	
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.	N		7	
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	N		8	
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	N		9	
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N		10	
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	N		11	
				Y/N	
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.			Y 12	
13	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	
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.			N 14	
BED COMPLEMENT					
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.			N 15	
PS&R REPORT DATA					
		PART A		PART B	
		Y/N	DATE	Y/N	DATE
16	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)	1 Y	2 01/18/2013	3 Y	4 01/18/2013
17	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
18	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 THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N	18
19	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
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N	20
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N	21

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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 COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)

CAPITAL RELATED COST

- 22 HAVE ASSETS BEEN RELIEFED FOR MEDICARE PURPOSES? IF YES, SEE INSTRUCTIONS. 22
- 23 HAVE CHANGES OCCURRED IN THE MEDICARE DEPRECIATION EXPENSE DUE TO APPRAISALS MADE DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. 23
- 24 WERE NEW LEASES AND/OR AMENDMENTS TO EXISTING LEASES ENTERED INTO DURING THIS COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. 24
- 25 HAVE THERE BEEN NEW CAPITALIZED LEASES ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. 25
- 26 WERE ASSETS SUBJECT TO SEC. 2314 OF DEFRA ACQUIRED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. 26
- 27 HAS THE PROVIDER'S CAPITALIZED POLICY CHANGED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. 27

INTEREST EXPENSE

- 28 WERE NEW LOANS, MORTGAGE AGREEMENTS OR LETTERS OF CREDIT ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. 28
- 29 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. 29
- 30 HAS EXISTING DEBT BEEN REPLACED PRIOR TO ITS SCHEDULED MATURITY WITH NEW DEBT? IF YES, SEE INSTRUCTIONS. 30
- 31 HAS DEBT BEEN RECALLED BEFORE SCHEDULED MATURITY WITHOUT ISSUANCE OF NEW DEBT? IF YES, SEE INSTRUCTIONS. 31

PURCHASED SERVICES

- 32 HAVE CHANGES OR NEW AGREEMENTS OCCURRED IN PATIENT CARE SERVICES FURNISHED THROUGH CONTRACTUAL ARRANGEMENTS WITH SUPPLIERS OF SERVICES? IF YES, SEE INSTRUCTIONS. 32
- 33 IF LINE 32 IS YES, WERE THE REQUIREMENTS OF SEC. 2135.2 APPLIED PERTAINING TO COMPETITIVE BIDDING? IF NO, SEE INSTRUCTIONS. 33

PROVIDER-BASED PHYSICIANS

- 34 ARE SERVICES FURNISHED AT THE PROVIDER FACILITY UNDER AN ARRANGEMENT WITH PROVIDER-BASED PHYSICIANS? IF YES, SEE INSTRUCTIONS. 34
- 35 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

HOME OFFICE COSTS

- | | Y/N | DATE | |
|---|-----|------|----|
| 36 WERE HOME OFFICE COSTS CLAIMED ON THE COST REPORT? | 1 | 2 | 36 |
| 37 IF LINE 36 IS YES, HAS A HOME OFFICE COST STATEMENT BEEN PREPARED BY THE HOME OFFICE? IF YES, SEE INSTRUCTIONS. | | | 37 |
| 38 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 |
| 39 IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO OTHER CHAIN COMPONENTS? IF YES, SEE INSTRUCTIONS. | | | 39 |
| 40 IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO THE HOME OFFICE? IF YES, SEE INSTRUCTIONS. | | | 40 |

COST REPORT PREPARER CONTACT INFORMATION

- | | | | |
|-----------------------------|--|--------------------------|----|
| 41 FIRST NAME: MICHAEL | LAST NAME: FREEMAN | TITLE: MANAGING DIRECTOR | 41 |
| 42 EMPLOYER: TFG CONSULTING | | | 42 |
| 43 PHONE NUMBER: 2256101100 | E-MAIL ADDRESS: MFREEMAN@TFGCONSULTING.ORG | | 43 |

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
 PART II & III

PART II - WAGE DATA

	WKST A LINE NUMBER	AMOUNT REPORTED	RECLASS OF SALARIES (FROM WKST A-6)	ADJUSTED SALARIES (COL. 2 + COL. 3)	PAID HOURS RELATED TO SALARIES IN COL. 4	AVERAGE HOURLY WAGE (COL. 4 + COL. 5)
	1	2	3	4	5	6
SALARIES						
1	TOTAL SALARIES (SEE INSTRUCTIONS)	200	792,726		23,251.87	1
2	NON-PHYSICIAN ANESTHETIST PART A					2
3	NON-PHYSICIAN ANESTHETIST PART B					3
4	PHYSICIAN-PART A ADMINISTRATIVE					4
4.01	PHYSICIAN-PART A - TEACHING					4.01
5	PHYSICIAN-PART B					5
6	NON-PHYSICIAN-PART B					6
7	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)	21				7
7.01	CONTRACTED INTERNS & RESIDENTS (IN AN APPROVED PGM)					7.01
8	HOME OFFICE PERSONNEL					8
9	SNF	44				9
10	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)					10
OTHER WAGES & RELATED COSTS						
11	CONTRACT LABOR (SEE INSTRUCTIONS)					11
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE SERVICES					12
13	CONTRACT LABOR: PHYSICIAN-PART A - ADMINISTRATIVE					13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS					14
15	HOME OFFICE: PHYSICIAN-PART A - ADMINISTRATIVE					15
16	HOME OFFICE & CONTRACT PHYSICIANS-PART A - TEACHING WAGE-RELATED COSTS					16
17	WAGE-RELATED COSTS (CORE)		112,361			17
18	WAGE-RELATED COSTS (OTHER)					18
19	EXCLUDED AREAS					19
20	NON-PHYSICIAN ANESTHETIST PART A					20
21	NON-PHYSICIAN ANESTHETIST PART B					21
22	PHYSICIAN PART A - ADMINISTRATIVE					22
22.01	PHYSICIAN PART A - TEACHING					22.01
23	PHYSICIAN PART B					23
24	WAGE-RELATED COSTS (RHC/FQHC)					24
25	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)					25
OVERHEAD COSTS - DIRECT SALARIES						
26	EMPLOYEE BENEFITS					26
27	ADMINISTRATIVE & GENERAL		112,139		3,145.00	27
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)					28
29	MAINTENANCE & REPAIRS					29
30	OPERATION OF PLANT					30
31	LAUNDRY & LINEN SERVICE					31
32	HOUSEKEEPING					32
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)					33
34	DIETARY		16,146		384.00	34
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)					35
36	CAFETERIA					36
37	MAINTENANCE OF PERSONNEL					37
38	NURSING ADMINISTRATION				73.58	38
39	CENTRAL SERVICES AND SUPPLY					39
40	PHARMACY					40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		21,086		567.00	41
42	SOCIAL SERVICE				477.00	42
43	OTHER GENERAL SERVICE					43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	792,726		792,726	23,251.87	34.09	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)						2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	792,726		792,726	23,251.87	34.09	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)						4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)	112,361		112,361		14.17%	5
6	TOTAL (SUM OF LINES 3 THRU 5)	905,087		905,087	23,251.87	38.93	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	149,371		149,371	4,646.58	32.15	7

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
 PART IV

PART A - CORE LIST

	AMOUNT REPORTED
RETIREMENT COST	
1 401K EMPLOYER CONTRIBUTIONS	1
2 TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION	2
3 NONQUALIFIED DEFINED BENEFIT PLAN COST (SEE INSTRUCTIONS)	3
4 QUALIFIED DEFINED BENEFIT PLAN COST (SEE INSTRUCTIONS)	4
PLAN ADMINISTRATIVE COSTS (PAID TO EXTERNAL ORGANIZATION)	
5 401K/TSA PLAN ADMINISTRATION FEES	5
6 LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN	6
7 EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES	7
HEALTH AND INSURANCE COST	
8 HEALTH INSURANCE (PURCHASED OR SELF FUNDED)	44,027 8
9 PRESCRIPTION DRUG PLAN	9
10 DENTAL, HEARING AND VISION PLAN	10
11 LIFE INSURANCE (IF EMPLOYER IS OWNER OR BENEFICIARY)	11
12 ACCIDENTAL INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	12
13 DISABILITY INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	13
14 LONG-TERM CARE INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	14
15 WORKERS' COMPENSATION INSURANCE	15
16 RETIREMENT HEALTH CARE COST (ONLY CURRENT YEAR, NOT THE EXTRAORDINARY ACCRUAL REQUIRED BY FASB 106. NON CUMULATIVE PORTION)	16
TAXES	
17 FICA-EMPLOYERS PORTION ONLY	68,334 17
18 MEDICARE TAXES - EMPLOYERS PORTION ONLY	18
19 UNEMPLOYMENT INSURANCE	19
20 STATE OR FEDERAL UNEMPLOYMENT TAXES	20
OTHER	
21 EXECUTIVE DEFERRED COMPENSATION (OTHER THAN RETIREMENT COST REPORTED ON LINES 1 THROUGH 4 ABOVE) (SEE INSTRUCTIONS)	21
22 DAY CARE COSTS AND ALLOWANCES	22
23 TUITION REIMBURSEMENT	23
24 TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	112,361 24
PART B - OTHER THAN CORE RELATED COST	
25 OTHER WAGE RELATED (OTHER WAGE RELATED COST)	25

HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION

COMPONENT		CONTRACT	BENEFIT
0		LABOR	COST
		1	2
1	TOTAL FACILITY CONTRACT LABOR AND BENEFIT COST		1
2	HOSPITAL		2
3	SUBPROVIDER - IPF		3
4	SUBPROVIDER - IRF		4
5	SUBPROVIDER - (OTHER)		5
6	SWING BEDS - SNF		6
7	SWING BEDS - NF		7
8	HOSPITAL-BASED SNF		8
9	HOSPITAL-BASED NF		9
10	HOSPITAL-BASED OLTC		10
11	HOSPITAL-BASED HHA		11
12	SEPARATELY CERTIFIED ASC		12
13	HOSPITAL-BASED HOSPICE		13
14	HOSPITAL-BASED HEALTH CLINIC - RHC		14
15	HOSPITAL-BASED HEALTH CLINIC - FQHC		15
16	HOSPITAL-BASED (CMHC)		16
17	RENAL DIALYSIS		17
18	OTHER		18

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES 1	OTHER 2	TOTAL (COL. 1 + COL. 2) 3	RECLASSIFI- CATIONS 4
GENERAL SERVICE COST CENTERS					
1	00100 CAP REL COSTS-BLDG & FIXT		251,469	251,469	1
2	00200 CAP REL COSTS-MVBLE EQUIP				2
3	00300 OTHER CAPITAL RELATED COSTS				3
4	00400 EMPLOYEE BENEFITS		112,361	112,361	4
5	00500 ADMINISTRATIVE & GENERAL	112,139	261,016	373,155	5
6	00600 MAINTENANCE & REPAIRS				6
7	00700 OPERATION OF PLANT		4,006	4,006	7
8	00800 LAUNDRY & LINEN SERVICE		11,435	11,435	8
9	00900 HOUSEKEEPING		29,037	29,037	9
10	01000 DIETARY	16,146	25,850	41,996	10
11	01100 CAFETERIA				11
12	01200 MAINTENANCE OF PERSONNEL				12
13	01300 NURSING ADMINISTRATION				13
14	01400 CENTRAL SERVICES & SUPPLY				14
15	01500 PHARMACY				15
16	01600 MEDICAL RECORDS & LIBRARY	21,086	13,949	35,035	16
17	01700 SOCIAL SERVICE				17
18	01850 RECREATIONAL THERAPY				18
19	01900 NONPHYSICIAN ANESTHETISTS				19
20	02000 NURSING SCHOOL				20
21	02100 I&R SRVCES-SALARY & FRINGES APPRVD				21
22	02200 I&R SRVCES-OTHER PRGM COSTS APPRVD				22
23	02300 PARAMED ED PRGM-(SPECIFY)				23
INPATIENT ROUTINE SERV COST CENTERS					
30	03000 ADULTS & PEDIATRICS	523,350	57,701	581,051	30
ANCILLARY SERVICE COST CENTERS					
50	05000 OPERATING ROOM		76,498	76,498	50
54	05400 RADIOLOGY-DIAGNOSTIC		56,520	56,520	54
60	06000 LABORATORY		52,389	52,389	60
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	06500 RESPIRATORY THERAPY	115,315	13,116	128,431	65
66	06600 PHYSICAL THERAPY		38,598	38,598	66
67	06700 OCCUPATIONAL THERAPY		34,220	34,220	67
68	06800 SPEECH PATHOLOGY		23,348	23,348	68
71	07100 MEDICAL SUPPLIES CHRGD TO PATIENTS		26,470	26,470	71
73	07300 DRUGS CHARGED TO PATIENTS	4,690	238,467	243,157	73
74	07400 RENAL DIALYSIS		15,390	15,390	74
76.97	07697 CARDIAC REHABILITATION				76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY				76.98
76.99	07699 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS					
92	09200 OBSERVATION BEDS				92
OTHER REIMBURSABLE COST CENTERS					
99.10	09910 CORF				99.10
99.20	09920 OUTPATIENT PHYSICAL THERAPY				99.20
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY				99.40
SPECIAL PURPOSE COST CENTERS					
118	SUBTOTALS (SUM OF LINES 1-117)	792,726	1,341,840	2,134,566	118
NONREIMBURSABLE COST CENTERS					
200	TOTAL (SUM OF LINES 118-199)	792,726	1,341,840	2,134,566	200

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		RECLASSIFIED TRIAL BALANCE (COL. 3 ± COL. 4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL. 5 ± COL. 6) 7	
GENERAL SERVICE COST CENTERS					
1	00100	251,469	-75,542	175,927	1
2	00200				2
3	00300				3
4	00400	112,361		112,361	4
5	00500	373,155	-100,755	272,400	5
6	00600				6
7	00700	4,006		4,006	7
8	00800	11,435		11,435	8
9	00900	29,037		29,037	9
10	01000	41,996		41,996	10
11	01100				11
12	01200				12
13	01300				13
14	01400				14
15	01500				15
16	01600	35,035	-63	34,972	16
17	01700				17
18	01850				18
19	01900				19
20	02000				20
21	02100				21
22	02200				22
23	02300				23
INPATIENT ROUTINE SERV COST CENTERS					
30	03000	581,051		581,051	30
ANCILLARY SERVICE COST CENTERS					
50	05000	76,498		76,498	50
54	05400	56,520		56,520	54
60	06000	52,389		52,389	60
62.30	06250				62.30
65	06500	128,431		128,431	65
66	06600	38,598		38,598	66
67	06700	34,220		34,220	67
68	06800	23,348		23,348	68
71	07100	26,470		26,470	71
73	07300	243,157		243,157	73
74	07400	15,390		15,390	74
76.97	07697				76.97
76.98	07698				76.98
76.99	07699				76.99
OUTPATIENT SERVICE COST CENTERS					
92	09200				92
OTHER REIMBURSABLE COST CENTERS					
99.10	09910				99.10
99.20	09920				99.20
99.30	09930				99.30
99.40	09940				99.40
SPECIAL PURPOSE COST CENTERS					
118		2,134,566	-176,360	1,958,206	118
NONREIMBURSABLE COST CENTERS					
200		2,134,566	-176,360	1,958,206	200
GRAND TOTAL (INCREASES)					
GRAND TOTAL (DECREASES)					

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
 PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING BALANCES 1	ACQUISITIONS			DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7	
		PURCHASE 2	DONATION 3	TOTAL 4				
1 LAND								1
2 LAND IMPROVEMENTS								2
3 BUILDINGS AND FIXTURES								3
4 BUILDING IMPROVEMENTS								4
5 FIXED EQUIPMENT								5
6 MOVABLE EQUIPMENT		2,469,776		2,469,776		2,469,776		6
7 HIT DESIGNATED ASSETS								7
8 SUBTOTAL (SUM OF LINES 1-7)		2,469,776		2,469,776		2,469,776		8
9 RECONCILING ITEMS								9
10 TOTAL (LINE 7 MINUS LINE 9)		2,469,776		2,469,776		2,469,776		10

PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 AND 2

SUMMARY OF CAPITAL

DESCRIPTION	DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(1)
							(SUM OF COLS. 9-14) 15
1 CAP REL COSTS-BLDG & FIXT		175,927	75,542				251,469 1
2 CAP REL COSTS-MVBLE EQUIP							2
3 TOTAL (SUM OF LINES 1-2)		175,927	75,542				251,469 3

PART III - RECONCILIATION OF CAPITAL COST CENTERS

COMPUTATION OF RATIOS OF GROSS ASSETS FOR RATIO (SEE INSTR.)

DESCRIPTION	GROSS ASSETS 1	CAPITALIZED LEASES 2	FOR RATIO (COL. 1 - COL. 2) 3	RATIO (SEE INSTR.) 4	INSURANCE 5	TAXES 6	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 7	TOTAL
								(SUM OF COLS. 5-7) 8
1 CAP REL COSTS-BLDG & FIXT								1
2 CAP REL COSTS-MVBLE EQUIP								2
3 TOTAL (SUM OF LINES 1-2)								3

SUMMARY OF CAPITAL

DESCRIPTION	DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(2)
							(SUM OF COLS. 9-14) 15
1 CAP REL COSTS-BLDG & FIXT		175,927					175,927 1
2 CAP REL COSTS-MVBLE EQUIP							2
3 TOTAL		175,927					175,927 3

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF
			COST CENTER	LINE NO.	
	1	2	3	4	5
1 INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)			CAP REL COSTS-BLDG & FIXT	1	1
2 INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)			CAP REL COSTS-MVBLE EQUIP	2	2
3 INVESTMENT INCOME-OTHER (CHAPTER 2)					3
4 TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)					4
5 REFUNDS AND REBATES OF EXPENSES (CHAPTER 8)					5
6 RENTAL OF PROVIDER SPACE BY SUPPLIERS (CHAPTER 8)					6
7 TELEPHONE SERVICES (PAY STATIONS EXCL) (CHAPTER 21)					7
8 TELEVISION AND RADIO SERVICE (CHAPTER 21)					8
9 PARKING LOT (CHAPTER 21)					9
10 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-57,428			10
11 SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)					11
12 RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1	-32,146			12
13 LAUNDRY AND LINEN SERVICE					13
14 CAFETERIA - EMPLOYEES AND GUESTS					14
15 RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					15
16 SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS					16
17 SALE OF DRUGS TO OTHER THAN PATIENTS					17
18 SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-63	MEDICAL RECORDS & LIBRARY	16	18
19 NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)					19
20 VENDING MACHINES					20
21 INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (CHAPTER 21)					21
22 INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT	A	-75,542	CAP REL COSTS-BLDG & FIXT	1	11 22
23 ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		RESPIRATORY THERAPY	65	23
24 ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		PHYSICAL THERAPY	66	24
25 UTIL REVIEW-PHYSICIANS' COMPENSATION (CHAPTER 21)			UTILIZATION REVIEW-SNF	114	25
26 DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1	26
27 DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2	27
28 NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19	28
29 PHYSICIANS' ASSISTANT					29
30 ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67	30
31 ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		SPEECH PATHOLOGY	68	31
32 CAH HIT ADJ FOR DEPRECIATION AND					32
33 ADVERTISING	A	-9,497	ADMINISTRATIVE & GENERAL	5	33
34					34
35					35
36					36
37 OTHER	A	-1,684	ADMINISTRATIVE & GENERAL	5	37
38					38
39					39
40					40
41					41
42					42
43					43
44					44
45					45
46					46
47					47
48					48
49					49
50 TOTAL (SUM OF LINES 1 THRU 49)		-176,360			50
TRANSFER TO WKST A, COL. 6, LINE 200)					

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

WORKSHEET A-8-1

A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR THE CLAIMING OF HOME OFFICE COSTS:

LINE NO. 1	COST CENTER 2	EXPENSE ITEMS 3	AMOUNT OF ALLOWABLE COST 4	AMOUNT (INCL IN WKST A, COL. 5) 5	NET ADJ- USTMENTS (COL. 4-5) 6	WKST A-7 REF 7
1	5	ADMINISTRATIVE & GENERAL				1
2		HO OPERATING		32,146	-32,146	2
3						3
4						4
5		TOTALS (SUM OF LINES 1-4)		32,146	-32,146	5
		TRANSFER COL. 6, LINE 5 TO WKST A-8, COL. 2, LINE 12.				

B. INTERRELATIONSHIP OF RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

THE SECRETARY, BY VIRTUE OF 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.

THE INFORMATION IS USED BY THE HEALTH CARE FINANCING ADMINISTRATION AND ITS INTERMEDIARIES 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.

SYMBOL (1)	NAME 2	----- RELATED ORGANIZATION(S) AND/OR HOME OFFICE -----				6
		PERCENT OF OWNERSHIP 3	NAME 4	PERCENT OF OWNERSHIP 5	TYPE OF BUSINESS 6	
6	F		ACADIANA MANAGEMENT GROUP		MANAGEMENT COMPANY	6
7						7
8						8
9						9
10						10

- (1) USE THE FOLLOWING SYMBOLS TO INDICATE THE 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.
 - G. OTHER (FINANCIAL OR NON-FINANCIAL) SPECIFY:

PROVIDER CCN: 15-2025 CENTRAL INDIANA-AMG SPECIALTY
 PERIOD FROM 06/01/2012 TO 08/31/2012

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2012.11
 02/25/2013 11:31

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUNERA- TION INCL FRINGES	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD- JUSTED RCE LIMIT	5 PERCENT OF UNAD- JUSTED RCE LIMIT	
1	2	3	4	5	6	7	8	9	
1	5 ADMINISTRATIVE & GENERAL AGGREGATE	59,900	34,150	25,750	171,400	30	2,472	124	1
200	TOTAL	59,900	34,150	25,750		30	2,472	124	200

PROVIDER CCN: 15-2025 CENTRAL INDIANA-AMG SPECIALTY
 PERIOD FROM 06/01/2012 TO 08/31/2012

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2012.11
 02/25/2013 11:31

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBERSHIP & CONTIN. EDUCATION	PROVIDER COMPONENT SHARE OF COLUMN 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COLUMN 14	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUST- MENT	
LINE NO.		12	13	14	15	16	17	18	
1	5	ADMINISTRATIVE & GENERAL AGGREGATE				2,472	23,278	57,428	1
200		TOTAL				2,472	23,278	57,428	200

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION (FROM WKST A, COL.7) 0	CAP BLDGS & FIXTURES 1	EMPLOYEE BENEFITS 4	SUBTOTAL (COLS.0-4) 4A	ADMINIS- TRATIVE & GENERAL 5	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	175,927	175,927				1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS	112,361		112,361			4
5 ADMINISTRATIVE & GENERAL	272,400	18,269	15,895	306,564	306,564	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	4,006			4,006	744	7
8 LAUNDRY & LINEN SERVICE	11,435			11,435	2,122	8
9 HOUSEKEEPING	29,037			29,037	5,390	9
10 DIETARY	41,996		2,289	44,285	8,220	10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION						13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	34,972	3,362	2,989	41,323	7,670	16
17 SOCIAL SERVICE						17
18 RECREATIONAL THERAPY						18
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	581,051	133,976	74,178	789,205	146,484	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	76,498			76,498	14,199	50
54 RADIOLOGY-DIAGNOSTIC	56,520			56,520	10,491	54
60 LABORATORY	52,389			52,389	9,724	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	128,431	3,133	16,345	147,909	27,454	65
66 PHYSICAL THERAPY	38,598	1,697		40,295	7,479	66
67 OCCUPATIONAL THERAPY	34,220	1,697		35,917	6,667	67
68 SPEECH PATHOLOGY	23,348	1,686		25,034	4,647	68
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	26,470	12,107		38,577	7,160	71
73 DRUGS CHARGED TO PATIENTS	243,157		665	243,822	45,256	73
74 RENAL DIALYSIS	15,390			15,390	2,857	74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	1,958,206	175,927	112,361	1,958,206	306,564	118
NONREIMBURSABLE COST CENTERS						
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	1,958,206	175,927	112,361	1,958,206	306,564	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	MEDICAL RECORDS & LIBRARY 16	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	4,750					7
8 LAUNDRY & LINEN SERVICE		13,557				8
9 HOUSEKEEPING			34,427			9
10 DIETARY				52,505		10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION						13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	101		734		49,828	16
17 SOCIAL SERVICE						17
18 RECREATIONAL THERAPY						18
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	4,037	13,557	29,255	52,505	49,828	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
54 RADIOLOGY-DIAGNOSTIC						54
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	94		684			65
66 PHYSICAL THERAPY	51		371			66
67 OCCUPATIONAL THERAPY	51		371			67
68 SPEECH PATHOLOGY	51		368			68
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	365		2,644			71
73 DRUGS CHARGED TO PATIENTS						73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	4,750	13,557	34,427	52,505	49,828	118
NONREIMBURSABLE COST CENTERS						
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	4,750	13,557	34,427	52,505	49,828	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26	
GENERAL SERVICE COST CENTERS				
1 CAP REL COSTS-BLDG & FIXT				1
2 CAP REL COSTS-MVBLE EQUIP				2
4 EMPLOYEE BENEFITS				4
5 ADMINISTRATIVE & GENERAL				5
6 MAINTENANCE & REPAIRS				6
7 OPERATION OF PLANT				7
8 LAUNDRY & LINEN SERVICE				8
9 HOUSEKEEPING				9
10 DIETARY				10
11 CAFETERIA				11
12 MAINTENANCE OF PERSONNEL				12
13 NURSING ADMINISTRATION				13
14 CENTRAL SERVICES & SUPPLY				14
15 PHARMACY				15
16 MEDICAL RECORDS & LIBRARY				16
17 SOCIAL SERVICE				17
18 RECREATIONAL THERAPY				18
19 NONPHYSICIAN ANESTHETISTS				19
20 NURSING SCHOOL				20
21 I&R SRVCES-SALARY & FRINGES APPRVD				21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD				22
23 PARAMED ED PRGM-(SPECIFY)				23
INPATIENT ROUTINE SERV COST CENTERS				
30 ADULTS & PEDIATRICS	1,084,871		1,084,871	30
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	90,697		90,697	50
54 RADIOLOGY-DIAGNOSTIC	67,011		67,011	54
60 LABORATORY	62,113		62,113	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	176,141		176,141	65
66 PHYSICAL THERAPY	48,196		48,196	66
67 OCCUPATIONAL THERAPY	43,006		43,006	67
68 SPEECH PATHOLOGY	30,100		30,100	68
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	48,746		48,746	71
73 DRUGS CHARGED TO PATIENTS	289,078		289,078	73
74 RENAL DIALYSIS	18,247		18,247	74
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
92 OBSERVATION BEDS				92
OTHER REIMBURSABLE COST CENTERS				
99.10 CORF				99.10
99.20 OUTPATIENT PHYSICAL THERAPY				99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40 OUTPATIENT SPEECH PATHOLOGY				99.40
SPECIAL PURPOSE COST CENTERS				
118 SUBTOTALS (SUM OF LINES 1-117)	1,958,206		1,958,206	118
NONREIMBURSABLE COST CENTERS				
200 CROSS FOOT ADJUSTMENTS				200
201 NEGATIVE COST CENTER				201
202 TOTAL (SUM OF LINES 118-201)	1,958,206		1,958,206	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	CAP BLDGS & FIXTURES 1	SUBTOTAL 2A	ADMINIS- TRATIVE & GENERAL 5	OPERATION OF PLANT 7	
GENERAL SERVICE COST CENTERS						
1						1
2						2
4						4
5		18,269	18,269	18,269		5
6						6
7				44	44	7
8				126		8
9				321		9
10				490		10
11						11
12						12
13						13
14						14
15						15
16		3,362	3,362	457	1	16
17						17
18						18
19						19
20						20
21						21
22						22
23						23
INPATIENT ROUTINE SERV COST CENTERS						
30		133,976	133,976	8,731	39	30
ANCILLARY SERVICE COST CENTERS						
50				846		50
54				625		54
60				579		60
62.30						62.30
65		3,133	3,133	1,636	1	65
66		1,697	1,697	446		66
67		1,697	1,697	397		67
68		1,686	1,686	277		68
71		12,107	12,107	427	3	71
73				2,697		73
74				170		74
76.97						76.97
76.98						76.98
76.99						76.99
OUTPATIENT SERVICE COST CENTERS						
92						92
OTHER REIMBURSABLE COST CENTERS						
99.10						99.10
99.20						99.20
99.30						99.30
99.40						99.40
SPECIAL PURPOSE COST CENTERS						
118		175,927	175,927	18,269	44	118
NONREIMBURSABLE COST CENTERS						
200						200
201						201
202		175,927	175,927	18,269	44	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	MEDICAL RECORDS & LIBRARY 16	SUBTOTAL 24	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE	126					8
9 HOUSEKEEPING		321				9
10 DIETARY			490			10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION						13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY		7		3,827		16
17 SOCIAL SERVICE						17
18 RECREATIONAL THERAPY						18
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	126	274	490	3,827	147,463	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM					846	50
54 RADIOLOGY-DIAGNOSTIC					625	54
60 LABORATORY					579	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY		6			4,776	65
66 PHYSICAL THERAPY		3			2,146	66
67 OCCUPATIONAL THERAPY		3			2,097	67
68 SPEECH PATHOLOGY		3			1,966	68
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		25			12,562	71
73 DRUGS CHARGED TO PATIENTS					2,697	73
74 RENAL DIALYSIS					170	74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	126	321	490	3,827	175,927	118
NONREIMBURSABLE COST CENTERS						
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	126	321	490	3,827	175,927	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26	
GENERAL SERVICE COST CENTERS			
1 CAP REL COSTS-BLDG & FIXT			1
2 CAP REL COSTS-MVBLE EQUIP			2
4 EMPLOYEE BENEFITS			4
5 ADMINISTRATIVE & GENERAL			5
6 MAINTENANCE & REPAIRS			6
7 OPERATION OF PLANT			7
8 LAUNDRY & LINEN SERVICE			8
9 HOUSEKEEPING			9
10 DIETARY			10
11 CAFETERIA			11
12 MAINTENANCE OF PERSONNEL			12
13 NURSING ADMINISTRATION			13
14 CENTRAL SERVICES & SUPPLY			14
15 PHARMACY			15
16 MEDICAL RECORDS & LIBRARY			16
17 SOCIAL SERVICE			17
18 RECREATIONAL THERAPY			18
19 NONPHYSICIAN ANESTHETISTS			19
20 NURSING SCHOOL			20
21 I&R SRVCES-SALARY & FRINGES APPRVD			21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD			22
23 PARAMED ED PRGM-(SPECIFY)			23
INPATIENT ROUTINE SERV COST CENTERS			
30 ADULTS & PEDIATRICS		147,463	30
ANCILLARY SERVICE COST CENTERS			
50 OPERATING ROOM		846	50
54 RADIOLOGY-DIAGNOSTIC		625	54
60 LABORATORY		579	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS			62.30
65 RESPIRATORY THERAPY		4,776	65
66 PHYSICAL THERAPY		2,146	66
67 OCCUPATIONAL THERAPY		2,097	67
68 SPEECH PATHOLOGY		1,966	68
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		12,562	71
73 DRUGS CHARGED TO PATIENTS		2,697	73
74 RENAL DIALYSIS		170	74
76.97 CARDIAC REHABILITATION			76.97
76.98 HYPERBARIC OXYGEN THERAPY			76.98
76.99 LITHOTRIPSY			76.99
OUTPATIENT SERVICE COST CENTERS			
92 OBSERVATION BEDS			92
OTHER REIMBURSABLE COST CENTERS			
99.10 CORF			99.10
99.20 OUTPATIENT PHYSICAL THERAPY			99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY			99.30
99.40 OUTPATIENT SPEECH PATHOLOGY			99.40
SPECIAL PURPOSE COST CENTERS			
118 SUBTOTALS (SUM OF LINES 1-117)		175,927	118
NONREIMBURSABLE COST CENTERS			
200 CROSS FOOT ADJUSTMENTS			200
201 NEGATIVE COST CENTER			201
202 TOTAL (SUM OF LINES 118-201)		175,927	202

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS GROSS SALARIES	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM COST	
	1	2	4	5A	5	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	16,900					1
2 CAP REL COSTS-MVBLE EQUIP		16,900				2
4 EMPLOYEE BENEFITS			792,726			4
5 ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS	1,755	1,755	112,139	-306,564	1,651,642	5
6 OPERATION OF PLANT					4,006	6
7 LAUNDRY & LINEN SERVICE					11,435	7
8 HOUSEKEEPING					29,037	8
9 DIETARY			16,146		44,285	9
10 CAFETERIA						10
11 MAINTENANCE OF PERSONNEL						11
12 NURSING ADMINISTRATION						12
13 CENTRAL SERVICES & SUPPLY						13
14 PHARMACY						14
15 MEDICAL RECORDS & LIBRARY	323	323	21,086		41,323	15
16 SOCIAL SERVICE						16
17 RECREATIONAL THERAPY						17
18 NONPHYSICIAN ANESTHETISTS						18
19 NURSING SCHOOL						19
20 I&R SRVCES-SALARY & FRINGES APPRVD						20
21 I&R SRVCES-OTHER PRGM COSTS APPRVD						21
22 PARAMED ED PRGM-(SPECIFY)						22
23 INPATIENT ROUTINE SERV COST CENTERS						23
30 ADULTS & PEDIATRICS	12,870	12,870	523,350		789,205	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM					76,498	50
54 RADIOLOGY-DIAGNOSTIC					56,520	54
60 LABORATORY					52,389	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	301	301	115,315		147,909	65
66 PHYSICAL THERAPY	163	163			40,295	66
67 OCCUPATIONAL THERAPY	163	163			35,917	67
68 SPEECH PATHOLOGY	162	162			25,034	68
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	1,163	1,163			38,577	71
73 DRUGS CHARGED TO PATIENTS			4,690		243,822	73
74 RENAL DIALYSIS					15,390	74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	16,900	16,900	792,726	-306,564	1,651,642	118
NONREIMBURSABLE COST CENTERS						
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	175,927		112,361		306,564	202
203 UNIT COST MULT-WS B PT I	10.409882		0.141740		0.185612	203
204 COST TO BE ALLOC PER B PT II					18,269	204
205 UNIT COST MULT-WS B PT II					0.011061	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	MAIN-	OPERATION	LAUNDRY	HOUSE-	DIETARY	
	TENANCE & REPAIRS SQUARE FEET	OF PLANT SQUARE FEET	& LINEN SERVICE POUNDS OF LAUNDRY	KEEPING SQUARE FEET	MEALS SERVED	
	6	7	8	9	10	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS	15,145					6
7 OPERATION OF PLANT		15,145				7
8 LAUNDRY & LINEN SERVICE			1,136			8
9 HOUSEKEEPING				15,145		9
10 DIETARY					3,408	10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION						13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	323	323		323		16
17 SOCIAL SERVICE						17
18 RECREATIONAL THERAPY						18
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
30 INPATIENT ROUTINE SERV COST CENTERS						
ADULTS & PEDIATRICS	12,870	12,870	1,136	12,870	3,408	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
54 RADIOLOGY-DIAGNOSTIC						54
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	301	301		301		65
66 PHYSICAL THERAPY	163	163		163		66
67 OCCUPATIONAL THERAPY	163	163		163		67
68 SPEECH PATHOLOGY	162	162		162		68
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	1,163	1,163		1,163		71
73 DRUGS CHARGED TO PATIENTS						73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	15,145	15,145	1,136	15,145	3,408	118
NONREIMBURSABLE COST CENTERS						
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I		4,750	13,557	34,427	52,505	202
203 UNIT COST MULT-WS B PT I		0.313635	11.933979	2.273159	15.406397	203
204 COST TO BE ALLOC PER B PT II		44	126	321	490	204
205 UNIT COST MULT-WS B PT II		0.002905	0.110915	0.021195	0.143779	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	NURSING ADMINIS- TRATION DIRECT NRSING HRS 13	CENTRAL SERVICES & SUPPLY COSTED REQUIS. 14	MEDICAL RECORDS & LIBRARY TIME SPENT 16	SOCIAL SERVICE TIME SPENT 17	
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5 ADMINISTRATIVE & GENERAL					5
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION	74				13
14 CENTRAL SERVICES & SUPPLY		1,236			14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY			567		16
17 SOCIAL SERVICE				476	17
18 RECREATIONAL THERAPY					18
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SRVCES-SALARY & FRINGES APPRVD					21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD					22
23 PARAMED ED PRGM-(SPECIFY)					23
30 INPATIENT ROUTINE SERV COST CENTERS ADULTS & PEDIATRICS	74	1,136	567	476	30
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM					50
54 RADIOLOGY-DIAGNOSTIC					54
60 LABORATORY					60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY					65
66 PHYSICAL THERAPY					66
67 OCCUPATIONAL THERAPY					67
68 SPEECH PATHOLOGY					68
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		100			71
73 DRUGS CHARGED TO PATIENTS					73
74 RENAL DIALYSIS					74
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
99.10 CORF					99.10
99.20 OUTPATIENT PHYSICAL THERAPY					99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY					99.30
99.40 OUTPATIENT SPEECH PATHOLOGY					99.40
SPECIAL PURPOSE COST CENTERS					
118 SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	74	1,236	567	476	118
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 COST TO BE ALLOC PER B PT I			49,828		202
203 UNIT COST MULT-WS B PT I			87.880071		203
204 COST TO BE ALLOC PER B PT II			3,827		204
205 UNIT COST MULT-WS B PT II			6.749559		205

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I

COST CENTER DESCRIPTION	TOTAL COST	THERAPY	TOTAL COSTS	RCE	TOTAL COSTS	
	(FROM WKST B, PART I, COL 26)	LIMIT ADJUSTMENT		DISALLOWANCE		
	1	2	3	4	5	
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	1,084,871		1,084,871		1,084,871	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	90,697		90,697		90,697	50
54 RADIOLOGY-DIAGNOSTIC	67,011		67,011		67,011	54
60 LABORATORY	62,113		62,113		62,113	60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	176,141		176,141		176,141	65
66 PHYSICAL THERAPY	48,196		48,196		48,196	66
67 OCCUPATIONAL THERAPY	43,006		43,006		43,006	67
68 SPEECH PATHOLOGY	30,100		30,100		30,100	68
71 MEDICAL SUPPLIES CHRGED TO	48,746		48,746		48,746	71
73 DRUGS CHARGED TO PATIENTS	289,078		289,078		289,078	73
74 RENAL DIALYSIS	18,247		18,247		18,247	74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THE						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
200 SUBTOTAL (SEE INSTRUCTIONS)	1,958,206		1,958,206		1,958,206	200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)	1,958,206		1,958,206		1,958,206	202

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I (CONT)

COST CENTER DESCRIPTION	----- CHARGES -----			COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11
	INPATIENT 6	OUTPATIENT 7	TOTAL (COLS. 6 + 7) 8			
30 INPATIENT ROUTINE SERV COST CENTERS						
ADULTS & PEDIATRICS	1,272,431		1,272,431			30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	58,858		58,858	1.540946	1.540946	1.540946 50
54 RADIOLOGY-DIAGNOSTIC	100,093		100,093	0.669487	0.669487	0.669487 54
60 LABORATORY	300,403		300,403	0.206766	0.206766	0.206766 60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	980,181		980,181	0.179703	0.179703	0.179703 65
66 PHYSICAL THERAPY	69,742		69,742	0.691061	0.691061	0.691061 66
67 OCCUPATIONAL THERAPY	68,552		68,552	0.627349	0.627349	0.627349 67
68 SPEECH PATHOLOGY	101,676		101,676	0.296038	0.296038	0.296038 68
71 MEDICAL SUPPLIES CHRGED TO	299,225		299,225	0.162908	0.162908	0.162908 71
73 DRUGS CHARGED TO PATIENTS	285,819		285,819	1.011402	1.011402	1.011402 73
74 RENAL DIALYSIS	46,927		46,927	0.388838	0.388838	0.388838 74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THE						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
200 SUBTOTAL (SEE INSTRUCTIONS)	3,583,907		3,583,907			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)	3,583,907		3,583,907			202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

CHECK [] TITLE V
 APPLICABLE [XX] TITLE XVIII-PT A
 BOXES [] TITLE XIX

COST CENTER DESCRIPTION	CAP-REL COST		REDUCED CAP-REL COST	TOTAL PATIENT DAYS	PER DIEM	INPAT PGM DAYS	INPAT PGM CAP COST	
	(FROM WKST B, PT. II, COL. 26)	SWING-BED ADJUSTMENT	(COL.1 MINUS COL.2)		(COL.3 + COL.4)		(COL.5 x COL.6)	
	1	2	3	4	5	6	7	
INPAT ROUTINE SERV COST CTRS								
30 ADULTS & PEDIATRICS	147,463		147,463	1,136	129.81	1,062	137,858	30
31 INTENSIVE CARE UNIT								31
32 CORONARY CARE UNIT								32
33 BURN INTENSIVE CARE UNIT								33
34 SURGICAL INTENSIVE CARE UNIT								34
35 OTHER SPECIAL CARE (SPECIFY)								35
40 SUBPROVIDER - IPF								40
41 SUBPROVIDER - IRF								41
42 SUBPROVIDER I								42
43 NURSERY								43
44 SKILLED NURSING FACILITY								44
45 NURSING FACILITY								45
200 TOTAL (LINES 30-199)	147,463		147,463	1,136		1,062	137,858	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK [] TITLE V [XX] HOSPITAL (15-2025) [] SUB (OTHER) [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [] TITLE XIX [] IRF

COST CENTER DESCRIPTION	CAP-REL COST	TOTAL CHARGES	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	CAPITAL	
	(FROM WKST B, PT. II, COL. 26) 1	(FROM WKST C, PT. I, COL. 8) 2	(COL.1 ÷ COL.2) 3	4	(COL.3 x COL.4) 5	
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	846	58,858	0.014374	58,192	836	50
54 RADIOLOGY-DIAGNOSTIC	625	100,093	0.006244	93,788	586	54
60 LABORATORY	579	300,403	0.001927	274,995	530	60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY	4,776	980,181	0.004873	920,980	4,488	65
66 PHYSICAL THERAPY	2,146	69,742	0.030771	62,716	1,930	66
67 OCCUPATIONAL THERAPY	2,097	68,552	0.030590	62,137	1,901	67
68 SPEECH PATHOLOGY	1,966	101,676	0.019336	94,705	1,831	68
71 MEDICAL SUPPLIES CHRGED TO PA	12,562	299,225	0.041982	281,312	11,810	71
73 DRUGS CHARGED TO PATIENTS	2,697	285,819	0.009436	270,439	2,552	73
74 RENAL DIALYSIS	170	46,927	0.003623	46,927	170	74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL (SUM OF LINES 50-199)	28,464	2,311,476		2,166,191	26,634	200

PROVIDER CCN: 15-2025 CENTRAL INDIANA-AMG SPECIALTY
PERIOD FROM 06/01/2012 TO 08/31/2012

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2012.11
02/25/2013 11:31

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

CHECK [] TITLE V
APPLICABLE [XX] TITLE XVIII-PT A
BOXES [] TITLE XIX

COST CENTER DESCRIPTION	NURSING SCHOOL 1	ALLIED HEALTH COST 2	ALL OTHER MEDICAL EDUCATION COST 3	SWING-BED ADJUSTMENT AMOUNT (SEE INSTR.) 4	TOTAL COSTS (SUM OF COLS. 1-3 MINUS COL. 4) 5
30 INPAT ROUTINE SERV COST CTRS					30
31 ADULTS & PEDIATRICS					31
32 INTENSIVE CARE UNIT					32
33 CORONARY CARE UNIT					32
34 BURN INTENSIVE CARE UNIT					33
35 SURGICAL INTENSIVE CARE UNIT					34
40 OTHER SPECIAL CARE (SPECIFY)					35
41 SUBPROVIDER - IPF					40
42 SUBPROVIDER - IRF					41
43 SUBPROVIDER I					42
44 NURSERY					43
45 SKILLED NURSING FACILITY					44
200 NURSING FACILITY					45
TOTAL (SUM OF LINES 30-199)					200

PROVIDER CCN: 15-2025 CENTRAL INDIANA-AMG SPECIALTY
 PERIOD FROM 06/01/2012 TO 08/31/2012

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2012.11
 02/25/2013 11:31

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

CHECK [] TITLE V
 APPLICABLE [XX] TITLE XVIII-PT A
 BOXES [] TITLE XIX

COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 6	PER DIEM COL. 5 + COL. 6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM PASS THRU COSTS (COL. 7 x COL. 8) 9	
INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS	1,136		1,062		30
31 INTENSIVE CARE UNIT					31
32 CORONARY CARE UNIT					32
33 BURN INTENSIVE CARE UNIT					33
34 SURGICAL INTENSIVE CARE UNIT					34
35 OTHER SPECIAL CARE (SPECIFY)					35
40 SUBPROVIDER - IPF					40
41 SUBPROVIDER - IRF					41
42 SUBPROVIDER I					42
43 NURSERY					43
44 SKILLED NURSING FACILITY					44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)	1,136		1,062		200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (15-2025) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN ANESTHETIST COST 1			MEDICAL EDUCATION COST 4	COST (SUM OF COLS. 1-4) 5	COST (SUM OF COLS. 2-4) 6
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
54 RADIOLOGY-DIAGNOSTIC						54
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
71 MEDICAL SUPPLIES CHRGD TO PA						71
73 DRUGS CHARGED TO PATIENTS						73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL (SUM OF LINES 50-199)						200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (15-2025) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF

COST CENTER DESCRIPTION	TOTAL CHARGES	RATIO OF COST TO CHARGES	O/P RATIO OF COST TO CHARGES	INPAT PGM CHARGES	INPAT PGM PASS-THRU COSTS	O/P PGM CHARGES	O/P PGM PASS-THRU COSTS
	(FROM WKST C, PT. I, COL. 8)	(COL. 5 ÷ COL. 7)	(COL. 6 ÷ COL. 7)	PGM COL. 10	(COL. 8 x COL. 10)	COL. 12	(COL. 9 x COL. 12)
	7	8	9	10	11	12	13
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	58,858			58,192			50
54 RADIOLOGY-DIAGNOSTIC	100,093			93,788			54
60 LABORATORY	300,403			274,995			60
62.30 BLOOD CLOTTING FOR HEMOPHILI							62.30
65 RESPIRATORY THERAPY	980,181			920,980			65
66 PHYSICAL THERAPY	69,742			62,716			66
67 OCCUPATIONAL THERAPY	68,552			62,137			67
68 SPEECH PATHOLOGY	101,676			94,705			68
71 MEDICAL SUPPLIES CHRGED TO P	299,225			281,312			71
73 DRUGS CHARGED TO PATIENTS	285,819			270,439			73
74 RENAL DIALYSIS	46,927			46,927			74
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
92 OBSERVATION BEDS							92
OTHER REIMBURSABLE COST CENTERS							
200 TOTAL (SUM OF LINES 50-199)	2,311,476			2,166,191			200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (15-2025) [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [XX] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO		COST REIMB.	COST REIMB.	COST	COST	
	CHARGE RATIO	PPS	SERVICES	SVCES NOT	SERVICES	SVCES NOT	
FROM WKST C,	REIMBURSED	SUBJECT TO	SUBJECT TO	PPS	SUBJECT TO	SUBJECT TO	
PT I, COL. 9	SERVICES	DED & COINS	DED & COINS	SERVICES	DED & COINS	DED & COINS	
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	1.540946						50
54 RADIOLOGY-DIAGNOSTIC	0.669487						54
60 LABORATORY	0.206766						60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.179703						65
66 PHYSICAL THERAPY	0.691061						66
67 OCCUPATIONAL THERAPY	0.627349						67
68 SPEECH PATHOLOGY	0.296038						68
71 MEDICAL SUPPLIES CHRGD TO PATI	0.162908						71
73 DRUGS CHARGED TO PATIENTS	1.011402						73
74 RENAL DIALYSIS	0.388838						74
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
92 OBSERVATION BEDS							92
OTHER REIMBURSABLE COST CENTERS							
200 SUBTOTAL (SEE INSTRUCTIONS)							200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)							202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

CHECK [] TITLE V
 APPLICABLE [] TITLE XVIII-PT A
 BOXES [XX] TITLE XIX

COST CENTER DESCRIPTION	CAP-REL COST		REDUCED CAP-REL COST	TOTAL PATIENT DAYS	PER DIEM	INPAT PGM DAYS	INPAT PGM CAP COST	
	(FROM WKST B, PT. II, COL. 26)	SWING-BED ADJUSTMENT	(COL.1 MINUS COL.2)		(COL.3 + COL.4)		(COL.5 x COL.6)	7
	1	2	3	4	5	6	7	8
INPAT ROUTINE SERV COST CTRS								
30 ADULTS & PEDIATRICS	147,463		147,463	1,136	129.81	65	8,438	30
31 INTENSIVE CARE UNIT								31
32 CORONARY CARE UNIT								32
33 BURN INTENSIVE CARE UNIT								33
34 SURGICAL INTENSIVE CARE UNIT								34
35 OTHER SPECIAL CARE (SPECIFY)								35
40 SUBPROVIDER - IPF								40
41 SUBPROVIDER - IRF								41
42 SUBPROVIDER I								42
43 NURSERY								43
44 SKILLED NURSING FACILITY								44
45 NURSING FACILITY								45
200 TOTAL (LINES 30-199)	147,463		147,463	1,136		65	8,438	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK [] TITLE V [XX] HOSPITAL (15-2025) [] SUB (OTHER) [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] OTHER

COST CENTER DESCRIPTION	CAP-REL	TOTAL	RATIO OF	INPATIENT	CAPITAL
	COST	CHARGES	COST TO		
	(FROM WKST	(FROM WKST	CHARGES	PROGRAM	(COL.3 x
	B, PT. II,	C, PT. I,	(COL.1 +	CHARGES	COL.4)
	COL. 26)	COL. 8)	COL.2)		
	1	2	3	4	5
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	846	58,858	0.014374		50
54 RADIOLOGY-DIAGNOSTIC	625	100,093	0.006244		54
60 LABORATORY	579	300,403	0.001927		60
62.30 BLOOD CLOTTING FOR HEMOPHILIA					62.30
65 RESPIRATORY THERAPY	4,776	980,181	0.004873		65
66 PHYSICAL THERAPY	2,146	69,742	0.030771		66
67 OCCUPATIONAL THERAPY	2,097	68,552	0.030590		67
68 SPEECH PATHOLOGY	1,966	101,676	0.019336		68
71 MEDICAL SUPPLIES CHRGED TO PA	12,562	299,225	0.041982		71
73 DRUGS CHARGED TO PATIENTS	2,697	285,819	0.009436		73
74 RENAL DIALYSIS	170	46,927	0.003623		74
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
200 TOTAL (SUM OF LINES 50-199)	28,464	2,311,476			200

PROVIDER CCN: 15-2025 CENTRAL INDIANA-AMG SPECIALTY
PERIOD FROM 06/01/2012 TO 08/31/2012

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2012.11
02/25/2013 11:31

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

CHECK [] TITLE V
APPLICABLE [] TITLE XVIII-PT A
BOXES [XX] TITLE XIX

COST CENTER DESCRIPTION	NURSING SCHOOL 1	ALLIED HEALTH COST 2	ALL OTHER MEDICAL EDUCATION COST 3	SWING-BED ADJUSTMENT AMOUNT (SEE INSTR.) 4	TOTAL COSTS (SUM OF COLS. 1-3 MINUS COL. 4) 5
30 INPAT ROUTINE SERV COST CTRS					30
31 ADULTS & PEDIATRICS					31
32 INTENSIVE CARE UNIT					32
33 CORONARY CARE UNIT					32
34 BURN INTENSIVE CARE UNIT					33
35 SURGICAL INTENSIVE CARE UNIT					34
40 OTHER SPECIAL CARE (SPECIFY)					35
41 SUBPROVIDER - IPF					40
42 SUBPROVIDER - IRF					41
43 SUBPROVIDER I					42
44 NURSERY					43
45 SKILLED NURSING FACILITY					44
200 NURSING FACILITY					45
TOTAL (SUM OF LINES 30-199)					200

PROVIDER CCN: 15-2025 CENTRAL INDIANA-AMG SPECIALTY
 PERIOD FROM 06/01/2012 TO 08/31/2012

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2012.11
 02/25/2013 11:31

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

CHECK [] TITLE V
 APPLICABLE [] TITLE XVIII-PT A
 BOXES [XX] TITLE XIX

COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 6	PER DIEM COL. 5 + COL. 6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM PASS THRU COSTS (COL. 7 x COL. 8) 9	
INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS	1,136		65		30
31 INTENSIVE CARE UNIT					31
32 CORONARY CARE UNIT					32
33 BURN INTENSIVE CARE UNIT					33
34 SURGICAL INTENSIVE CARE UNIT					34
35 OTHER SPECIAL CARE (SPECIFY)					35
40 SUBPROVIDER - IPF					40
41 SUBPROVIDER - IRF					41
42 SUBPROVIDER I					42
43 NURSERY					43
44 SKILLED NURSING FACILITY					44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)	1,136		65		200

PROVIDER CCN: 15-2025 CENTRAL INDIANA-AMG SPECIALTY
 PERIOD FROM 06/01/2012 TO 08/31/2012

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2012.11
 02/25/2013 11:31

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (15-2025) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] NF [] OTHER

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN ANESTHETIST COST 1			MEDICAL EDUCATION COST 4	COST (SUM OF COLS. 1-4) 5	COST (SUM OF COLS. 2-4) 6
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
54 RADIOLOGY-DIAGNOSTIC						54
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
71 MEDICAL SUPPLIES CHRGD TO PA						71
73 DRUGS CHARGED TO PATIENTS						73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL (SUM OF LINES 50-199)						200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK	[]	TITLE V	[XX]	HOSPITAL (15-2025)	[]	SUB (OTHER)	[]	ICF/MR	[XX]	PPS
APPLICABLE	[]	TITLE XVIII-PT A	[]	IPF	[]	SNF			[]	TEFRA
BOXES	[XX]	TITLE XIX	[]	IRF	[]	NF			[]	OTHER

COST CENTER DESCRIPTION	TOTAL	RATIO OF	O/P RATIO	INPAT	INPAT PGM	O/P PGM	O/P PGM
	CHARGES	COST TO	OF COST TO		PASS-THRU		PASS-THRU
	(FROM WKST	CHARGES	CHARGES	PGM	COSTS	CHARGES	COSTS
	C, PT. I,	(COL. 5 ÷	(COL. 6 ÷	CHARGES	(COL. 8 x	(COL. 9 x	(COL. 9 x
	COL. 8)	COL. 7)	COL. 7)		COL. 10)	COL. 12)	COL. 12)
	7	8	9	10	11	12	13
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	58,858					50
54	RADIOLOGY-DIAGNOSTIC	100,093					54
60	LABORATORY	300,403					60
62.30	BLOOD CLOTTING FOR HEMOPHILI						62.30
65	RESPIRATORY THERAPY	980,181					65
66	PHYSICAL THERAPY	69,742					66
67	OCCUPATIONAL THERAPY	68,552					67
68	SPEECH PATHOLOGY	101,676					68
71	MEDICAL SUPPLIES CHRGD TO P	299,225					71
73	DRUGS CHARGED TO PATIENTS	285,819					73
74	RENAL DIALYSIS	46,927					74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
92	OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (SUM OF LINES 50-199)	2,311,476					200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (15-2025) [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [XX] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO		COST REIMB.	COST REIMB.	COST	COST	
	CHARGE RATIO	PPS	SERVICES	SVCES NOT	SERVICES	SVCES NOT	
FROM WKST C,	REIMBURSED	SUBJECT TO	SUBJECT TO	PPS	SUBJECT TO	SUBJECT TO	
PT I, COL. 9	SERVICES	DED & COINS	DED & COINS	SERVICES	DED & COINS	DED & COINS	
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	1.540946						50
54 RADIOLOGY-DIAGNOSTIC	0.669487						54
60 LABORATORY	0.206766						60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.179703						65
66 PHYSICAL THERAPY	0.691061						66
67 OCCUPATIONAL THERAPY	0.627349						67
68 SPEECH PATHOLOGY	0.296038						68
71 MEDICAL SUPPLIES CHRGD TO PATI	0.162908						71
73 DRUGS CHARGED TO PATIENTS	1.011402						73
74 RENAL DIALYSIS	0.388838						74
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
92 OBSERVATION BEDS							92
OTHER REIMBURSABLE COST CENTERS							
200 SUBTOTAL (SEE INSTRUCTIONS)							200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)							202

WORKSHEET D-1
 PART I

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (15-2025) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [] NF [] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	1,136	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	1,136	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	1,136	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	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)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	1,062	9
10	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)		10
11	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)		11
12	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		12
13	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)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	1,084,871	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	1,084,871	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	1,272,431	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1,272,431	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 + LINE 28)	0.852597	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 + LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 + LINE 4)	1,120.10	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	1,084,871	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (15-2025) [] SUB (OTHER) [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 954.99 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 1,014,199 39
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35) 40
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40) 1,014,199 41

	TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 ÷ COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 4) 5
42 NURSERY (TITLES V AND XIX ONLY)					42

INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS

43 INTENSIVE CARE UNIT					43
44 CORONARY CARE UNIT					44
45 BURN INTENSIVE CARE UNIT					45
46 SURGICAL INTENSIVE CARE UNIT					46
47 OTHER SPECIAL CARE (SPECIFY)					47
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					822,781 48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					1,836,980 49

PASS-THROUGH COST ADJUSTMENTS

50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)					137,858 50
51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV)					26,634 51
52 TOTAL PROGRAM EXCLUDABLE COST					164,492 52
53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)					1,672,488 53

TARGET AMOUNT AND LIMIT COMPUTATION

54 PROGRAM DISCHARGES					54
55 TARGET AMOUNT PER DISCHARGE					55
56 TARGET AMOUNT (LINE 54 x LINE 55)					56
57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT					57
58 BONUS PAYMENT (SEE INSTRUCTIONS)					58
59 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET					59
60 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET					60
61 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)					61
62 RELIEF PAYMENT (SEE INSTRUCTIONS)					62
63 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)					63

PROGRAM INPATIENT ROUTINE SWING BED COST

64 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY)					64
65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY)					65
66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS)					66
67 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19)					67
68 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20)					68
69 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68)					69

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS)					87
88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 + LINE 2)					954.99 88
89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS)					89

	COMPUTATION OF OBSERVATION BED PASS-THROUGH COST	COST 1	ROUTINE COST (FROM LINE 27) 2	COL. 1 ÷ COL. 2 3	TOTAL OBS. BED COST (FROM LINE 89) 4	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) (SEE INSTR.) 5
90 CAPITAL-RELATED COST						90
91 NURSING SCHOOL COST						91
92 ALLIED HEALTH COST						92
93 ALL OTHER MEDICAL EDUCATION						93

WORKSHEET D-1
 PART I

COMPUTATION OF INPATIENT OPERATING COST

CHECK TITLE V-INPT HOSPITAL (15-2025) SUB (OTHER) ICF/MR PPS
 APPLICABLE TITLE XVIII-PT A IPF SNF TEFRA
 BOXES TITLE XIX-INPT IRF NF OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	1,136	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	1,136	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	1,136	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	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)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	65	9
10	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)		10
11	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)		11
12	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		12
13	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)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	1,084,871	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	1,084,871	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	1,272,431	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1,272,431	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 + LINE 28)	0.852597	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 + LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 + LINE 4)	1,120.10	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	1,084,871	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (15-2025) [] SUB (OTHER) [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [XX] TITLE XIX-INPT [] IRF [] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 954.99 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 62,074 39
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35) 40
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40) 62,074 41

	TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 ÷ COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 4) 5
42 NURSERY (TITLES V AND XIX ONLY)					42

INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS
 43 INTENSIVE CARE UNIT 43
 44 CORONARY CARE UNIT 44
 45 BURN INTENSIVE CARE UNIT 45
 46 SURGICAL INTENSIVE CARE UNIT 46
 47 OTHER SPECIAL CARE (SPECIFY) 47
 48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200) 48
 49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS) 62,074 49

PASS-THROUGH COST ADJUSTMENTS
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 8,438 50
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 51
 52 TOTAL PROGRAM EXCLUDABLE COST 8,438 52
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 53,636 53

TARGET AMOUNT AND LIMIT COMPUTATION
 54 PROGRAM DISCHARGES 54
 55 TARGET AMOUNT PER DISCHARGE 55
 56 TARGET AMOUNT (LINE 54 x LINE 55) 56
 57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT 57
 58 BONUS PAYMENT (SEE INSTRUCTIONS) 58
 59 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET 59
 60 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET 60
 61 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) 61
 62 RELIEF PAYMENT (SEE INSTRUCTIONS) 62
 63 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS) 63

PROGRAM INPATIENT ROUTINE SWING BED COST
 64 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY) 64
 65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY) 65
 66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS) 66
 67 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19) 67
 68 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20) 68
 69 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68) 69

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS) 87
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 + LINE 2) 88
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 89

	COMPUTATION OF OBSERVATION BED PASS-THROUGH COST	COST 1	ROUTINE COST (FROM LINE 27) 2	COL. 1 ÷ COL. 2 3	TOTAL OBS. BED COST (FROM LINE 89) 4	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) (SEE INSTR.) 5
90 CAPITAL-RELATED COST						90
91 NURSING SCHOOL COST						91
92 ALLIED HEALTH COST						92
93 ALL OTHER MEDICAL EDUCATION						93

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [XX] HOSPITAL (15-2025) [] SUB (OTHER) [] S/B SNF [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] S/B NF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF [] ICF/MR [] OTHER

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	(COL.1 x COL.2)	3
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS		1,189,990		30
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	1.540946	58,192	89,671	50
54 RADIOLOGY-DIAGNOSTIC	0.669487	93,788	62,790	54
60 LABORATORY	0.206766	274,995	56,860	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	0.179703	920,980	165,503	65
66 PHYSICAL THERAPY	0.691061	62,716	43,341	66
67 OCCUPATIONAL THERAPY	0.627349	62,137	38,982	67
68 SPEECH PATHOLOGY	0.296038	94,705	28,036	68
71 MEDICAL SUPPLIES CHRGED TO PATI	0.162908	281,312	45,828	71
73 DRUGS CHARGED TO PATIENTS	1.011402	270,439	273,523	73
74 RENAL DIALYSIS	0.388838	46,927	18,247	74
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
92 OBSERVATION BEDS				92
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		2,166,191	822,781	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		2,166,191		202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [XX] HOSPITAL (15-2025) [] SUB (OTHER) [] S/B SNF [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] S/B NF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] NF [] ICF/MR [] OTHER

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS
	1	2	(COL.1 x COL.2) 3
INPATIENT ROUTINE SERVICE COST CENTERS			
30 ADULTS & PEDIATRICS			30
ANCILLARY SERVICE COST CENTERS			
50 OPERATING ROOM	1.540946		50
54 RADIOLOGY-DIAGNOSTIC	0.669487		54
60 LABORATORY	0.206766		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS			62.30
65 RESPIRATORY THERAPY	0.179703		65
66 PHYSICAL THERAPY	0.691061		66
67 OCCUPATIONAL THERAPY	0.627349		67
68 SPEECH PATHOLOGY	0.296038		68
71 MEDICAL SUPPLIES CHRGED TO PATI	0.162908		71
73 DRUGS CHARGED TO PATIENTS	1.011402		73
74 RENAL DIALYSIS	0.388838		74
76.97 CARDIAC REHABILITATION			76.97
76.98 HYPERBARIC OXYGEN THERAPY			76.98
76.99 LITHOTRIPSY			76.99
OUTPATIENT SERVICE COST CENTERS			
92 OBSERVATION BEDS			92
OTHER REIMBURSABLE COST CENTERS			
200 TOTAL (SUM OF LINES 50-94 AND 96-98)			200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES			201
202 NET CHARGES (LINE 200 MINUS LINE 201)			202

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART B

CHECK APPLICABLE BOX: HOSPITAL (15-2025) IPF IRF
 SUB (OTHER) SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)		1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPTS (SEE INSTRUCTIONS)		2
3	PPS PAYMENTS		3
4	OUTLIER PAYMENT (SEE INSTRUCTIONS)		4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (SEE INSTRUCTIONS)		5
6	LINE 2 TIMES LINE 5		6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6		7
8	TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)		8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200		9
10	ORGAN ACQUISITION		10
11	TOTAL COST (SUM OF LINES 1 AND 10) (SEE INSTRUCTIONS)		11
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
12	ANCILLARY SERVICE CHARGES		12
13	ORGAN ACQUISITION CHARGES (FROM WKST D-4, PART III, LINE 69, COL. 4)		13
14	TOTAL REASONABLE CHARGES (SUM OF LINES 12 AND 13)		14
	CUSTOMARY CHARGES		
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		15
16	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)		16
17	RATIO OF LINE 15 TO LINE 16 (NOT TO EXCEED 1.000000)	1.000000	17
18	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 18 EXCEEDS LINE 11 (SEE INSTRUCTIONS))		19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 11 EXCEEDS LINE 18 (SEE INSTRUCTIONS))		20
21	LESSER OF COST OR CHARGES (LINE 11 MINUS LINE 20) (FOR CAH, SEE INSTRUCTIONS)		21
22	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)		22
23	COST OF TEACHING PHYSICIANS (SEE INSTR., 42 CFR 415.160 AND CMS PUB. 15-1 §2148)		23
24	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 3, 4, 8 AND 9)		24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25	DEDUCTIBLES AND COINSURANCE (SEE INSTRUCTIONS)		25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (SEE INSTRUCTIONS)		26
27	SUBTOTAL {(LINES 21 AND 24 - THE SUM OF LINES 25 AND 26) PLUS THE SUM OF LINES 22 AND 23} (SEE INSTRUCTIONS)		27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 50)		28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (FROM WKST E-4, LINE 36)		29
30	SUBTOTAL (SUM OF LINES 27 THROUGH 29)		30
31	PRIMARY PAYER PAYMENTS		31
32	SUBTOTAL (LINE 30 MINUS LINE 31)		32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33	COMPOSITE RATE ESRD (FROM WKST I-5, LINE 11)		33
34	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)		34
35	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		36
37	SUBTOTAL (SUM OF LINES 32, 33 AND 34 OR 35) (LINE 35 HOSPITAL AND SUBPROVIDERS ONLY)		37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R		38
39	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		39
40	SUBTOTAL (LINE 37 PLUS OR MINUS LINES 39 MINUS 38)		40
41	INTERIM PAYMENTS		41
42	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		42
43	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS THE SUM OF LINES 41 AND 42)		43
44	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2		44
	TO BE COMPLETED BY CONTRACTOR		
90	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)		90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY		92
93	TIME VALUE OF MONEY (SEE INSTRUCTIONS)		93
94	TOTAL (SUM OF LINES 91 AND 93)		94

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK [XX] HOSPITAL (15-2025) [] CAH
APPLICABLE BOX

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	1,136 4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168	7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (SEE INSTRUCTIONS)	8

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	INITIAL/INTERIM HIT PAYMENT(S)	30
31	OTHER ADJUSTMENTS (SPECIFY)	31
32	BALANCE DUE PROVIDER (LINE 8 MINUS LINE 30 ± LINE 31)	32

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
PART IV

CHECK [XX] HOSPITAL (15-2025)
APPLICABLE BOX:

PART IV - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER LTCH PPS

1	NET FEDERAL PPS PAYMENT (SEE INSTRUCTIONS)	1,278,534	1
2	OUTLIER PAYMENTS	51,813	2
3	TOTAL PPS PAYMENTS (SUM OF LINES 1 AND 2)	1,330,347	3
4	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENTS (SEE INSTRUCTIONS)		4
5	ORGAN ACQUISITION		5
6	COST OF TEACHING PHYSICIANS		6
7	SUBTOTAL (SEE INSTRUCTIONS)	1,330,347	7
8	PRIMARY PAYER PAYMENTS		8
9	SUBTOTAL (LINE 7 LESS LINE 8)	1,330,347	9
10	DEDUCTIBLES	6,869	10
11	SUBTOTAL (LINE 9 MINUS LINE 10)	1,323,478	11
12	COINSURANCE	56,933	12
13	SUBTOTAL (LINE 11 MINUS LINE 12)	1,266,545	13
14	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) (SEE INSTRUCTIONS)		14
15	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		15
16	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		16
17	SUBTOTAL (SUM OF LINES 13 AND 15)	1,266,545	17
18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 49) (FOR FREESTANDING LTCH ONLY)		18
19	OTHER PASS THROUGH COSTS (SEE INSTRUCTIONS)		19
20	OUTLIER PAYMENTS RECONCILIATION		20
21	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		21
22	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SEE INSTRUCTIONS)	1,266,545	22
23	INTERIM PAYMENTS	1,266,545	23
24	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		24
25	BALANCE DUE PROVIDER/PROGRAM (LINE 22 MINUS THE SUM OF LINES 23 AND 24)		25
26	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		26
TO BE COMPLETED BY CONTRACTOR			
50	ORIGINAL PPS PAYMENT AND OUTLIER AMOUNT FROM WORKSHEET E-3, PART IV, LINE 3 (SEE INSTRUCTIONS)		50
51	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		51
52	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (SEE INSTRUCTIONS)		52
53	TIME VALUE OF MONEY (SEE INSTRUCTIONS)		53

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
 PART VII

CHECK [] TITLE V [XX] HOSPITAL (15-2025) [] SNF [XX] PPS
 APPLICABLE [XX] TITLE XIX [] IPF [] NF [] TEFRA
 BOXES: [] IRF [] ICF/MR [] OTHER
 [] SUB (OTHER)

PART VII - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR TITLE XIX SERVICES

	INPATIENT	OUTPATIENT
	TITLE V OR	TITLE V OR
	TITLE XIX	TITLE XIX
COMPUTATION OF NET COST OF COVERED SERVICES		
1 INPATIENT HOSPITAL SNF/NF SERVICES		1
2 MEDICAL AND OTHER SERVICES		2
3 ORGAN ACQUISITION (CERTIFIED TRANSPLANT CENTERS ONLY)		3
4 SUBTOTAL (SUM OF LINES 1, 2 AND 3)		4
5 INPATIENT PRIMARY PAYER PAYMENTS		5
6 OUTPATIENT PRIMARY PAYER PAYMENTS		6
7 SUBTOTAL (LINE 4 LESS SUM OF LINES 5 AND 6)		7
COMPUTATION OF LESSER OF COST OR CHARGES		
REASONABLE CHARGES		
8 ROUTINE SERVICE CHARGES		8
9 ANCILLARY SERVICE CHARGES		9
10 ORGAN ACQUISITION CHARGES, NET OF REVENUE		10
11 INCENTIVE FROM TARGET AMOUNT COMPUTATION		11
12 TOTAL REASONABLE CHARGES (SUM OF LINES 8-11)		12
CUSTOMARY CHARGES		
13 AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		13
14 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)		14
15 RATIO OF LINE 13 TO LINE 14 (NOT TO EXCEED 1.000000)	1.000000	1.000000 15
16 TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		16
17 EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 16 EXCEEDS LINE 4 (SEE INSTRUCTIONS))		17
18 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 4 EXCEEDS LINE 16 (SEE INSTRUCTIONS))		18
19 INTERNS AND RESIDENTS (SEE INSTRUCTIONS)		19
20 COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)		20
21 COST OF COVERED SERVICES (LESSER OF LINE 4 OR LINE 16) (FOR CAH, SEE INSTRUCTIONS)		21
PROSPECTIVE PAYMENT AMOUNT		
22 OTHER THAN OUTLIER PAYMENTS		22
23 OUTLIER PAYMENTS		23
24 PROGRAM CAPITAL PAYMENTS		24
25 CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)		25
26 ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS		26
27 SUBTOTAL (SUM OF LINES 22 THROUGH 26)		27
28 CUSTOMARY CHARGES (TITLES V OR XIX PPS COVERED SERVICES ONLY)		28
29 SUM OF LINES 27 AND 21		29
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
30 EXCESS OF REASONABLE COST (FROM LINE 18)		30
31 SUBTOTAL (SUM OF LINES 19 AND 20 PLUS 29 MINUS LINES 5 AND 6)		31
32 DEDUCTIBLES		32
33 COINSURANCE		33
34 ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)		34
35 UTILIZATION REVIEW		35
36 SUBTOTAL (SUM OF LINES 31, 34 AND 35 MINUS THE SUM OF LINES 32 AND 33)		36
37 OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		37
38 SUBTOTAL (LINE 36 ± LINE 37)		38
39 DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4)		39
40 TOTAL AMOUNT PAYABLE TO THE PROVIDER (SUM OF LINES 38 AND 39)		40
41 INTERIM PAYMENTS		41
42 BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS 41)		42
43 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		43

BALANCE SHEET

WORKSHEET G

ASSETS		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	407,863			1
2	TEMPORARY INVESTMENTS				2
3	NOTES RECEIVABLE				3
4	ACCOUNTS RECEIVABLE	1,019,137			4
5	OTHER RECEIVABLES				5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE				6
7	INVENTORY				7
8	PREPAID EXPENSES	84,194			8
9	OTHER CURRENT ASSETS				9
10	DUE FROM OTHER FUNDS				10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	1,511,194			11
FIXED ASSETS					
12	LAND				12
13	LAND IMPROVEMENTS				13
14	ACCUMULATED DEPRECIATION				14
15	BUILDINGS				15
16	ACCUMULATED DEPRECIATION				16
17	LEASEHOLD IMPROVEMENTS				17
18	ACCUMULATED AMORTIZATION				18
19	FIXED EQUIPMENT				19
20	ACCUMULATED DEPRECIATION				20
21	AUTOMOBILES AND TRUCKS				21
22	ACCUMULATED DEPRECIATION				22
23	MAJOR MOVABLE EQUIPMENT	2,469,776			23
24	ACCUMULATED DEPRECIATION				24
25	MINOR EQUIPMENT DEPRECIABLE				25
26	ACCUMULATED DEPRECIATION				26
27	HIT DESIGNATED ASSETS				27
28	ACCUMULATED DEPRECIATION				28
29	MINOR EQUIPMENT-NONDEPRECIABLE				29
30	TOTAL FIXED ASSETS (SUM OF LINES 12-29)	2,469,776			30
OTHER ASSETS					
31	INVESTMENTS				31
32	DEPOSITS ON LEASES	22,600			32
33	DUE FROM OWNERS/OFFICERS				33
34	OTHER ASSETS	225,288			34
35	TOTAL OTHER ASSETS (SUM OF LINES 31-34)	247,888			35
36	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	4,228,858			36
LIABILITIES AND FUND BALANCES		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	1,496,822			37
38	SALARIES, WAGES & FEES PAYABLE	109,494			38
39	PAYROLL TAXES PAYABLE				39
40	NOTES & LOANS PAYABLE (SHORT TERM)				40
41	DEFERRED INCOME				41
42	ACCELERATED PAYMENTS				42
43	DUE TO OTHER FUNDS	891,200			43
44	OTHER CURRENT LIABILITIES				44
45	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	2,497,516			45
LONG-TERM LIABILITIES					
46	MORTGAGE PAYABLE				46
47	NOTES PAYABLE	2,060,454			47
48	UNSECURED LOANS				48
49	OTHER LONG TERM LIABILITIES				49
50	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	2,060,454			50
51	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	4,557,970			51
CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	-329,112			52
53	SPECIFIC PURPOSE FUND BALANCE				53
54	DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED				54
55	DONOR CREATED-ENDOWMENT FUND BAL-UNRESTRICTED				55
56	GOVERNING BODY CREATED - ENDOWMENT FUND BAL				56
57	PLANT FUND BALANCE - INVESTED IN PLANT				57
58	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				58
59	TOTAL FUND BALANCES (SUM OF LINES 52-58)	-329,112			59
60	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	4,228,858			60

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

	GENERAL FUND 1	2	SPECIFIC PURPOSE FUND 3	4	ENDOWMENT FUND 5	6	PLANT FUND 7	8	
1 FUND BALANCES AT BEGINNING OF PERIOD									1
2 NET INCOME (LOSS) (FROM WKST G-3, LINE 29)		-329,112							2
3 TOTAL (SUM OF LINE 1 AND LINE 2)		-329,112							3
4 ADDITIONS (CREDIT ADJUSTMENTS)									4
5									5
6									6
7									7
8									8
9									9
10 TOTAL ADDITIONS (SUM OF LINES 4-9)									10
11 SUBTOTAL (LINE 3 PLUS LINE 10)		-329,112							11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)									12
13 DISTRIBUTIONS									13
14 DISTRIBUTIONS									14
15									15
16									16
17									17
18 TOTAL DEDUCTIONS (SUM OF LINES 12-17)									18
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (LINE 11 MINUS LINE 18)		-329,112							19

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
 PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
1 GENERAL INPATIENT ROUTINE CARE SERVICES				1
2 HOSPITAL	1,272,431		1,272,431	2
3 SUBPROVIDER IPF				3
5 SUBPROVIDER IRF				5
6 SWING BED - SNF				6
7 SWING BED - NF				7
8 SKILLED NURSING FACILITY				8
9 NURSING FACILITY				9
10 OTHER LONG TERM CARE				10
TOTAL GENERAL INPATIENT CARE SERVICES (SUM OF LINES 1-9)	1,272,431		1,272,431	11
11 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				11
12 INTENSIVE CARE UNIT				12
13 CORONARY CARE UNIT				13
14 BURN INTENSIVE CARE UNIT				14
15 SURGICAL INTENSIVE CARE UNIT				15
16 OTHER SPECIAL CARE (SPECIFY)				16
TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)				17
17 TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	1,272,431		1,272,431	18
18 ANCILLARY SERVICES	2,311,476		2,311,476	19
19 OUTPATIENT SERVICES				20
20 RHC				21
21 FQHC				22
22 HOME HEALTH AGENCY				23
23 AMBULANCE				25
25 ASC				26
26 HOSPICE				27
27 OTHER (SPECIFY)				27.01
27.01 PART B PHYSICIAN REVENUE	82,735		82,735	28
28 TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	3,666,642		3,666,642	

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		2,134,566	29
30 ADD (SPECIFY)			30
31			31
32			32
33			33
34			34
35			35
36 TOTAL ADDITIONS (SUM OF LINES 30-35)			36
37 DEDUCT (SPECIFY)			37
38			38
39			39
40			40
41			41
42 TOTAL DEDUCTIONS (SUM OF LINES 37-41)			42
43 TOTAL OPERATING EXPENSES (SUM OF LINES 29 AND 36 MINUS LINE 42) (TRANSFER TO WKST G-3, LINE 4)		2,134,566	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	3,666,642	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	1,861,251	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	1,805,391	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	2,134,566	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	-329,175	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS		7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS		14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	63	18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE		22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (OTHER INCOME)		24
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	63	25
26	TOTAL (LINE 5 PLUS LINE 25)	-329,112	26
27			27
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)		28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	-329,112	29

Central Indiana - AMG Specialty Hospital
Worksheet A Expense Groupings
August 31, 2012

Account Number	Division	Account Description	Medicare Balance	Cost Center Subtotal	MC #	Cost Center Description
100710		Facility Expense - Fixed	0		1.02	Capital Related Costs - Buildings
100920		80295 · Rent	115,247		1.02	Capital Related Costs - Buildings
101010		80110 · Equipment Rentals-Nursing	60,680		1.02	Capital Related Costs - Buildings
101500		63400 · Interest Expense	75,542	251,469	1.02	Capital Related Costs - Buildings
100780		80105 · Employee Health and Screening	1,556		5.02	Employee Benefits - Other
100800		80145 · Insurance-Employee Health/Life	42,471		5.02	Employee Benefits - Other
101370		Payroll Tax Expense	68,334	112,361	5.02	Employee Benefits - Other
101200		Administrator	30,132		6.01	Administrative & General - Salary
101220		Admissions Coordinator	4,594		6.01	Administrative & General - Salary
101230		Case Manager	16,981		6.01	Administrative & General - Salary
101240		Clerical-Admin. Asst.	23,508		6.01	Administrative & General - Salary
101360		Ward Clerk/Receptionist	16,469		6.01	Administrative & General - Salary
101460		QA/Infection Control	20,455	112,139	6.01	Administrative & General - Salary
100720		80020 · Bank Fees	357		6.02	Administrative & General - Other
100730		80035 · Cable Services	851		6.02	Administrative & General - Other
100740		80050 · Computer Software Lease/Maint.	17,659		6.02	Administrative & General - Other
100750		80075 · Continuing Education	1,850		6.02	Administrative & General - Other
100760		80080 · Copier Lease/Maintenance	3,074		6.02	Administrative & General - Other
100770		80100 · Dues and Subscriptions	1,241		6.02	Administrative & General - Other
100810		80150 · Insurance-Prof. Liability	12,683		6.02	Administrative & General - Other
100820		80175 · Licenses and Permits	1,972		6.02	Administrative & General - Other
100830		80180 · Marketing and Advertising	9,497		6.02	Administrative & General - Other
100840		80190 · Medical Director/Asst Med Dir	59,900		6.02	Administrative & General - Other
100850		80205 · Miscellaneous Expense	1,684		6.02	Administrative & General - Other
100860		80210 · Office Expense / Printing	2,495		6.02	Administrative & General - Other
100870		80225 · Parking	270		6.02	Administrative & General - Other
100880		80235 · Payroll Processing Fees	2,189		6.02	Administrative & General - Other
100890		80260 · Postage & Freight	1,563		6.02	Administrative & General - Other
100900		80270 · Professional Fees - Legal	21,649		6.02	Administrative & General - Other
100910		80275 · Professional Fees - Other	6,144		6.02	Administrative & General - Other
100950		80400 · Travel	35,388		6.02	Administrative & General - Other
100960		80025 · Billing/Collections/AP	14,287		6.02	Administrative & General - Other
101180		80390 · Transcription Services	2,979		6.02	Administrative & General - Other
101190		80395 · Transportation	4,550		6.02	Administrative & General - Other
101210		Mgmt Contract-Administrator	40,875		6.02	Administrative & General - Other
101490		80178 · Management Oversight	17,859	261,016	6.02	Administrative & General - Other
100930		80300 · Repairs and Maintenance	2,700		8.02	Operation of Plant - Other
100940		80385 · Telephone Service	1,306	4,006	8.02	Operation of Plant - Other
101030		80170 · Laundry - Contract Services	11,435	11,435	9.02	Laundry & Linen - Other
100790		80130 · Housekeeping-Contract Services	23,082		10.02	Housekeeping - Other
101100		80320 · Supplies-Housekeeping/Janitoria	5,955	29,037	10.02	Housekeeping - Other
101250		Dietary Staff	3,529		11.01	Dietary - Salary
101260		Dietician	466		11.01	Dietary - Salary
101270		Dietary Supervisor	12,151	16,146	11.01	Dietary - Salary
100990		80090 · Dietary, Food	6,811		11.02	Dietary - Other
101000		80095 · Dietary, Purchased Services	17,350		11.02	Dietary - Other
101090		80315 · Supplies-Dietary/Kitchen	1,689	25,850	11.02	Dietary - Other
101280		HIM/Coding	21,086	21,086	17.01	Med Records & Library - Salary
101130		80345 · Supplies-Office/HIM	7,804		17.02	Med Records & Library - Other
101290		HIM/Coding - Contract Services	6,145	13,949	17.02	Med Records & Library - Other
101340		Social Services	0	0	18.01	Social Service - Salary
101300		Nurses - Nurse Liaison	26,818		25.01	Adults and Pediatrics - Salary
101310		Nurses - Chief Clinical Officer	17,218		25.01	Adults and Pediatrics - Salary
101330		Physician	74,796		25.01	Adults and Pediatrics - Salary
101380		Nurses - RN	169,165		25.01	Adults and Pediatrics - Salary
101390		Nurses - LPN	113,425		25.01	Adults and Pediatrics - Salary
101400		Nurses - Aides/CNAs	66,797		25.01	Adults and Pediatrics - Salary
101410		Nurses - Contract Services	45,411		25.01	Adults and Pediatrics - Salary
101420		Nurses - RN - Other Pay	5,926		25.01	Adults and Pediatrics - Salary
101430		Nurses - LPN - Other Pay	1,735		25.01	Adults and Pediatrics - Salary
101440		Nurses - Aides/CNAs - Other Pay	2,059		25.01	Adults and Pediatrics - Salary
101450		Nurses - Wound Care - Other Pay	0	523,350	25.01	Adults and Pediatrics - Salary

Central Indiana - AMG Specialty Hospital
 Worksheet A Expense Groupings
 August 31, 2012

Account Number	Division	Account Description	Medicare Balance	Cost Center Subtotal	MC #	Cost Center Description
101110	80335	Supplies-Nursing	57,701	57,701	25.02	Adults and Pediatrics - Other
101050	80215	Outpatient Procedures	76,498	76,498	37.02	Operating Room-Other
101080	80290	Radiology - Contract Services	56,520	56,520	41.02	Xray - Other
100970	80030	Blood Storage & Processing	3,911		44.02	Laboratory - Other
101020	80165	Laboratory Fees	48,478	52,389	44.02	Laboratory - Other
101350		Therapy - Respiratory Therapist	115,315	115,315	49.01	Oxygen (Inhal) Therapy - Salary
101160	80360	Supplies-Respiratory Therapy	13,116	13,116	49.02	Oxygen (Inhal) Therapy - Other
101150	80355	Supplies-Physical Therapy	1,017		50.02	Physical Therapy - Other
101461		Therapy - Contract PT	37,581	38,598	50.02	Physical Therapy - Other
101120	80340	Supplies-Occupational Therapy	75		51.02	Occupational Therapy - Other
101470		Therapy - Contract OT	34,145	34,220	51.02	Occupational Therapy - Other
101480		Therapy - Contract Speech	23,348	23,348	52.02	Speech Pathology - Other
101040	80195	Medical Gas	1,772		55.02	Medical Supplies Chargeable - Other
101170	80365	Supplies-Wound Care	24,698	26,470	55.02	Medical Supplies Chargeable - Other
101320		Pharmacist	4,690	4,690	56.01	Drugs Chargeable - Salary
101060	80250	Pharmacy	93,324		56.02	Drugs Chargeable - Other
101070	80255	Pharmacy - Contracted Services	144,734		56.02	Drugs Chargeable - Other
101140	80350	Supplies-Pharmacy	409	238,467	56.02	Drugs Chargeable - Other
100980	80085	Dialysis - Contract Services	15,390	15,390	57.02	Dialysis - Other
TOTAL			2,134,566	2,134,566		

Central Indiana - AMG Specialty Hospital
 Worksheet A-8 Adjustments to Expenses
August 31, 2012

Account Number	Division	Account Description	MC #	W/S A-8 Subtotal	A-8	Worksheet A-8 Description
101500	63400	Interest Expense	1.02	75,542	21	Interest Expense on Medicare Overpayments
100830	80180	Marketing and Advertising	6.02	9,497	31	Advertising/Marketing
100850	80205	Miscellaneous Expense	6.02	1,684	44	Other
100700		Income-Medical Records	318	(63)	18	Sale of Medical Records
TOTAL				86,660		

CNI Current Year Net (Income) Loss

Revenues
 Expenses
 Net (Income) Loss

ADJUSTMENT LEGEND

Central Indiana - AMG Specialty Hospital
August 31, 2012
Inpatient Part A
Summary of PS&R
Claims Paid through 1/18/2013

	6/1/12-8/31/12	Total
110 Room - Board/PVT	240,300	
111 MedSurg	113,490	113,490
120 R&B Semi	145,000	145,000
121 Med Surg 2 Bed	691,200	691,200
Total Accomadations	1,189,990	1,189,990

Discharges	42	42
Medicare Days	1,062	1,062

CR
Line #

56	230 Nursing Increm	894	894
56	250 Pharmacy	201,667	201,667
56	257 Pharmacy-Experiment	0	0
56	258 IV-Therapy	0	0
56	259 Pharmacy	0	0
	262 IV-Therapy	67,472	67,472
55	270 Med-Surg Supplies	59,946	59,946
55	271 Med-Surg Supplies	160,800	160,800
55	272 Med-Surg Supplies	15,456	15,456
55	274 Med-Surg Supplies	0	0
55	276 Med-Surg Supplies	0	0
55	278 Med-Surg Supplies	0	0
55	291 Med-Surg Supplies	44,894	44,894
44	300 Lab	143,549	143,549
44	301 Lab	98,175	98,175
44	302 Lab	0	0
44	305 Lab	25	25
44	306 Lab	10,985	10,985
44	307 Lab	933	933
44	309 Lab	1,225	1,225
44	310 Lab	0	0
44	311 Lab	0	0
41	320 DX Xray	13,549	13,549
41	324 DX Xray	2,093	2,093
41	340 Nuclear Medicine	0	0
41	341 Nuclear Medicine	0	0
	350 CT Scan	23,321	23,321
41	351 CT Scan	0	0
41	352 CT Scan	0	0
37	360 OR Services	6,315	6,315
37	361 OR Services	46,790	46,790
37	370 Anesthesia	0	0
44	380 Blood	0	0
44	381 Blood	7,812	7,812
44	383 Blood	0	0
44	384 Blood	0	0
44	391 Blood	12,291	12,291
	400 Image Service	0	0
41	401 Imaging Service	0	0
41	402 Imaging Service	3,369	3,369
41	403 Imaging Service	0	0
49	410 Respiratory Svc	919,526	919,526
49	412 Inhalation Therapy	0	0
	413 Hyperbaric O2	0	0
50	420 Physical Therapy	62,594	62,594
50	423 Physical Therapy	0	0
50	424 Physical Therapy	122	122
51	430 Occupational Therapy	61,833	61,833
51	433 Occupational Therapy	0	0
51	434 Occupational Therapy	304	304
52	440 Speech Therapy	94,705	94,705
52	444 Speech Therapy	0	0
	444 Speech Therapy	0	0
49	460 Pulmonary	0	0
49	480 Cardiology	1,454	1,454
49	482 Cardiology	0	0
37	490 Amb-Surg-Care	0	0
99	510 Clinic	0	0
99	542 Ambulance	0	0
41	610 MRI	1,223	1,223
41	612 MRI	0	0
56	636 Drugs Detail	1,300	1,300
37	710 Recovery Room	0	0
	732 Telemetry	37,869	37,869
41	730 EKG	12,364	12,364
41	731 Holter Mont	0	0
41	740 EEG	1,359	1,359
37	750 Gastr Intest	0	0
37	760 Observation Room	0	0
37	761 Observation Room	3,728	3,728
57	801 Inpatient Dialysis	46,927	46,927
41	915 Psych Services	0	0
41	920 Other DX Service	0	0
44	921 Perivascular Lab	0	0
41	922 EMG	0	0
49	947 Complex Medical Equip	216	216
	Total Ancillary	2,167,085	2,167,085
	Total Charges	3,357,075	3,357,075
	Federal Specific	1,278,534	1,278,534
	Cost Outlier	51,813	51,813
	LIP Payment	0	0
	Gross Reimbursement	1,330,347	1,330,347
	Deductible	6,869	6,869
	Coinsurance	56,933	56,933
	Net Reimbursement	1,266,545	1,266,545

Worksheet D-4 by Line #

37	OR/Surgery/Anesth	58,192	58,192
41	Xray	93,788	93,788
44	Lab	274,995	274,995
49	Respiratory Therapy	920,980	920,980
50	PT	62,716	62,716
51	OT	62,137	62,137
52	ST	94,705	94,705
55	Medical Supplies	281,312	281,312
56	Drugs	270,439	270,439
57	Dialysis	46,927	46,927
58	Psych	0	0
		2,166,191	2,166,191

PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM

REPORT COVER PAGE FOR REQUEST: TEUC366-S-1680105

Provider#-Report Type	Total # of Pages	Provider#-Report Type	Total # of Pages	Provider#-Report Type	Total # of Pages
152025-118	4	152025-11S	5		

P R O V I D E R S T A T I S T I C A L A N D R E I M B U R S E M E N T S Y S T E M

Program ID: REDESIGN
 Paid Dates: 09/01/11 THRU 01/18/13
 Report Run Date: 01/21/13
 Provider FYE: 08/31

PROVIDER SUMMARY REPORT
 INPATIENT - PART A MANAGED CARE

Provider Number: 152025 RENAISSANCE SPECIALITY HOSP OF CENTRAL INDIAN

Page: 1
 Report #: OD44203
 Report Type: 118

SERVICES FOR PERIOD	SERVICES FOR PERIOD	SERVICES FOR PERIOD
09/01/11 - 05/31/12	06/01/12 - 08/31/12	No Data Requested
0	4	
0	65	
0	4	

STATISTIC SECTION

DISCHARGES	0	4
MEDICARE DAYS	0	65
CLAIMS	0	4

CHARGE SECTION

*** ACCOMMODATION CHARGES ***

REV CODE	DESCRIPTION	UNITS	CHARGES	UNITS	CHARGES	UNITS	CHARGES
0111	MED-SUR-GY/PVT	0	\$0.00	8	\$9,360.00		
0121	MED-SUR-GY/2BED	0	\$0.00	57	\$61,560.00		
TOTAL ACCOMMODATIONS		0	\$0.00	65	\$70,920.00		

*** ANCILLARY CHARGES ***

REV CODE	DESCRIPTION	UNITS	CHARGES	UNITS	CHARGES	UNITS	CHARGES
0230	NURSING INCREM	0	\$0.00	2	\$65.00		
0250	PHARMACY	0	\$0.00	1,124	\$15,600.00		
0270	MED-SUR SUPPLIES	0	\$0.00	83	\$1,683.36		
0271	NONSTER SUPPLY	0	\$0.00	115	\$13,800.00		
0300	LABORATORY or (LAB)	0	\$0.00	428	\$14,523.84		
0301	LAB/CHEMISTRY	0	\$0.00	117	\$8,113.26		
0306	LAB/BACT-MICRO	0	\$0.00	12	\$595.54		
0307	LAB/UROLOGY	0	\$0.00	1	\$37.38		
0309	LAB/OTHER	0	\$0.00	1	\$198.45		
0320	DX X-RAY	0	\$0.00	3	\$476.55		
0324	DX X-RAY/CHEST	0	\$0.00	2	\$183.60		
0350	CT SCAN	0	\$0.00	1	\$864.00		

P R O V I D E R S T A T I S T I C A L A N D R E I M B U R S E M E N T S Y S T E M

Page: 3
Report #: OD44203
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P R O V I D E R S U M M A R Y R E P O R T
I N P A T I E N T - P A R T A M A N A G E D C A R E

Program ID: REDESIGN
Paid Dates: 09/01/11 THRU 01/18/13
Report Run Date: 01/21/13
Provider FYE: 08/31
Provider Number: 152025 RENAISSANCE SPECIALTY HOSP OF CENTRAL INDIAN

	SERVICES FOR PERIOD 09/01/11 - 05/31/12	SERVICES FOR PERIOD 06/01/12 - 08/31/12	SERVICES FOR PERIOD No Data Requested
HOSPITAL SPECIFIC	\$0.00	\$0.00	No Data Requested
FEDERAL SPECIFIC	\$0.00	\$0.00	
OUTLIER	\$0.00	\$0.00	
HOLD HARMLESS	\$0.00	\$0.00	
DSH	\$0.00	\$0.00	
INDIRECT MEDICAL EDUCATION	\$0.00	\$0.00	
EXCEPTIONS	\$0.00	\$0.00	
TOTAL CAPITAL PAYMENTS	\$0.00	\$0.00	

PAYMENT			
GROSS REIMBURSEMENT	\$0.00	\$69,801.15	
LESS			
DEVICE CREDIT	\$0.00	\$0.00	
CASH DEDUCTIBLE	\$0.00	\$0.00	
BLOOD DEDUCTIBLE	\$0.00	\$0.00	
COINSURANCE	\$0.00	\$0.00	
NET MSP PAYMENTS	\$0.00	\$0.00	
MSP PASS THRU RECONCILIATION	\$0.00	\$0.00	
OTHER ADJUSTMENTS	\$0.00	\$69,801.15	
NET REIMBURSEMENT	\$0.00	\$0.00	

ADDITIONAL INFORMATION SECTION

CALCULATED NET REIMB FOR PIP	\$0.00
ACTUAL CLAIM PAYMENTS FOR PIP	\$0.00
CLAIM INTEREST PAYMENTS	\$0.00

P R O V I D E R S T A T I S T I C A L A N D R E I M B U R S E M E N T S Y S T E M

Program ID: REDESIGN
 Paid Dates: 09/01/11 THRU 01/18/13
 Report Run Date: 01/21/13
 Provider FYE: 08/31

PROVIDER SUMMARY REPORT
 INPATIENT - PART A MANAGED CARE

Provider Number: 152025 RENAISSANCE SPECIALTY HOSP OF CENTRAL INDIAN

SERVICES FOR PERIOD 09/01/11 - 05/31/12 SERVICES FOR PERIOD 06/01/12 - 08/31/12 SERVICES FOR PERIOD No Data Requested

	SERVICES FOR PERIOD 09/01/11 - 05/31/12	SERVICES FOR PERIOD 06/01/12 - 08/31/12	SERVICES FOR PERIOD No Data Requested
IRF PENALTY AMOUNT	\$0.00	\$0.00	
LTC SHORT STAY OUTLIER PAYMENTS	\$0.00	\$38,838.79	
CAP FED-SPECIFIC @ 100%	\$0.00	\$0.00	
CAP OUTLIER @ 100%	\$0.00	\$0.00	
DISCHARGES	0	4	
DRG/CMG WEIGHT	0.0000	3.9437	
WEIGHT/DISCHARGES		0.9859	
DISCHARGE FRACTION	0	0	
DRG WEIGHT FRACTION	0.0000	0.0000	
DRG WEIGHT FRACTION/DISCHARGES		0	
PPS PAYMENTS	\$0.00	\$0.00	

P R O V I D E R S T A T I S T I C A L A N D R E I M B U R S E M E N T S Y S T E M

Page: 1
Report #: OD44203
Report Type: 115

PROVIDER SUMMARY REPORT
INPATIENT LONG TERM CARE - PART A.PPS

Program ID: REDESIGN
Paid Dates: 09/01/11 THRU 01/18/13
Report Run Date: 01/21/13
Provider FYE: 08/31
Provider Number: 152025 RENAISSANCE SPECIALTY HOSP OF CENTRAL INDIAN

SERVICES FOR PERIOD 09/01/11 - 05/31/12	SERVICES FOR PERIOD 06/01/12 - 08/31/12	SERVICES FOR PERIOD No Data Requested
131	42	No Data Requested
3,428	1,062	No Data Requested
131	42	No Data Requested

STATISTIC SECTION

DISCHARGES	131	42	
MEDICARE DAYS	3,428	1,062	
CLAIMS	131	42	

CHARGE SECTION

*** ACCOMMODATION CHARGES ***

REV CODE	DESCRIPTION	UNITS	CHARGES	UNITS	CHARGES	UNITS	CHARGES
0110	ROOM-BOARD/PVT	1,372	\$1,831,620.00	180	\$240,300.00		
0111	MED-SUR-GY/PVT	0	\$0.00	97	\$113,490.00		
0120	ROOM-BOARD/SEMI	2,056	\$2,056,000.00	145	\$145,000.00		
0121	MED-SUR-GY/2BED	0	\$0.00	640	\$691,200.00		
0180	LEAVE OF ABSENCE OR LOA	0	\$0.00	0	\$0.00		
TOTAL ACCOMMODATIONS		3,428	\$3,887,620.00	1,062	\$1,189,990.00		

*** ANCILLARY CHARGES ***

REV CODE	DESCRIPTION	UNITS	CHARGES	UNITS	CHARGES	UNITS	CHARGES
0230	NURSING INCREM	0	\$0.00	44	\$894.50		
0250	PHARMACY	114,422	\$1,243,187.05	22,256	\$201,666.62		
0257	DRUGS/NONPSRPT	1	\$153.44	2	\$0.32		
0262	IV THER/PHARM/SVC	26,875	\$966,742.74	2,271	\$67,471.88		
0270	MED-SUR SUPPLIES	61,927	\$339,761.85	5,921	\$59,945.51		
0271	NONSTER SUPPLY	0	\$0.00	1,340	\$160,800.00		
0272	STERILE SUPPLY	37,236	\$148,530.10	2,775	\$15,456.20		
0279	SUPPLY/OTHER	23	\$1,693.10	0	\$0.00		
0290	MED EQUIP/DURAB	595	\$27,275.80	0	\$0.00		
0291	MED EQUIP/RENT	18,081	\$735,362.61	1,055	\$44,894.22		

P R O V I D E R S T A T I S T I C A L A N D R E I M B U R S E M E N T S Y S T E M

Program ID: REDESIGN
 Paid Dates: 09/01/11 THRU 01/18/13
 Report Run Date: 01/21/13

PROVIDER SUMMARY REPORT
 INPATIENT LONG TERM CARE - PART A PPS

Page: 2
 Report #: OD44203
 Report Type: 115

Provider FYE: 08/31
 Provider Number: 152025 RENAISSANCE SPECIALITY HOSP OF CENTRAL INDIAN

REV CODE	DESCRIPTION	SERVICES FOR PERIOD 09/01/11 - 05/31/12		SERVICES FOR PERIOD 06/01/12 - 08/31/12		SERVICES FOR PERIOD No Data Requested		SERVICES FOR PERIOD No Data Requested	
		UNITS	CHARGES	UNITS	CHARGES	UNITS	CHARGES	UNITS	CHARGES
0300	LABORATORY or (LAB)	16,521	\$304,554.38	5,025	\$143,549.39				
0301	LAB/CHEMISTRY	0	\$0.00	1,226	\$98,174.78				
0305	LAB/HEMATOLOGY	1	\$615.00	5	\$25.10				
0306	LAB/BACT-MICRO	0	\$0.00	185	\$10,985.13				
0307	LAB/UROLOGY	0	\$0.00	30	\$932.76				
0309	LAB/OTHER	0	\$0.00	7	\$1,225.11				
0320	DX X-RAY	391	\$131,267.91	117	\$13,549.32				
0324	DX X-RAY/CHEST	0	\$0.00	23	\$2,092.50				
0340	NUCLEAR MEDICINE or (NUC	5	\$7,857.93	0	\$0.00				
0341	NUC MED/DX	1	\$888.99	0	\$0.00				
0350	CT SCAN	54	\$53,932.95	29	\$23,321.40				
0351	CT SCAN/HEAD	12	\$10,859.43	0	\$0.00				
0352	CT SCAN/BODY	21	\$11,589.51	0	\$0.00				
0360	OR SERVICES	48	\$101,893.40	3	\$6,315.00				
0361	OR/MINOR	41	\$77,033.61	112	\$46,790.44				
0381	BLOOD/PKD RED	0	\$0.00	12	\$7,812.00				
0391	BLOOD/ADMIN	0	\$0.00	56	\$12,291.11				
0402	ULTRASOUND	13	\$4,514.70	4	\$3,368.80				
0410	RESPIRATORY SVC	32,070	\$949,818.59	27,827	\$919,526.20				
0420	PHYSICAL THERP	7,246	\$384,516.00	1,034	\$62,594.00				
0424	PHYS THERP/EVAL	0	\$0.00	2	\$121.50				
0430	OCCUPATION THER	6,751	\$357,934.50	957	\$61,833.00				
0434	OCCUP THERP/EVAL	0	\$0.00	5	\$303.75				
0440	SPEECH PATHOL	4,530	\$252,992.52	635	\$94,704.90				

P R O V I D E R S T A T I S T I C A L A N D R E I M B U R S E M E N T S Y S T E M

Program ID: REDESIGN
 Paid Dates: 09/01/11 THRU 01/18/13
 Report Run Date: 01/21/13
 Provider FYE: 08/31
 Provider Number: 152025 RENAISSANCE SPECIALTY HOSP OF CENTRAL INDIAN

PROVIDER SUMMARY REPORT
 INPATIENT LONG TERM CARE - PART A PPS

Page: 3
 Report #: OD44203
 Report Type: 11S

REV CODE	DESCRIPTION	SERVICES FOR PERIOD 09/01/11 - 05/31/12		SERVICES FOR PERIOD 06/01/12 - 08/31/12		SERVICES FOR PERIOD No Data Requested	
		UNITS	CHARGES	UNITS	CHARGES	UNITS	CHARGES
0444	SPEECH PATH/EVAL	6	\$2,221.17	0	\$0.00		
0450	EMERG ROOM	1	\$1,180.80	0	\$0.00		
0480	CARDIOLOGY	1	\$796.20	3	\$1,453.95		
0610	MRT	7	\$12,049.02	1	\$1,223.10		
0611	MRI - BRAIN	0	\$0.00	1	\$1,300.05		
0621	MED-SUR SUPP/INCIDENT RAD	1	\$218.16	0	\$0.00		
0730	EKG/EKG	323	\$41,932.44	114	\$12,364.40		
0732	TELEMETRY	812	\$180,577.50	107	\$37,869.20		
0740	EEG	10	\$6,089.76	4	\$1,358.61		
0761	TREATMENT RM	0	\$0.00	58	\$3,727.50		
0801	DIALY/INPT	138	\$160,560.69	41	\$46,927.08		
0918	BH/TESTING	54	\$40,500.00	0	\$0.00		
0920	OTHER DX SVS	1	\$383.97	0	\$0.00		
0921	PERI VASCUL LAB	5	\$2,144.70	0	\$0.00		
0947	COMPLX MED EQUIP-ANC	0	\$0.00	2	\$216.00		
TOTAL ANCILLARY		328,224	\$6,561,630.52	73,289	\$2,167,085.33		
TOTAL COVERED CHARGES			\$10,449,250.52		\$3,357,075.33		

REIMBURSEMENT SECTION		OPERATING	HOSPITAL SPECIFIC	FEDERAL SPECIFIC	OUTLIER	DSH/LIP
			\$0.00	\$1,278,533.91	\$51,812.60	\$0.00
			\$0.00	\$4,348,628.83	\$448,243.24	\$0.00
			\$0.00	\$4,348,628.83	\$448,243.24	\$0.00
			\$0.00	\$4,348,628.83	\$448,243.24	\$0.00

P R O V I D E R S T A T I S T I C A L A N D R E I M B U R S E M E N T S Y S T E M

Program ID: REDESIGN

Paid Dates: 09/01/11 THRU 01/18/13

Report Run Date: 01/21/13

Provider FYE: 08/31

Provider Number: 152025 RENAISSANCE SPECIALITY HOSP OF CENTRAL INDIAN

PROVIDER SUMMARY REPORT

INPATIENT LONG TERM CARE - PART A PPS

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Report #: OD44203

Report Type: 115

	SERVICES FOR PERIOD 09/01/11 - 05/31/12	SERVICES FOR PERIOD 06/01/12 - 08/31/12	SERVICES FOR PERIOD No Data Requested	SERVICES FOR PERIOD No Data Requested
IME/TEACHING ADJ.	\$0.00	\$0.00		
NEW TECHNOLOGY	\$0.00	\$0.00		
IPF ECT	\$0.00	\$0.00		
TOTAL OPERATING PAYMENTS	\$4,796,872.07	\$1,330,346.51		

LOW VOLUME	\$0.00	\$0.00		
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CAPITAL				
HOSPITAL SPECIFIC	\$0.00	\$0.00		
FEDERAL SPECIFIC	\$0.00	\$0.00		
OUTLIER	\$0.00	\$0.00		
HOLD HARMLESS	\$0.00	\$0.00		
DSH	\$0.00	\$0.00		
INDIRECT MEDICAL EDUCATION	\$0.00	\$0.00		
EXCEPTIONS	\$0.00	\$0.00		
TOTAL CAPITAL PAYMENTS	\$0.00	\$0.00		

PAYMENT			
GROSS REIMBURSEMENT	\$4,796,872.07	\$1,330,346.51	

LESS			
DEVICE CREDIT	\$0.00	\$0.00	
CASH DEDUCTIBLE	\$9,104.00	\$2,312.00	
BLOOD DEDUCTIBLE	\$0.00	\$4,557.00	
COINSURANCE	\$205,864.00	\$56,933.00	
NET MSP PAYMENTS	\$0.00	\$0.00	
MSP PASS THRU RECONCILIATION	\$0.00	\$0.00	

P R O V I D E R S T A T I S T I C A L A N D R E I M B U R S E M E N T S Y S T E M

Program ID: REDESIGN
 Paid Dates: 09/01/11 THRU 01/18/13
 Report Run Date: 01/21/13
 Provider FYE: 08/31
 Provider Number: 152025 RENAISSANCE SPECIALITY HOSP OF CENTRAL INDIAN

PROVIDER SUMMARY REPORT
 INPATIENT LONG TERM CARE - PART A PPS

Page: 5
 Report #: OD44203
 Report Type: 115

	SERVICES FOR PERIOD 09/01/11 - 05/31/12	SERVICES FOR PERIOD 06/01/12 - 08/31/12	SERVICES FOR PERIOD No Data Requested
OTHER ADJUSTMENTS	\$0.00	\$0.00	\$0.00
NET REIMBURSEMENT	\$4,581,904.07	\$1,266,544.51	

ADDITIONAL INFORMATION SECTION

CALCULATED NET REIMB FOR PIP	\$0.00	\$0.00	
ACTUAL CLAIM PAYMENTS FOR PIP	\$0.00	\$0.00	
CLAIM INTEREST PAYMENTS	\$0.00	\$0.00	
IRF PENALTY AMOUNT	\$0.00	\$0.00	
LTC SHORT STAY OUTLIER PAYMENTS	\$534,312.60	\$264,650.48	
CAP FED-SPECIFIC @ 100%	\$0.00	\$0.00	
CAP OUTLIER @ 100%	\$0.00	\$0.00	
DISCHARGES	131	42	
DRG/CMG WEIGHT	152.3942	52.0346	
WEIGHT/DISCHARGES	1.1633	1.2389	
DISCHARGE FRACTION	0	0	
DRG WEIGHT FRACTION	0.0000	0.0000	
DRG WEIGHT FRACTION/DISCHARGES	0.0000	0.0000	
PPS PAYMENTS	\$0.00	\$0.00	

Central Indiana - AMG Specialty Hospital
Worksheet G Balance Sheet Groupings
August 31, 2012

Account Number	Division	Account Description	Medicare Balance	Cost Center Subtotal	MC #	Cost Center Description
100010		Business 1st-Operating	(683)		101	Cash on Hand and in Banks
100020		Business 1st-Payroll	496		101	Cash on Hand and in Banks
100030		Regions Bank - Oper.	408,050	407,863	101	Cash on Hand and in Banks
100040		Due from Dr. Reddy	1,800		104	Accounts Receivable
100050		Accounts Receivable-Billings	987,924		104	Accounts Receivable
100060		Allowance for Contractuals	(25,210)		104	Accounts Receivable
100070		Accounts Receivable-Part B	104,264		104	Accounts Receivable
100080		Allow for Contractuals-Part B	(49,641)	1,019,137	104	Accounts Receivable
100090		Prepaid Pharmacy	71,523		108	Prepaid Expenses
100100		Prepaid Insurance	12,671	84,194	108	Prepaid Expenses
100110		Computer Equipment/Software	23,847		123	Major Moveable Equipment
100120		15000 · Hospital Equipment	76,654		123	Major Moveable Equipment
100130		Investment in Central Indiana	2,369,275	2,469,776	123	Major Moveable Equipment
100150		Start-up Costs	225,288	225,288	126	Other Fixed Assets
100140		Security Deposits	22,600	22,600	129	Deposits on Leases
100160		2000 · Accounts Payable	(1,450,169)		134	Accounts Payable
100210		Due to Medicare	(46,653)	(1,496,822)	134	Accounts Payable
100220		Accrued Payroll	(109,494)	(109,494)	135	Salaries, Wages & Fees Payable
100180		Due to AMG	(200)		141	Intercompany Accounts
100190		Due to KCI-Wound Vac Purchase	(20,000)		141	Intercompany Accounts
100200		Due to LTAC of Greenwood	(116,000)		141	Intercompany Accounts
100250		Due to LTAC of LA - Loan	(755,000)	(891,200)	141	Intercompany Accounts
100170		Note Payable, Med One Capital	(4,735)		144	Notes Payable
100230		Note Payable, Imperial Credit	(3,821)		144	Notes Payable
100240		Note Payable, Star Equipment	(29,516)		144	Notes Payable
100260		Note Payable, NGS (ERP 2007)	(2,022,382)	(2,060,454)	144	Notes Payable
TOTAL			(329,112)	(329,112)		

Central Indiana - AMG Specialty Hospital
Worksheet G Revenue Groupings
August 31, 2012

Account Number	Division	Account Description	Medicare Balance	Cost Center Subtotal	MC #	Cost Center Description
100270		Room and Board-Medicare	(1,189,990)		201	Adults and Pediatrics
100280		Room and Board-Private	(76,050)		201	Adults and Pediatrics
100290		Room and Board-Mcare Adv	(5,400)		201	Adults and Pediatrics
100430		Nursing Care Spec-Medicare	(894)		201	Adults and Pediatrics
100440		Nursing Care Spec-Private	(97)	(1,272,431)	201	Adults and Pediatrics
100680		Physician Billings	(82,735)	(82,735)	205.5	Part B Physician Revenue
100410		Minor Procedures-Medicare	(56,833)		206.37	Operating / Surgery
100420		Minor Procedures-Private	(2,025)	(58,858)	206.37	Operating / Surgery
100540		Radiology Rev-Mcare Adv	(1,029)		206.41	X-Ray
100550		Radiology Rev-Medicare	(97,901)		206.41	X-Ray
100560		Radiology Rev-Private	(1,163)	(100,093)	206.41	X-Ray
100300		Blood Prod/Admin-Medicare	(20,103)		206.44	Laboratory
100310		Blood Products/Admin-Mcare Adv	(68)		206.44	Laboratory
100320		Blood Products/Admin-Private	(387)		206.44	Laboratory
100350		Laboratory Rev-Mcare Adv	(1,625)		206.44	Laboratory
100360		Laboratory Rev-Medicare	(254,892)		206.44	Laboratory
100370		Laboratory Rev-Private	(23,328)	(300,403)	206.44	Laboratory
100570		Respiratory Therapy-Mcare Adv	(7,788)		206.49	Oxygen (Inhal) Therapy
100580		Respiratory Therapy-Medicare	(919,526)		206.49	Oxygen (Inhal) Therapy
100590		Respiratory Therapy-Private	(52,867)	(980,181)	206.49	Oxygen (Inhal) Therapy
100510		Physical Therapy-Mcare Adv	(380)		206.5	Physical Therapy
100520		Physical Therapy-Medicare	(62,716)		206.5	Physical Therapy
100530		Physical Therapy-Private	(6,646)	(69,742)	206.5	Physical Therapy
100450		Occupational Therapy-Mcare Adv	(138)		206.51	Occupational Therapy
100460		Occupational Therapy-Medicare	(62,137)		206.51	Occupational Therapy
100470		Occupational Therapy-Private	(6,277)	(68,552)	206.51	Occupational Therapy
100600		Speech Therapy-Mcare Adv	(270)		206.52	Speech Pathology
100610		Speech Therapy-Medicare	(94,705)		206.52	Speech Pathology
100620		Speech Therapy-Private	(6,701)	(101,676)	206.52	Speech Pathology
100330		Complex Med Equip-Medicare	(215)		206.55	Medical Supplies Chargeable
100380		Medical Supplies-Mcare Adv	(972)		206.55	Medical Supplies Chargeable
100390		Medical Supplies-Medicare	(281,312)		206.55	Medical Supplies Chargeable
100400		Medical Supplies-Private	(16,726)	(299,225)	206.55	Medical Supplies Chargeable
100480		Pharmacy Rev-Mcare Adv	(1,200)		206.56	Drugs Chargeable
100490		Pharmacy Rev-Medicare	(269,139)		206.56	Drugs Chargeable
100500		Pharmacy Rev-Private	(15,480)	(285,819)	206.56	Drugs Chargeable
100340		Dialysis Rev-Medicare	(46,927)	(46,927)	206.57	Dialysis
100630		Cont Adj - Medicare	1,765,292		302	Less: Allowances and Discounts
100640		Cont Adj - Private	34,418		302	Less: Allowances and Discounts
100650		Cont Adj - Mcare Adv	11,900		302	Less: Allowances and Discounts
100660		Cont Adj Bad Debt	25,210		302	Less: Allowances and Discounts
100670		Cost Report Settlement	(25,210)		302	Less: Allowances and Discounts
100690		Cont Adj - Physician Billings	49,641	1,861,251	302	Less: Allowances and Discounts
100700		Income-Medical Records	(63)	(63)	318	Sale of Medical Records and Abstracts
TOTAL			(1,805,454)	(1,805,454)		

Central Indiana - AMG Specialty Hospital

Working Trial Balance

August 31, 2012

Account Number	Division	Account Description	Debit	Credit
100010		Business 1st-Operating		683
100020		Business 1st-Payroll	496	
100030		Regions Bank - Oper.	408,050	
100040		Due from Dr. Reddy	1,800	
100050		Accounts Receivable-Billings	987,924	
100060		Allowance for Contractuals		25,210
100070		Accounts Receivable-Part B	104,264	
100080		Allow for Contractuals-Part B		49,641
100090		Prepaid Pharmacy	71,523	
100100		Prepaid Insurance	12,671	
100110		Computer Equipment/Software	23,847	
100120		15000 · Hospital Equipment	76,654	
100130		Investment in Central Indiana	2,369,275	
100140		Security Deposits	22,600	
100150		Start-up Costs	225,288	
100160		2000 · Accounts Payable		1,450,169
100170		Note Payable, Med One Capital		4,735
100180		Due to AMG		200
100190		Due to KCI-Wound Vac Purchase		20,000
100200		Due to LTAC of Greenwood		116,000
100210		Due to Medicare		46,653
100220		Accrued Payroll		109,494
100230		Note Payable, Imperial Credit		3,821
100240		Note Payable, Star Equipment		29,516
100250		Due to LTAC of LA - Loan		755,000
100260		Note Payable, NGS (ERP 2007)		2,022,382
100270		Room and Board-Medicare		1,189,990
100280		Room and Board-Private		76,050
100290		Room and Board-Mcare Adv		5,400
100300		Blood Prod/Admin-Medicare		20,103
100310		Blood Products/Admin-Mcare Adv		68
100320		Blood Products/Admin-Private		387
100330		Complex Med Equip-Medicare		215
100340		Dialysis Rev-Medicare		46,927
100350		Laboratory Rev-Mcare Adv		1,625
100360		Laboratory Rev-Medicare		254,892
100370		Laboratory Rev-Private		23,328
100380		Medical Supplies-Mcare Adv		972
100390		Medical Supplies-Medicare		281,312
100400		Medical Supplies-Private		16,726
100410		Minor Procedures-Medicare		56,833
100420		Minor Procedures-Private		2,025

Central Indiana - AMG Specialty Hospital

Working Trial Balance

August 31, 2012

Account Number	Division	Account Description	Debit	Credit
100430		Nursing Care Spec-Medicare		894
100440		Nursing Care Spec-Private		97
100450		Occupational Therapy-Mcare Adv		138
100460		Occupational Therapy-Medicare		62,137
100470		Occupational Therapy-Private		6,277
100480		Pharmacy Rev-Mcare Adv		1,200
100490		Pharmacy Rev-Medicare		269,139
100500		Pharmacy Rev-Private		15,480
100510		Physical Therapy-Mcare Adv		380
100520		Physical Therapy-Medicare		62,716
100530		Physical Therapy-Private		6,646
100540		Radiology Rev-Mcare Adv		1,029
100550		Radiology Rev-Medicare		97,901
100560		Radiology Rev-Private		1,163
100570		Respiratory Therapy-Mcare Adv		7,788
100580		Respiratory Therapy-Medicare		919,526
100590		Respiratory Therapy-Private		52,867
100600		Speech Therapy-Mcare Adv		270
100610		Speech Therapy-Medicare		94,705
100620		Speech Therapy-Private		6,701
100630		Cont Adj - Medicare	1,765,292	
100640		Cont Adj - Private	34,418	
100650		Cont Adj - Mcare Adv	11,900	
100660		Cont Adj Bad Debt	25,210	
100670		Cost Report Settlement		25,210
100680		Physician Billings		82,735
100690		Cont Adj - Physician Billings	49,641	
100700		Income-Medical Records		63
100710		Facility Expense - Fixed		
100720		80020 · Bank Fees	357	
100730		80035 · Cable Services	851	
100740		80050 · Computer Software Lease/Maint.	17,659	
100750		80075 · Continuing Education	1,850	
100760		80080 · Copier Lease/Maintenance	3,074	
100770		80100 · Dues and Subscriptions	1,241	
100780		80105 · Employee Health and Screening	1,556	
100790		80130 · Housekeeping-Contract Services	23,082	
100800		80145 · Insurance-Employee Health/Life	42,471	
100810		80150 · Insurance-Prof. Liability	12,683	
100820		80175 · Licenses and Permits	1,972	
100830		80180 · Marketing and Advertising	9,497	
100840		80190 · Medical Director/Asst Med Dir	59,900	

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Working Trial Balance

August 31, 2012

Account Number	Divi sio n	Account Description	Debit	Credit
100850	80205	Miscellaneous Expense	1,684	
100860	80210	Office Expense / Printing	2,495	
100870	80225	Parking	270	
100880	80235	Payroll Processing Fees	2,189	
100890	80260	Postage & Freight	1,563	
100900	80270	Professional Fees - Legal	21,649	
100910	80275	Professional Fees - Other	6,144	
100920	80295	Rent	115,247	
100930	80300	Repairs and Maintenance	2,700	
100940	80385	Telephone Service	1,306	
100950	80400	Travel	35,388	
100960	80025	Billing/Collections/AP	14,287	
100970	80030	Blood Storage & Processing	3,911	
100980	80085	Dialysis - Contract Services	15,390	
100990	80090	Dietary, Food	6,811	
101000	80095	Dietary, Purchased Services	17,350	
101010	80110	Equipment Rentals-Nursing	60,680	
101020	80165	Laboratory Fees	48,478	
101030	80170	Laundry - Contract Services	11,435	
101040	80195	Medical Gas	1,772	
101050	80215	Outpatient Procedures	76,498	
101060	80250	Pharmacy	93,324	
101070	80255	Pharmacy - Contracted Services	144,734	
101080	80290	Radiology - Contract Services	56,520	
101090	80315	Supplies-Dietary/Kitchen	1,689	
101100	80320	Supplies-Housekeeping/Janitoria	5,955	
101110	80335	Supplies-Nursing	57,701	
101120	80340	Supplies-Occupational Therapy	75	
101130	80345	Supplies-Office/HIM	7,804	
101140	80350	Supplies-Pharmacy	409	
101150	80355	Supplies-Physical Therapy	1,017	
101160	80360	Supplies-Respiratory Therapy	13,116	
101170	80365	Supplies-Wound Care	24,698	
101180	80390	Transcription Services	2,979	
101190	80395	Transportation	4,550	
101200		Administrator	30,132	
101210		Mgmt Contract-Administrator	40,875	
101220		Admissions Coordinator	4,594	
101230		Case Manager	16,981	
101240		Clerical-Admin. Asst.	23,508	
101250		Dietary Staff	3,529	
101260		Dietician	466	

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Working Trial Balance

August 31, 2012

Account Number	Division	Account Description	Debit	Credit
101270		Dietary Supervisor	12,151	
101280		HIM/Coding	21,086	
101290		HIM/Coding - Contract Services	6,145	
101300		Nurses - Nurse Liaison	26,818	
101310		Nurses - Chief Clinical Officer	17,218	
101320		Pharmacist	4,690	
101330		Physician	74,796	
101340		Social Services		
101350		Therapy - Respiratory Therapist	115,315	
101360		Ward Clerk/Receptionist	16,469	
101370		Payroll Tax Expense	68,334	
101380		Nurses - RN	169,165	
101390		Nurses - LPN	113,425	
101400		Nurses - Aides/CNAs	66,797	
101410		Nurses - Contract Services	45,411	
101420		Nurses - RN - Other Pay	5,926	
101430		Nurses - LPN - Other Pay	1,735	
101440		Nurses - Aides/CNAs - Other Pay	2,059	
101450		Nurses - Wound Care - Other Pay		
101460		QA/Infection Control	20,455	
101461		Therapy - Contract PT	37,581	
101470		Therapy - Contract OT	34,145	
101480		Therapy - Contract Speech	23,348	
101490		80178 · Management Oversight	17,859	
101500		63400 · Interest Expense	75,542	
TOTAL			8,325,419	8,325,419