

CENTRAL INDIANA-AMG SPECIALTY HOSPIT Provider CCN: 15-2025	In Lieu of Form CMS-2552-10	Period : From: 09/01/2016 To: 08/31/2017	Run Date: 01/31/2018 Run Time: 09:40 Version: 2017.10 (12/05/2017)
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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. <input type="checkbox"/> Electronically filed cost report 2. <input checked="" type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted the cost report 4. <input checked="" type="checkbox"/> Medicare Utilization. Enter 'F' for full or 'L' for low.	Date: 01/31/2018 Time: 09:40
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ____ 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by CENTRAL INDIANA-AMG SPECIALTY HOSPIT (15-2025) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 09/01/2016 and ending 08/31/2017, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

Title

Date

PART III - SETTLEMENT SUMMARY

		TITLE XVIII					
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		50,417				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		50,417				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. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

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HOSPITAL AND HOSPITAL 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	P.O. Box:								1
2	City: MUNCIE	State: IN	ZIP Code: 47303	County: DELAWARE						2

Hospital and Hospital-Based Component Identification:

Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
						V	XVIII	XIX		
0	1	2	3	4	5	6	7	8		
3	Hospital	CENTRAL INDIANA-AMG SPECIALTY HOSPIT	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: 09 / 01 / 2016	To: 08 / 31 / 2017							20
21	Type of control (see instructions)	4								21

Inpatient PPS Information

		1	2	3	
22	Does this facility qualify for and receive disproportionate share hospital payments in accordance with 42 CFR §412.106? In column 1, enter 'Y' for yes or 'N' for no. Is this facility subject to 42 CFR §412.06(c)(2)(Pickle amendment hospital)? In column 2, enter 'Y' for yes or 'N' for no.	N	N		22
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, 'Y' for yes or 'N' for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, 'Y' for yes or 'N' for no.	N	N	N	22.03
23	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 Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
	1	2	3	4	5	6	
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.						24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.						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 is in effect in the cost reporting period.						37
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with the FY 2016 OPPS final rule? Enter 'Y' for yes or 'N' for no. (see instructions)	N					37.01
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:		Ending:			38

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		1	2	
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	N	N	39
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40
Prospective Payment System (PPS)-Capital		V	XVIII	XIX
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	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 Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	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	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	48

		1	2	3	
Teaching Hospitals					
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 Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub 15-1, chapter 21, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. 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
		Y/N	IME	Direct GME	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06

Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.

	Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	1	2	3	4	

Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.

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 Nonprovider Settings

63	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 'Y' for yes or 'N' for no. If yes, complete lines 64-67. (see instructions)	N			63
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
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 nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)				64
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)					
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))
	1	2	3	4	5
65					65
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)				66
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	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))
	1	2	3	4	5
67					67

Inpatient Psychiatric Facility PPS

		1	2	3	
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, indicate which program year began during this cost reporting period. (see instructions)				71

Inpatient Rehabilitation Facility PPS

		1	2	3	
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, indicate which program year began during this cost reporting period. (see instructions)				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
81	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter 'Y' for yes and 'N' for no.	N			81

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.				86
87	Is this hospital a 'subclause (II)' LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter 'Y' for yes and 'N' for no.	N			87

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Title V and XIX Services		V	XIX	
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/IID 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

		1	2			
105	Does this hospital qualify as a critical access hospital (CAH)?	N		105		
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106		
107	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. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.			107		
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.	Physical	Occupational	Speech	Respiratory	109
110	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter 'Y' for yes or 'N' for no.			N		110

Miscellaneous Cost Reporting Information

115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, section 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	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.	N			121
122	Does the cost report contain state health or similar taxes? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.	N			122

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

All Providers

		1	2	
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 (see instructions)	Y	HB0043	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: 07201	141
142	Street: STREET: 101 LA RUE FRANCE, SU	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 Wkst. A, line 74 are the costs for inpatient services only? Enter 'Y' for yes, or 'N' for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2.	Y	N	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, chapter 40, §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				
		Part A	Part B	Title V	Title XIX	
		1	2	3	4	
155	Hospital	N	N	N	N	155
156	Subprovider - IPF	N	N			156
157	Subprovider - IRF	N	N			157
158	Subprovider - Other					158
159	SNF	N	N			159
160	HHA	N	N			160
161	CMHC		N			161
161.10	CORF					161.10

Multicampus

165	Is this hospital part of a multicampus hospital that has one or more campuses in different CBSAs? Enter 'Y' for yes or 'N' for no.	N				165
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. (see instructions)					166
	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 is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)				168
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)				168.01
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transition factor. (see instructions)				169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)				170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no in column 1. If column 1 is 'Y', enter the number of section 1876 Medicare days in column 2. (see instructions)	N		0	171

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HOSPITAL AND HOSPITAL 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)	N			1
		Y/N	Date	V/I	
2					
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.	N			2
3					
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

		Y/N	Type	Date	
Financial Data and Reports					
		I	2	3	
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.	N			4
5	Are the cost report total expenses and total revenues different from those in the filed financial statements? If yes, submit reconciliation.	N			5

		Y/N	Y/N	
Approved Educational Activities				
		1	2	
6	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider the legal operator of the program?	N		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 Interns and Residents in approved GME programs claimed on the current cost report? If yes, see instructions.	N		9
10	Was an approved Intern and Resident GME 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	
Bad Debts			
		Y	
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

		Y/N	
Bed Complement			
		N	
15	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15

		Part A		Part B	
		Y/N	Date	Y/N	Date
PS&R Report Data					
		I	2	3	4
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)	Y	11/22/2017	Y	11/22/2017
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	
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	
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	
20	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	

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HOSPITAL AND HOSPITAL 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 relifed 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 capitalization 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	
		1	2	
36	Are home office costs claimed on the cost report?			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.			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
42	Employer: TFG CONSULTING		
43	Phone number: 2256101100	E-mail Address: MFREEMAN@TFGCONSULTING.ORG	

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Inpatient Days / Outpatient Visits / Trips			Total All Patients	
						Title V	Title XVIII	Title XIX		
		1	2	3	4	5	6	7	8	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	32	11,680			6,832		9,526	1
2	HMO and other (see instructions)						936	629		2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider									4
5	Hospital Adults & Peds. Swing Bed SNF									5
6	Hospital Adults & Peds. Swing Bed NF									6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		32	11,680			6,832		9,526	7
8	Intensive Care Unit	31								8
9	Coronary Care Unit	32								9
10	Burn Intensive Care Unit	33								10
11	Surgical Intensive Care Unit	34								11
12	Other Special Care (specify)	35								12
13	Nursery	43								13
14	Total (see instructions)		32	11,680			6,832		9,526	14
15	CAH Visits									15
16	Subprovider - IPF	40								16
17	Subprovider - IRF	41								17
18	Subprovider I	42								18
19	Skilled Nursing Facility	44								19
20	Nursing Facility	45								20
21	Other Long Term Care	46								21
22	Home Health Agency	101								22
23	ASC (Distinct Part)	115								23
24	Hospice (Distinct Part)	116								24
24.10	Hospice (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88								26
27	Total (sum of lines 14-26)		32							27
28	Observation Bed Days									28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)									32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33

CENTRAL INDIANA-AMG SPECIALTY HOSPIT Provider CCN: 15-2025	In Lieu of Form CMS-2552-10	Period : From: 09/01/2016 To: 08/31/2017	Run Date: 01/31/2018 Run Time: 09:40 Version: 2017.10 (12/05/2017)
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

	Component	Full Time Equivalents			DISCHARGES				
		Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					278		388	1
2	HMO and other (see instructions)					35	30		2
3	HMO IPF Subprovider								3
4	HMO IRF Subprovider								4
5	Hospital Adults & Peds. Swing Bed SNF								5
6	Hospital Adults & Peds. Swing Bed NF								6
7	Total Adults & Peds. (exclude observation beds) (see instructions)								7
8	Intensive Care Unit								8
9	Coronary Care Unit								9
10	Burn Intensive Care Unit								10
11	Surgical Intensive Care Unit								11
12	Other Special Care (specify)								12
13	Nursery								13
14	Total (see instructions)		89.96			278		388	14
15	CAH Visits								15
16	Subprovider - IPF								16
17	Subprovider - IRF								17
18	Subprovider I								18
19	Skilled Nursing Facility								19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency								22
23	ASC (Distinct Part)								23
24	Hospice (Distinct Part)								24
24.10	Hospice (non-distinct part)								24.10
25	CMHC								25
26	RHC								26
27	Total (sum of lines 14-26)		89.96						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

CENTRAL INDIANA-AMG SPECIALTY HOSPIT Provider CCN: 15-2025	In Lieu of Form CMS-2552-10	Period : From: 09/01/2016 To: 08/31/2017	Run Date: 01/31/2018 Run Time: 09:40 Version: 2017.10 (12/05/2017)
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HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

Part II - Wage Data

	Wkst A Line No.	Amount Reported	Reclassif- ication of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in Column 4	Average Hourly wage (column 4 ± column 5)	
	1	2	3	4	5	6	
SALARIES							
1	Total salaries (see instructions)	200	5,060,148		187,119.13		1
2	Non-physician anesthetist Part A						2
3	Non-physician anesthetest 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 program)						7.01
8	Home office and/or related organization 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
14.01	Home office salaries						14.01
14.02	Related organization salaries						14.02
15	Home office: Physician Part A - Administrative						15
16	Home office & Contract Physicians Part A - Teaching						16
WAGE-RELATED COSTS							
17	Wage-related costs (core)(see instructions)		932,098				17
18	Wage-related costs (other)(see instructions)						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
25.50	Home office wage-related						25.50
25.51	Related organization wage-related						25.51
25.52	Home office: Physician Part A - Administrative - wage-related						25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related						25.53
OVERHEAD COSTS - DIRECT SALARIES							
26	Employee Benefits Department						26
27	Administrative & General		838,823		35,701.28		27
28	Administrative & General under contract (see instructions)						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						34
35	Dietary under contract (see instructions)						35
36	Cafeteria						36
37	Maintenance of Personnel						37
38	Nursing Administration						38
39	Central Services and Supply						39
40	Pharmacy						40
41	Medical Records & Medical Records Library		100,849		3,760.83		41
42	Social Service		9,000		99.13		42
43	Other General Service						43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		5,060,148		5,060,148	187,119.13	27.04	1
2	Excluded area salaries (see instructions)							2
3	Subtotal salaries (line 1 minus line 2)		5,060,148		5,060,148	187,119.13	27.04	3
4	Subtotal other wages & related costs (see instructions)							4
5	Subtotal wage-related costs (see instructions)		932,098		932,098		18.42%	5
6	Total (sum of lines 3 through 5)		5,992,246		5,992,246	187,119.13	32.02	6
7	Total overhead cost (see instructions)		948,672		948,672	39,561.24	23.98	7

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HOSPITAL WAGE RELATED COSTS

**WORKSHEET S-3
PART IV**

Part IV - Wage Related Cost

Part A - Core List

		Amount Reported	
	RETIREMENT COST		
1	401K Employer Contributions	45,610	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)		8
8.01	Health Insurance (Self Funded without a Third Party Administrator)		8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		8.02
8.03	Health Insurance (Purchased)		8.03
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan		10
11	Life Insurance (If employee is owner or beneficiary)		11
12	Accident 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	224,319	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	414,244	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)	684,173	24

Part B - Other Than Core Related Cost

25	OTHER WAGE RELATED COSTs (SPECIFY)	9,131	25
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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 Labor	Benefit Cost	
	0	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

CENTRAL INDIANA-AMG SPECIALTY HOSPIT Provider CCN: 15-2025	In Lieu of Form CMS-2552-10	Period : From: 09/01/2016 To: 08/31/2017	Run Date: 01/31/2018 Run Time: 09:40 Version: 2017.10 (12/05/2017)
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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt		1,549,968	1,549,968		1,549,968	-1,103	1,548,865	1
2	00200	Cap Rel Costs-Mvble Equip								2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department		932,098	932,098		932,098		932,098	4
5	00500	Administrative & General	838,823	2,938,439	3,777,262		3,777,262	-1,091,826	2,685,436	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant		113,462	113,462		113,462		113,462	7
8	00800	Laundry & Linen Service		35,021	35,021		35,021		35,021	8
9	00900	Housekeeping		225,906	225,906		225,906		225,906	9
10	01000	Dietary		271,739	271,739		271,739		271,739	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	100,849	82,551	183,400		183,400	-1,292	182,108	16
17	01700	Social Service	9,000		9,000		9,000		9,000	17
18	01850	RECREATIONAL THERAPY								18
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd								21
22	02200	I&R Services-Other Prgm Costs Apprvd								22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	3,407,434	805,829	4,213,263		4,213,263		4,213,263	30
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room		411,808	411,808		411,808		411,808	50
54	05400	Radiology-Diagnostic		236,119	236,119		236,119		236,119	54
60	06000	Laboratory		309,493	309,493		309,493		309,493	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	353,798	571,274	925,072		925,072		925,072	65
66	06600	Physical Therapy	14,085	151,500	165,585		165,585		165,585	66
67	06700	Occupational Therapy		166,228	166,228		166,228		166,228	67
68	06800	Speech Pathology		82,826	82,826		82,826		82,826	68
71	07100	Medical Supplies Charged to Patients	16,543	126,237	142,780		142,780		142,780	71
73	07300	Drugs Charged to Patients	319,616	951,738	1,271,354		1,271,354		1,271,354	73
74	07400	Renal Dialysis		250,205	250,205		250,205		250,205	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 (Non-Distinct Part)								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)	5,060,148	10,212,441	15,272,589		15,272,589	-1,094,221	14,178,368	118
		NONREIMBURSABLE COST CENTERS								
200		TOTAL (sum of lines 118-199)	5,060,148	10,212,441	15,272,589		15,272,589	-1,094,221	14,178,368	200

CENTRAL INDIANA-AMG SPECIALTY HOSPIT Provider CCN: 15-2025	In Lieu of Form CMS-2552-10	Period : From: 09/01/2016 To: 08/31/2017	Run Date: 01/31/2018 Run Time: 09:40 Version: 2017.10 (12/05/2017)
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RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES			
		COST CENTER	LINE #	SALARY	OTHER
	1	2	3	4	5
GRAND TOTAL (Increases)					

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

CENTRAL INDIANA-AMG SPECIALTY HOSPIT Provider CCN: 15-2025	In Lieu of Form CMS-2552-10	Period : From: 09/01/2016 To: 08/31/2017	Run Date: 01/31/2018 Run Time: 09:40 Version: 2017.10 (12/05/2017)
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RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	DECREASES				Wkst A-7 Ref. 10
		COST CENTER	LINE #	SALARY	OTHER	
	1	6	7	8	9	
GRAND TOTAL (Decreases)						

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

CENTRAL INDIANA-AMG SPECIALTY HOSPIT Provider CCN: 15-2025	In Lieu of Form CMS-2552-10	Period : From: 09/01/2016 To: 08/31/2017	Run Date: 01/31/2018 Run Time: 09:40 Version: 2017.10 (12/05/2017)
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RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

	Description	Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
			Purchases	Donation	Total				
		1	2	3	4	5	6	7	
1	Land								1
2	Land Improvements								2
3	Buildings and Fixtures	96,287					96,287		3
4	Building Improvements								4
5	Fixed Equipment								5
6	Movable Equipment	902,692	37,127		37,127		939,819		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	998,979	37,127		37,127		1,036,106		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	998,979	37,127		37,127		1,036,106		10

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

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	514,522	888,373	79,971	27,628	39,474		1,549,968	1
2	Cap Rel Costs-Mvble Equip								2
3	Total (sum of lines 1-2)	514,522	888,373	79,971	27,628	39,474		1,549,968	3

(1) The amount in columns 9 through 14 must equal the amount on Worksheet A, column 2, lines 1 and 2. Enter in each column the appropriate amounts including any directly assigned cost that may have been included in Worksheet A, column 2, lines 1 and 2.

* All lines numbers are to be consistent with Worksheet A line numbers for capital cost centers.

PART III - RECONCILIATION OF CAPITAL COST CENTERS

		COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
	Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi				0.000000					1
2	Cap Rel Costs-Mvble Equip				0.000000					2
3	Total (sum of lines 1-2)				0.000000					3

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	513,419	888,373	79,971	27,628	39,474		1,548,865	1
2	Cap Rel Costs-Mvble Equip								2
3	Total (sum of lines 1-2)	513,419	888,373	79,971	27,628	39,474		1,548,865	3

(2) The amounts on lines 1 and 2 must equal the corresponding amounts on Worksheet A, column 7, lines 1 and 2. Columns 9 through 14 should include related Worksheet A-6 reclassifications, Worksheet A-8 adjustments, and Worksheet A-8-1 related organizations and home office costs. (See instructions.)

CENTRAL INDIANA-AMG SPECIALTY HOSPIT Provider CCN: 15-2025	In Lieu of Form CMS-2552-10	Period : From: 09/01/2016 To: 08/31/2017	Run Date: 01/31/2018 Run Time: 09:40 Version: 2017.10 (12/05/2017)
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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		Wkst. A-7 Ref.
				COST CENTER	LINE#	
		1	2	3	4	5
1	Investment income-buildings & fixtures (chapter 2)	B	-1,103	Cap Rel Costs-Bldg & Fixt	1	9
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	-798,985			10
11	Sale of scrap, waste, etc. (chapter 23)					11
12	Related organization transactions (chapter 10)	Wkst A-8-1	-240,336			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	-1,292	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 overpayments					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					32
33	ADVERTISING	A	-51,713	Administrative & General	5	33
34	OTHER	B	-370	Administrative & General	5	34
35	DONATIONS	A	-422	Administrative & General	5	35
36						36
37						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) (Transfer to worksheet A, column 6, line 200)		-1,094,221			50

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

Note: See instructions for column 5 referencing to Worksheet A-7.

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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 CLAIMED HOME OFFICE COSTS:

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.
	1	2	3	4	5	6	7
1	5	Administrative & General	HO OPERATING	1,178,155	1,418,491	-240,336	1
2							2
3							3
4							4
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12			1,178,155	1,418,491	-240,336	5

* The amounts on lines 1 through 4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which have not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

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

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office		Type of Business	
				Name	Percentage of Ownership		
	1	2	3	4	5	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:

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun- eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	5	Administrative & Gen AGGREGATE	822,575	775,375	47,200	211,500	232	23,590	1,180	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	822,575	775,375	47,200		232	23,590	1,180	200

CENTRAL INDIANA-AMG SPECIALTY HOSPIT Provider CCN: 15-2025	In Lieu of Form CMS-2552-10	Period : From: 09/01/2016 To: 08/31/2017	Run Date: 01/31/2018 Run Time: 09:40 Version: 2017.10 (12/05/2017)
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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	5	Administrative & Gen AGGREGATE					23,590	23,610	798,985	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL					23,590	23,610	798,985	200

CENTRAL INDIANA-AMG SPECIALTY HOSPIT Provider CCN: 15-2025	In Lieu of Form CMS-2552-10	Period : From: 09/01/2016 To: 08/31/2017	Run Date: 01/31/2018 Run Time: 09:40 Version: 2017.10 (12/05/2017)
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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS-TRATIVE & GENERAL	OPERATION OF PLANT	
		0	1	4	4A	5	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	1,548,865	1,548,865					1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department	932,098		932,098				4
5	Administrative & General	2,685,436	160,844	154,515	3,000,795	3,000,795		5
6	Maintenance & Repairs							6
7	Operation of Plant	113,462			113,462	30,461	143,923	7
8	Laundry & Linen Service	35,021			35,021	9,402		8
9	Housekeeping	225,906			225,906	60,648		9
10	Dietary	271,739			271,739	72,953		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	182,108	29,603	18,577	230,288	61,824	3,069	16
17	Social Service	9,000		1,658	10,658	2,861		17
18	RECREATIONAL THERAPY							18
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	4,213,263	1,179,519	627,660	6,020,442	1,616,282	122,305	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	411,808			411,808	110,556		50
54	Radiology-Diagnostic	236,119			236,119	63,390		54
60	Laboratory	309,493			309,493	83,088		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	925,072	27,586	65,171	1,017,829	273,252	2,860	65
66	Physical Therapy	165,585	14,939	2,595	183,119	49,161	1,549	66
67	Occupational Therapy	166,228	14,939		181,167	48,637	1,549	67
68	Speech Pathology	82,826	14,847		97,673	26,222	1,539	68
71	Medical Supplies Charged to Patients	142,780	106,588	3,047	252,415	67,765	11,052	71
73	Drugs Charged to Patients	1,271,354		58,875	1,330,229	357,121		73
74	Renal Dialysis	250,205			250,205	67,172		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 (Non-Distinct Part)							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)	14,178,368	1,548,865	932,098	14,178,368	3,000,795	143,923	118
	NONREIMBURSABLE COST CENTERS							
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	14,178,368	1,548,865	932,098	14,178,368	3,000,795	143,923	202

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	
		8	9	10	16	17	24	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	44,423						8
9	Housekeeping		286,554					9
10	Dietary			344,692				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		6,111		301,292			16
17	Social Service					13,519		17
18	RECREATIONAL THERAPY							18
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	44,423	243,510	344,692	301,292	13,519	8,706,465	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room						522,364	50
54	Radiology-Diagnostic						299,509	54
60	Laboratory						392,581	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		5,695				1,299,636	65
66	Physical Therapy		3,084				236,913	66
67	Occupational Therapy		3,084				234,437	67
68	Speech Pathology		3,065				128,499	68
71	Medical Supplies Charged to Patients		22,005				353,237	71
73	Drugs Charged to Patients						1,687,350	73
74	Renal Dialysis						317,377	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 (Non-Distinct Part)							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)	44,423	286,554	344,692	301,292	13,519	14,178,368	118
	NONREIMBURSABLE COST CENTERS							
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	44,423	286,554	344,692	301,292	13,519	14,178,368	202

CENTRAL INDIANA-AMG SPECIALTY HOSPIT Provider CCN: 15-2025	In Lieu of Form CMS-2552-10	Period : From: 09/01/2016 To: 08/31/2017	Run Date: 01/31/2018 Run Time: 09:40 Version: 2017.10 (12/05/2017)
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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	I&R COST & POST STEP- DOWN ADJS	TOTAL				
		25	26				
	GENERAL SERVICE COST CENTERS						
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						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 Services-Salary & Fringes Apprvd						21
22	I&R Services-Other Prgm Costs Apprvd						22
23	Paramed Ed Prgm-(specify)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	Adults & Pediatrics		8,706,465				30
	ANCILARY SERVICE COST CENTERS						
50	Operating Room		522,364				50
54	Radiology-Diagnostic		299,509				54
60	Laboratory		392,581				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy		1,299,636				65
66	Physical Therapy		236,913				66
67	Occupational Therapy		234,437				67
68	Speech Pathology		128,499				68
71	Medical Supplies Charged to Patients		353,237				71
73	Drugs Charged to Patients		1,687,350				73
74	Renal Dialysis		317,377				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 (Non-Distinct Part)						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)		14,178,368				118
	NONREIMBURSABLE COST CENTERS						
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)		14,178,368				202

CENTRAL INDIANA-AMG SPECIALTY HOSPIT Provider CCN: 15-2025	In Lieu of Form CMS-2552-10	Period : From: 09/01/2016 To: 08/31/2017	Run Date: 01/31/2018 Run Time: 09:40 Version: 2017.10 (12/05/2017)
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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	SUBTOTAL	ADMINIS- TRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		0	1	2A	5	7	8	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General		160,844	160,844	160,844			5
6	Maintenance & Repairs							6
7	Operation of Plant				1,633	1,633		7
8	Laundry & Linen Service				504		504	8
9	Housekeeping				3,251			9
10	Dietary				3,910			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		29,603	29,603	3,314	35		16
17	Social Service				153			17
18	RECREATIONAL THERAPY							18
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		1,179,519	1,179,519	86,632	1,388	504	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room				5,926			50
54	Radiology-Diagnostic				3,398			54
60	Laboratory				4,454			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		27,586	27,586	14,647	32		65
66	Physical Therapy		14,939	14,939	2,635	18		66
67	Occupational Therapy		14,939	14,939	2,607	18		67
68	Speech Pathology		14,847	14,847	1,406	17		68
71	Medical Supplies Charged to Patients		106,588	106,588	3,632	125		71
73	Drugs Charged to Patients				19,142			73
74	Renal Dialysis				3,600			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 (Non-Distinct Part)							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)		1,548,865	1,548,865	160,844	1,633	504	118
	NONREIMBURSABLE COST CENTERS							
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		1,548,865	1,548,865	160,844	1,633	504	202

CENTRAL INDIANA-AMG SPECIALTY HOSPIT Provider CCN: 15-2025	In Lieu of Form CMS-2552-10	Period : From: 09/01/2016 To: 08/31/2017	Run Date: 01/31/2018 Run Time: 09:40 Version: 2017.10 (12/05/2017)
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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	HOUSE-KEEPING	DIETARY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	
		9	10	16	17	24	25	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping	3,251						9
10	Dietary		3,910					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	69		33,021				16
17	Social Service				153			17
18	RECREATIONAL THERAPY							18
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	2,762	3,910	33,021	153	1,307,889		30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room					5,926		50
54	Radiology-Diagnostic					3,398		54
60	Laboratory					4,454		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	65				42,330		65
66	Physical Therapy	35				17,627		66
67	Occupational Therapy	35				17,599		67
68	Speech Pathology	35				16,305		68
71	Medical Supplies Charged to Patients	250				110,595		71
73	Drugs Charged to Patients					19,142		73
74	Renal Dialysis					3,600		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 (Non-Distinct Part)							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)	3,251	3,910	33,021	153	1,548,865		118
	NONREIMBURSABLE COST CENTERS							
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	3,251	3,910	33,021	153	1,548,865		202

CENTRAL INDIANA-AMG SPECIALTY HOSPIT Provider CCN: 15-2025	In Lieu of Form CMS-2552-10	Period : From: 09/01/2016 To: 08/31/2017	Run Date: 01/31/2018 Run Time: 09:40 Version: 2017.10 (12/05/2017)
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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	TOTAL					
		26					
	GENERAL SERVICE COST CENTERS						
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						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 Services-Salary & Fringes Apprvd						21
22	I&R Services-Other Prgm Costs Apprvd						22
23	Paramed Ed Prgm-(specify)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	Adults & Pediatrics	1,307,889					30
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	5,926					50
54	Radiology-Diagnostic	3,398					54
60	Laboratory	4,454					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	42,330					65
66	Physical Therapy	17,627					66
67	Occupational Therapy	17,599					67
68	Speech Pathology	16,305					68
71	Medical Supplies Charged to Patients	110,595					71
73	Drugs Charged to Patients	19,142					73
74	Renal Dialysis	3,600					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 (Non-Distinct Part)						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)	1,548,865					118
	NONREIMBURSABLE COST CENTERS						
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)	1,548,865					202

CENTRAL INDIANA-AMG SPECIALTY HOSPIT Provider CCN: 15-2025	In Lieu of Form CMS-2552-10	Period : From: 09/01/2016 To: 08/31/2017	Run Date: 01/31/2018 Run Time: 09:40 Version: 2017.10 (12/05/2017)
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECONCILIATION	ADMINISTRATIVE & GENERAL ACCUM COST	MAINTENANCE & REPAIRS SQUARE FEET	
		1	2	4	5A	5	6	
	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 Department			5,060,148				4
5	Administrative & General	1,755	1,755	838,823	-3,000,795	11,177,573		5
6	Maintenance & Repairs						15,145	6
7	Operation of Plant					113,462		7
8	Laundry & Linen Service					35,021		8
9	Housekeeping					225,906		9
10	Dietary					271,739		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	100,849		230,288	323	16
17	Social Service			9,000		10,658		17
18	RECREATIONAL THERAPY							18
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	12,870	12,870	3,407,434		6,020,442	12,870	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room					411,808		50
54	Radiology-Diagnostic					236,119		54
60	Laboratory					309,493		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	301	301	353,798		1,017,829	301	65
66	Physical Therapy	163	163	14,085		183,119	163	66
67	Occupational Therapy	163	163			181,167	163	67
68	Speech Pathology	162	162			97,673	162	68
71	Medical Supplies Charged to Patients	1,163	1,163	16,543		252,415	1,163	71
73	Drugs Charged to Patients			319,616		1,330,229		73
74	Renal Dialysis					250,205		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 (Non-Distinct Part)							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	5,060,148	-3,000,795	11,177,573	15,145	118
	NONREIMBURSABLE COST CENTERS							
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,548,865		932,098		3,000,795		202
203	Unit Cost Multiplier (Wkst. B, Part I)	91.648817		0.184204		0.268466		203
204	Cost to be allocated (Per Wkst. B, Part II)					160,844		204
205	Unit Cost Multiplier (Wkst. B, Part II)					0.014390		205

CENTRAL INDIANA-AMG SPECIALTY HOSPIT Provider CCN: 15-2025	In Lieu of Form CMS-2552-10	Period : From: 09/01/2016 To: 08/31/2017	Run Date: 01/31/2018 Run Time: 09:40 Version: 2017.10 (12/05/2017)
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	OPERATION	LAUNDRY	HOUSE-	DIETARY	NURSING	CENTRAL	
		OF PLANT	& LINEN	KEEPING		ADMINIS-	SERVICES &	
		SQUARE	SERVICE	SQUARE	MEALS	TRATION	SUPPLY	
		FEET	POUNDS OF	FEET	SERVED	DIRECT	COSTED	
		7	LAUNDRY	9	10	NRSING HRS	REQUIS.	
			8			13	14	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	15,145						7
8	Laundry & Linen Service		9,477					8
9	Housekeeping			15,145				9
10	Dietary				28,578			10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration					104,471		13
14	Central Services & Supply						100	14
15	Pharmacy							15
16	Medical Records & Library	323		323				16
17	Social Service							17
18	RECREATIONAL THERAPY							18
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	12,870	9,477	12,870	28,578	104,471		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				65
66	Physical Therapy	163		163				66
67	Occupational Therapy	163		163				67
68	Speech Pathology	162		162				68
71	Medical Supplies Charged to Patients	1,163		1,163			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 (Non-Distinct Part)							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	9,477	15,145	28,578	104,471	100	118
	NONREIMBURSABLE COST CENTERS							
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	143,923	44,423	286,554	344,692			202
203	Unit Cost Multiplier (Wkst. B, Part I)	9.503004	4.687454	18.920700	12.061446			203
204	Cost to be allocated (Per Wkst. B, Part II)	1,633	504	3,251	3,910			204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.107824	0.053181	0.214658	0.136819			205

CENTRAL INDIANA-AMG SPECIALTY HOSPIT Provider CCN: 15-2025	In Lieu of Form CMS-2552-10	Period : From: 09/01/2016 To: 08/31/2017	Run Date: 01/31/2018 Run Time: 09:40 Version: 2017.10 (12/05/2017)
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY TIME SPENT	SOCIAL SERVICE TIME SPENT				
	16	17				

GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						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	3,761					16
17	Social Service		99				17
18	RECREATIONAL THERAPY						18
19	Nonphysician Anesthetists						19
20	Nursing School						20
21	I&R Services-Salary & Fringes Apprvd						21
22	I&R Services-Other Prgm Costs Apprvd						22
23	Paramed Ed Prgm-(specify)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	Adults & Pediatrics	3,761	99				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 Charged to Patients						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 (Non-Distinct Part)						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)	3,761	99				118
	NONREIMBURSABLE COST CENTERS						
200	Cross foot adjustments						200
201	Negative cost centers						201
202	Cost to be allocated (Per Wkst. B, Part I)	301,292	13,519				202
203	Unit Cost Multiplier (Wkst. B, Part I)	80.109545	136.555556				203
204	Cost to be allocated (Per Wkst. B, Part II)	33,021	153				204
205	Unit Cost Multiplier (Wkst. B, Part II)	8.779846	1.545455				205

CENTRAL INDIANA-AMG SPECIALTY HOSPIT Provider CCN: 15-2025	In Lieu of Form CMS-2552-10	Period : From: 09/01/2016 To: 08/31/2017	Run Date: 01/31/2018 Run Time: 09:40 Version: 2017.10 (12/05/2017)
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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	WORKSHEET			
DESCRIPTION	PART	LINE NO.	AMOUNT	
1	2	3	4	

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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	COSTS					
		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	8,706,465		8,706,465		8,706,465	30
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	522,364		522,364		522,364	50
54	Radiology-Diagnostic	299,509		299,509		299,509	54
60	Laboratory	392,581		392,581		392,581	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	1,299,636		1,299,636		1,299,636	65
66	Physical Therapy	236,913		236,913		236,913	66
67	Occupational Therapy	234,437		234,437		234,437	67
68	Speech Pathology	128,499		128,499		128,499	68
71	Medical Supplies Charged to Patients	353,237		353,237		353,237	71
73	Drugs Charged to Patients	1,687,350		1,687,350		1,687,350	73
74	Renal Dialysis	317,377		317,377		317,377	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 (Non-Distinct Part)						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
200	Subtotal (sum of lines 30 thru 199)	14,178,368		14,178,368		14,178,368	200
201	Less Observation Beds						201
202	Total (line 200 minus line 201)	14,178,368		14,178,368		14,178,368	202

CENTRAL INDIANA-AMG SPECIALTY HOSPIT Provider CCN: 15-2025	In Lieu of Form CMS-2552-10	Period : From: 09/01/2016 To: 08/31/2017	Run Date: 01/31/2018 Run Time: 09:40 Version: 2017.10 (12/05/2017)
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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	CHARGES			Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		Inpatient	Outpatient	Total (column 6 + column 7)				
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	13,371,795		13,371,795				30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,228,971		1,228,971	0.425042	0.425042	0.425042	50
54	Radiology-Diagnostic	2,436,234		2,436,234	0.122939	0.122939	0.122939	54
60	Laboratory	1,384,846		1,384,846	0.283484	0.283484	0.283484	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	11,107,226		11,107,226	0.117008	0.117008	0.117008	65
66	Physical Therapy	238,055		238,055	0.995203	0.995203	0.995203	66
67	Occupational Therapy	219,386		219,386	1.068605	1.068605	1.068605	67
68	Speech Pathology	374,761		374,761	0.342883	0.342883	0.342883	68
71	Medical Supplies Charged to Patients	2,100,670		2,100,670	0.168154	0.168154	0.168154	71
73	Drugs Charged to Patients	2,374,950		2,374,950	0.710478	0.710478	0.710478	73
74	Renal Dialysis	391,308		391,308	0.811067	0.811067	0.811067	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 (Non-Distinct Part)							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
200	Subtotal (sum of lines 30 thru 199)	35,228,202		35,228,202				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	35,228,202		35,228,202				202

CENTRAL INDIANA-AMG SPECIALTY HOSPIT Provider CCN: 15-2025	In Lieu of Form CMS-2552-10	Period : From: 09/01/2016 To: 08/31/2017	Run Date: 01/31/2018 Run Time: 09:40 Version: 2017.10 (12/05/2017)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

**WORKSHEET D
PART I**

Check Title V PPS
 Applicable Title XVIII, Part A TEFRA
 Boxes: Title XIX

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	1,307,889		1,307,889	9,526	137.30	6,832	938,034	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)	1,307,889		1,307,889	9,526		6,832	938,034	200

(A) Worksheet A line numbers

CENTRAL INDIANA-AMG SPECIALTY HOSPIT Provider CCN: 15-2025	In Lieu of Form CMS-2552-10	Period : From: 09/01/2016 To: 08/31/2017	Run Date: 01/31/2018 Run Time: 09:40 Version: 2017.10 (12/05/2017)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 15-2025

**WORKSHEET D
PART II**

Check Title V Hospital SUB (Other) PPS
 Applicable Title XVIII, Part A IPF TEFRA
 Boxes: Title XIX IRF

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	5,926	1,228,971	0.004822	603,310	2,909	50
54	Radiology-Diagnostic	3,398	2,436,234	0.001395	1,999,214	2,789	54
60	Laboratory	4,454	1,384,846	0.003216	1,165,807	3,749	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	42,330	11,107,226	0.003811	8,533,466	32,521	65
66	Physical Therapy	17,627	238,055	0.074046	171,662	12,711	66
67	Occupational Therapy	17,599	219,386	0.080219	156,592	12,562	67
68	Speech Pathology	16,305	374,761	0.043508	278,523	12,118	68
71	Medical Supplies Charged to Pat	110,595	2,100,670	0.052647	1,496,635	78,793	71
73	Drugs Charged to Patients	19,142	2,374,950	0.008060	1,724,714	13,901	73
74	Renal Dialysis	3,600	391,308	0.009200	225,941	2,079	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 (Non-Distinct)						92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	240,976	21,856,407		16,355,864	174,132	200

(A) Worksheet A line numbers

CENTRAL INDIANA-AMG SPECIALTY HOSPIT Provider CCN: 15-2025	In Lieu of Form CMS-2552-10	Period : From: 09/01/2016 To: 08/31/2017	Run Date: 01/31/2018 Run Time: 09:40 Version: 2017.10 (12/05/2017)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

Check Title V PPS
 Applicable Title XVIII, Part A TEFRA
 Boxes: Title XIX Other

		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3 minus col 4.)	
(A)	Cost Center Description	1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics General Routine Care)						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)						200

(A) Worksheet A line numbers

CENTRAL INDIANA-AMG SPECIALTY HOSPIT Provider CCN: 15-2025	In Lieu of Form CMS-2552-10	Period : From: 09/01/2016 To: 08/31/2017	Run Date: 01/31/2018 Run Time: 09:40 Version: 2017.10 (12/05/2017)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

Check [] Title V [XX] PPS
Applicable [XX] Title XVIII, Part A [] TEFRA
Boxes: [] Title XIX [] Other

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	9,526		6,832		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)	9,526		6,832		200

(A) Worksheet A line numbers

CENTRAL INDIANA-AMG SPECIALTY HOSPIT Provider CCN: 15-2025	In Lieu of Form CMS-2552-10	Period : From: 09/01/2016 To: 08/31/2017	Run Date: 01/31/2018 Run Time: 09:40 Version: 2017.10 (12/05/2017)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 15-2025

**WORKSHEET D
PART IV**

Check Title V Hospital SUB (Other) ICF/IID PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX IRF NF Other

(A)	Cost Center Description	1 Non Physician Anesthetist Cost	2 Nursing School	3 Allied Health	4 All Other Medical Education Cost	5 Total Cost (sum of col. 1 through col. 4)	6 Total Outpatient Cost (sum of col. 2, 3, and 4)	
	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 Charged to Pat							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 (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

CENTRAL INDIANA-AMG SPECIALTY HOSPIT Provider CCN: 15-2025	In Lieu of Form CMS-2552-10	Period : From: 09/01/2016 To: 08/31/2017	Run Date: 01/31/2018 Run Time: 09:40 Version: 2017.10 (12/05/2017)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 15-2025

**WORKSHEET D
PART IV**

Check Title V Hospital SUB (Other) ICF/IID PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX IRF NF Other

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	1,228,971			603,310				50
54	Radiology-Diagnostic	2,436,234			1,999,214				54
60	Laboratory	1,384,846			1,165,807				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	11,107,226			8,533,466				65
66	Physical Therapy	238,055			171,662				66
67	Occupational Therapy	219,386			156,592				67
68	Speech Pathology	374,761			278,523				68
71	Medical Supplies Charged to Pat	2,100,670			1,496,635				71
73	Drugs Charged to Patients	2,374,950			1,724,714				73
74	Renal Dialysis	391,308			225,941				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 (Non-Distinct)								92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	21,856,407			16,355,864				200

(A) Worksheet A line numbers

CENTRAL INDIANA-AMG SPECIALTY HOSPIT Provider CCN: 15-2025	In Lieu of Form CMS-2552-10	Period : From: 09/01/2016 To: 08/31/2017	Run Date: 01/31/2018 Run Time: 09:40 Version: 2017.10 (12/05/2017)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 15-2025

WORKSHEET D
PART V

Check Title V - O/P Hospital SUB (Other) Swing Bed SNF
 Applicable Title XVIII, Part B IPF SNF Swing Bed NF
 Boxes: Title XIX - O/P IRF NF ICF/IID

(A)	Cost Center Description	Cost to Charge Ratio (from Wkst C, Part I, col. 9)	Program Charges			Program Cost			
			PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.425042							50
54	Radiology-Diagnostic	0.122939							54
60	Laboratory	0.283484							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.117008							65
66	Physical Therapy	0.995203							66
67	Occupational Therapy	1.068605							67
68	Speech Pathology	0.342883							68
71	Medical Supplies Charged to Pat	0.168154							71
73	Drugs Charged to Patients	0.710478							73
74	Renal Dialysis	0.811067							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 (Non-Distinct)								92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

CENTRAL INDIANA-AMG SPECIALTY HOSPIT Provider CCN: 15-2025	In Lieu of Form CMS-2552-10	Period : From: 09/01/2016 To: 08/31/2017	Run Date: 01/31/2018 Run Time: 09:40 Version: 2017.10 (12/05/2017)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

**WORKSHEET D
PART I**

Check Title V PPS
 Applicable Title XVIII, Part A TEFRA
 Boxes: Title XIX

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, (col. 26))	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	1,307,889		1,307,889	9,526	137.30			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)	1,307,889		1,307,889	9,526				200

(A) Worksheet A line numbers

CENTRAL INDIANA-AMG SPECIALTY HOSPIT Provider CCN: 15-2025	In Lieu of Form CMS-2552-10	Period : From: 09/01/2016 To: 08/31/2017	Run Date: 01/31/2018 Run Time: 09:40 Version: 2017.10 (12/05/2017)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 15-2025

WORKSHEET D
PART II

Check Title V Hospital SUB (Other) PPS
 Applicable Title XVIII, Part A IPF TEFRA
 Boxes: Title XIX IRF

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	5,926	1,228,971	0.004822			50
54	Radiology-Diagnostic	3,398	2,436,234	0.001395			54
60	Laboratory	4,454	1,384,846	0.003216			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	42,330	11,107,226	0.003811			65
66	Physical Therapy	17,627	238,055	0.074046			66
67	Occupational Therapy	17,599	219,386	0.080219			67
68	Speech Pathology	16,305	374,761	0.043508			68
71	Medical Supplies Charged to Pat	110,595	2,100,670	0.052647			71
73	Drugs Charged to Patients	19,142	2,374,950	0.008060			73
74	Renal Dialysis	3,600	391,308	0.009200			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 (Non-Distinct)						92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	240,976	21,856,407				200

(A) Worksheet A line numbers

CENTRAL INDIANA-AMG SPECIALTY HOSPIT Provider CCN: 15-2025	In Lieu of Form CMS-2552-10	Period : From: 09/01/2016 To: 08/31/2017	Run Date: 01/31/2018 Run Time: 09:40 Version: 2017.10 (12/05/2017)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

Check Title V PPS
 Applicable Title XVIII, Part A TEFRA
 Boxes: Title XIX Other

		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3 minus col 4.)	
(A)	Cost Center Description	1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics General Routine Care)						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)						200

(A) Worksheet A line numbers

CENTRAL INDIANA-AMG SPECIALTY HOSPIT Provider CCN: 15-2025	In Lieu of Form CMS-2552-10	Period : From: 09/01/2016 To: 08/31/2017	Run Date: 01/31/2018 Run Time: 09:40 Version: 2017.10 (12/05/2017)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

Check Title V PPS
 Applicable Title XVIII, Part A TEFRA
 Boxes: Title XIX Other

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	9,526				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)	9,526				200

(A) Worksheet A line numbers

CENTRAL INDIANA-AMG SPECIALTY HOSPIT Provider CCN: 15-2025	In Lieu of Form CMS-2552-10	Period : From: 09/01/2016 To: 08/31/2017	Run Date: 01/31/2018 Run Time: 09:40 Version: 2017.10 (12/05/2017)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 15-2025

**WORKSHEET D
PART IV**

Check Title V Hospital SUB (Other) ICF/IID PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX IRF NF Other

(A)	Cost Center Description	1 Non Physician Anesthetist Cost	2 Nursing School	3 Allied Health	4 All Other Medical Education Cost	5 Total Cost (sum of col. 1 through col. 4)	6 Total Outpatient Cost (sum of col. 2, 3, and 4)	
	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 Charged to Pat							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 (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

CENTRAL INDIANA-AMG SPECIALTY HOSPIT Provider CCN: 15-2025	In Lieu of Form CMS-2552-10	Period : From: 09/01/2016 To: 08/31/2017	Run Date: 01/31/2018 Run Time: 09:40 Version: 2017.10 (12/05/2017)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 15-2025

**WORKSHEET D
PART IV**

Check Title V Hospital SUB (Other) ICF/IID PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX IRF NF Other

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	1,228,971							50
54	Radiology-Diagnostic	2,436,234							54
60	Laboratory	1,384,846							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	11,107,226							65
66	Physical Therapy	238,055							66
67	Occupational Therapy	219,386							67
68	Speech Pathology	374,761							68
71	Medical Supplies Charged to Pat	2,100,670							71
73	Drugs Charged to Patients	2,374,950							73
74	Renal Dialysis	391,308							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 (Non-Distinct)								92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	21,856,407							200

(A) Worksheet A line numbers

CENTRAL INDIANA-AMG SPECIALTY HOSPIT Provider CCN: 15-2025	In Lieu of Form CMS-2552-10	Period : From: 09/01/2016 To: 08/31/2017	Run Date: 01/31/2018 Run Time: 09:40 Version: 2017.10 (12/05/2017)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 15-2025

WORKSHEET D
PART V

Check Title V - O/P Hospital SUB (Other) Swing Bed SNF
 Applicable Title XVIII, Part B IPF SNF Swing Bed NF
 Boxes: Title XIX - O/P IRF NF ICF/IID

(A)	Cost Center Description	Cost to Charge Ratio (from Wkst C, Part I, col. 9)	Program Charges			Program Cost			
			PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.425042							50
54	Radiology-Diagnostic	0.122939							54
60	Laboratory	0.283484							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.117008							65
66	Physical Therapy	0.995203							66
67	Occupational Therapy	1.068605							67
68	Speech Pathology	0.342883							68
71	Medical Supplies Charged to Pat	0.168154							71
73	Drugs Charged to Patients	0.710478							73
74	Renal Dialysis	0.811067							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 (Non-Distinct)								92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

CENTRAL INDIANA-AMG SPECIALTY HOSPIT Provider CCN: 15-2025	In Lieu of Form CMS-2552-10	Period : From: 09/01/2016 To: 08/31/2017	Run Date: 01/31/2018 Run Time: 09:40 Version: 2017.10 (12/05/2017)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-2025

WORKSHEET D-1
PART I

Check Title V - I/P Hospital SUB (Other) ICF/IID PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX - I/P IRF NF Other

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	9,526	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	9,526	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	9,526	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 (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	6,832	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 XIX only)		15
16	Nursery days (title V or 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)	8,706,465	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 (line 21 minus line 26)	8,706,465	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		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)		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 minus line 36)	8,706,465	37

CENTRAL INDIANA-AMG SPECIALTY HOSPIT Provider CCN: 15-2025	In Lieu of Form CMS-2552-10	Period : From: 09/01/2016 To: 08/31/2017	Run Date: 01/31/2018 Run Time: 09:40 Version: 2017.10 (12/05/2017)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-2025

WORKSHEET D-1
PART II

Check Title V - I/P Hospital SUB (Other) PPS
 Applicable Title XVIII, Part A IPF TEFRA
 Boxes: Title XIX - I/P IRF Other

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

38	Adjusted general inpatient routine service cost per diem (see instructions)					913.97	38
39	Program general inpatient routine service cost (line 9 x line 38)					6,244,243	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)					6,244,243	41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	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
							1
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					3,925,149	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					10,169,392	49
							PASS THROUGH COST ADJUSTMENTS
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					938,034	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					174,132	51
52	Total Program excludable cost (sum of lines 50 and 51)					1,112,166	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					9,057,226	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 (line 56 minus line 53)						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 (line 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

CENTRAL INDIANA-AMG SPECIALTY HOSPIT Provider CCN: 15-2025	In Lieu of Form CMS-2552-10	Period : From: 09/01/2016 To: 08/31/2017	Run Date: 01/31/2018 Run Time: 09:40 Version: 2017.10 (12/05/2017)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-2025

WORKSHEET D-1
PARTS III & IV

Check Title V - I/P Hospital SUB (Other) ICF/IID PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX - I/P IRF NF Other

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)	913.97	88				
89	Observation bed cost (line 87 x line 88) (see instructions)		89				
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

CENTRAL INDIANA-AMG SPECIALTY HOSPIT Provider CCN: 15-2025	In Lieu of Form CMS-2552-10	Period : From: 09/01/2016 To: 08/31/2017	Run Date: 01/31/2018 Run Time: 09:40 Version: 2017.10 (12/05/2017)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-2025

WORKSHEET D-1
PART I

Check Title V - I/P Hospital SUB (Other) ICF/IID PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX - I/P IRF NF Other

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	9,526	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	9,526	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	9,526	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 (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		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 XIX only)		15
16	Nursery days (title V or 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)	8,706,465	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 (line 21 minus line 26)	8,706,465	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		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)		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 minus line 36)	8,706,465	37

CENTRAL INDIANA-AMG SPECIALTY HOSPIT Provider CCN: 15-2025	In Lieu of Form CMS-2552-10	Period : From: 09/01/2016 To: 08/31/2017	Run Date: 01/31/2018 Run Time: 09:40 Version: 2017.10 (12/05/2017)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-2025

WORKSHEET D-1
PART II

Check Title V - I/P Hospital SUB (Other) PPS
 Applicable Title XVIII, Part A IPF TEFRA
 Boxes: Title XIX - I/P IRF Other

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

38	Adjusted general inpatient routine service cost per diem (see instructions)					913.97	38
39	Program general inpatient routine service cost (line 9 x line 38)						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)						41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	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
							1
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						49
	PASS THROUGH COST ADJUSTMENTS						
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						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 (sum of lines 50 and 51)						52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						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 (line 56 minus line 53)						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 (line 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

CENTRAL INDIANA-AMG SPECIALTY HOSPIT Provider CCN: 15-2025	In Lieu of Form CMS-2552-10	Period : From: 09/01/2016 To: 08/31/2017	Run Date: 01/31/2018 Run Time: 09:40 Version: 2017.10 (12/05/2017)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-2025

WORKSHEET D-1
PARTS III & IV

Check Title V - I/P Hospital SUB (Other) ICF/IID PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX - I/P IRF NF Other

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				
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

CENTRAL INDIANA-AMG SPECIALTY HOSPIT Provider CCN: 15-2025	In Lieu of Form CMS-2552-10	Period : From: 09/01/2016 To: 08/31/2017	Run Date: 01/31/2018 Run Time: 09:40 Version: 2017.10 (12/05/2017)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 15-2025

WORKSHEET D-3

Check Title V Hospital SUB (Other) Swing Bed SNF PPS
 Applicable Title XVIII, Part A IPF SNF Swing Bed NF TEFRA
 Boxes: Title XIX IRF NF ICF/IID Other

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		9,564,800		30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.425042	603,310	256,432	50
54	Radiology-Diagnostic	0.122939	1,999,214	245,781	54
60	Laboratory	0.283484	1,165,807	330,488	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.117008	8,533,466	998,484	65
66	Physical Therapy	0.995203	171,662	170,839	66
67	Occupational Therapy	1.068605	156,592	167,335	67
68	Speech Pathology	0.342883	278,523	95,501	68
71	Medical Supplies Charged to Patients	0.168154	1,496,635	251,665	71
73	Drugs Charged to Patients	0.710478	1,724,714	1,225,371	73
74	Renal Dialysis	0.811067	225,941	183,253	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 (Non-Distinct Part)				92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		16,355,864	3,925,149	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		16,355,864		202

(A) Worksheet A line numbers

CENTRAL INDIANA-AMG SPECIALTY HOSPIT Provider CCN: 15-2025	In Lieu of Form CMS-2552-10	Period : From: 09/01/2016 To: 08/31/2017	Run Date: 01/31/2018 Run Time: 09:40 Version: 2017.10 (12/05/2017)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 15-2025

WORKSHEET D-3

Check Title V Hospital SUB (Other) Swing Bed SNF PPS
 Applicable Title XVIII, Part A IPF SNF Swing Bed NF TEFRA
 Boxes: Title XIX IRF NF ICF/IID Other

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.425042			50
54	Radiology-Diagnostic	0.122939			54
60	Laboratory	0.283484			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.117008			65
66	Physical Therapy	0.995203			66
67	Occupational Therapy	1.068605			67
68	Speech Pathology	0.342883			68
71	Medical Supplies Charged to Patients	0.168154			71
73	Drugs Charged to Patients	0.710478			73
74	Renal Dialysis	0.811067			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 (Non-Distinct Part)				92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)				200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)				202

(A) Worksheet A line numbers

CENTRAL INDIANA-AMG SPECIALTY HOSPIT Provider CCN: 15-2025	In Lieu of Form CMS-2552-10	Period : From: 09/01/2016 To: 08/31/2017	Run Date: 01/31/2018 Run Time: 09:40 Version: 2017.10 (12/05/2017)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-2025

WORKSHEET E
PART B

Check applicable box: Hospital IPF IRF SUB (Other) SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
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 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. 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, col. 4, line 69)				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) (see instructions)				21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				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 minus 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 (see instructions)				37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)				40
40.01	Sequestration adjustment (see instructions)				40.01
41	Interim payments				41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)				43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §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

CENTRAL INDIANA-AMG SPECIALTY HOSPIT Provider CCN: 15-2025	In Lieu of Form CMS-2552-10	Period : From: 09/01/2016 To: 08/31/2017	Run Date: 01/31/2018 Run Time: 09:40 Version: 2017.10 (12/05/2017)
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 15-2025

WORKSHEET E-1
PART I

Check Hospital SUB (Other)
Applicable IPF SNF
Boxes: IRF Swing Bed SNF

	DESCRIPTION	INPATIENT PART A		PART B	
		mm/dd/yyyy 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4
1	Total interim payments paid to provider		10,453,288		1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero				2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)	08/31/2017	126,100		3.01
					3.02
	Program				3.03
	to				3.04
	Provider				3.05
					3.06
					3.07
					3.08
					3.09
					3.10
					3.50
					3.51
	Provider				3.52
	to				3.53
	Program				3.54
					3.55
					3.56
					3.57
					3.58
					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99	126,100		3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		10,579,388		4
TO BE COMPLETED BY CONTRACTOR					
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)				5.01
					5.02
	Program				5.03
	to				5.04
	Provider				5.05
					5.06
					5.07
					5.08
					5.09
					5.10
					5.50
					5.51
	Provider				5.52
	to				5.53
	Program				5.54
					5.55
					5.56
					5.57
					5.58
					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99			5.99
6	Determined net settlement amount (balance due) based on the cost report (1)	.01			6.01
		.02			6.02
7	Total Medicare program liability (see instructions)				7
8	Name of Contractor	Contractor Number		NPR Date (Month/Day/Year)	
					8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

CENTRAL INDIANA-AMG SPECIALTY HOSPIT Provider CCN: 15-2025	In Lieu of Form CMS-2552-10	Period : From: 09/01/2016 To: 08/31/2017	Run Date: 01/31/2018 Run Time: 09:40 Version: 2017.10 (12/05/2017)
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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

**WORKSHEET E-1
PART II**

Check applicable box: Hospital CAH

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 (Wkst. S-3, Pt. I, col. 15, line 14)		1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)		2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)		3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	9,526	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)		5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)		6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)		7
8	Calculation of the HIT incentive payment (see instructions)		8
9	Sequestration adjustment amount (see instructions)		9
10	Calculation of the HIT incentive payment after sequestration (see instructions)		10

INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH

30	Initial/interim HIT payment(s)		30
31	OTHER ADJUSTMENTS ()		31
32	Balance due provider (line 8 or line 10 minus line 30 and line 31) (see instructions)		32

(*) This worksheet is completed by the contractor for standard and non-standard cost reporting periods at cost report settlement. Providers may complete this worksheet for a standard cost reporting period.

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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
PART IV

Check [XX] Hospital
applicable box:

PART IV - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER LTCH PPS

1	Net Federal PPS payment (see instructions)	10,811,528	1
1.01	Full standard payment amount		1.01
1.02	Short stay outlier standard payment amount		1.02
1.03	Site neutral payment amount - Cost		1.03
1.04	Site neutral payment amount - IPPS comparable		1.04
2	Outlier payments	293,993	2
3	Total PPS payments (sum of lines 1 and 2)	11,105,521	3
4	Nursing and allied health managed care payments (see instructions)		4
5	Organ acquisition DO NOT USE THIS LINE		5
6	Cost of physicians' services in a teaching hospital (see instructions)		6
7	Subtotal (see instructions)	11,105,521	7
8	Primary payer payments		8
9	Subtotal (line 7 less line 8)	11,105,521	9
10	Deductibles	95,348	10
11	Subtotal (line 9 minus line 10)	11,010,173	11
12	Coinsurance	343,553	12
13	Subtotal (line 11 minus line 12)	10,666,620	13
14	Allowable bad debts (exclude bad debts for professional services) (see instructions)	277,107	14
15	Adjusted reimbursable bad debts (see instructions)	180,120	15
16	Allowable bad debts for dual eligible beneficiaries (see instructions)	205,699	16
17	Subtotal (sum of lines 13 and 15)	10,846,740	17
18	Direct graduate medical education payments (from Wkst. E-4, line 49)		18
19	Other pass through costs (see instructions)		19
20	Outlier payments reconciliation		20
21	Other adjustments (specify) (see instructions)		21
21.50	Pioneer ACO demonstration payment adjustment (see instructions)		21.50
22	Total amount payable to the provider (see instructions)	10,846,740	22
22.01	Sequestration adjustment (see instructions)	216,935	22.01
23	Interim payments	10,579,388	23
24	Tentative settlement (for contractor use only)		24
25	Balance due provider/program (line 22 minus lines 22.01, 23 and 24)	50,417	25
26	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		26

TO BE COMPLETED BY CONTRACTOR

50	Original PPS payment and outlier amount from Wkst. 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

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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-2025

WORKSHEET E-3
PART VII

Check Title V Hospital NF PPS
 Applicable Title XIX SUB (Other) ICF/IID TEFRA
 Boxes: SNF Other

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

	INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
COMPUTATION OF NET COST OF COVERED SERVICES			
1			1
2			2
3			3
4			4
5			5
6			6
7			7
COMPUTATION OF LESSER OF COST OR CHARGES			
REASONABLE CHARGES			
8			8
9			9
10			10
11			11
12			12
CUSTOMARY CHARGES			
13			13
14			14
15	1.000000	1.000000	15
16			16
17			17
18			18
19			19
20			20
21			21
PROSPECTIVE PAYMENT AMOUNT			
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43

CENTRAL INDIANA-AMG SPECIALTY HOSPIT Provider CCN: 15-2025	In Lieu of Form CMS-2552-10	Period : From: 09/01/2016 To: 08/31/2017	Run Date: 01/31/2018 Run Time: 09:40 Version: 2017.10 (12/05/2017)
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BALANCE SHEET

WORKSHEET G

(If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Assets (Omit Cents)		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1	2	3	4	
CURRENT ASSETS						
1	Cash on hand and in banks	-167,951				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	1,833,063				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable					6
7	Inventory					7
8	Prepaid expenses	386,475				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	2,051,587				11
FIXED ASSETS						
12	Land					12
13	Land improvements					13
14	Accumulated depreciation					14
15	Buildings					15
16	Accumulated depreciation					16
17	Leasehold improvements	96,287				17
18	Accumulated depreciation					18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Audomobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	939,819				23
24	Accumulated depreciation	-649,417				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)	386,689				30
OTHER ASSETS						
31	Investments					31
32	Deposits on leases	180,000				32
33	Due from owners/officers	5				33
34	Other assets	2,222,069				34
35	Total other assets (sum of lines 31-34)	2,402,074				35
36	Total assets (sum of lines 11, 30 and 35)	4,840,350				36
Liabilities and Fund Balances (Omit Cents)						
		1	2	3	4	
CURRENT LIABILITIES						
37	Accounts payable	4,091,315				37
38	Salaries, wages and fees payable	177,789				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)					40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities					44
45	Total current liabilities (sum of lines 37 thru 44)	4,269,104				45
LONG TERM LIABILITIES						
46	Mortgage payable					46
47	Notes payable	-582,302				47
48	Unsecured loans					48
49	Other long term liabilities					49
50	Total long term liabilities (sum of lines 46 thru 49)	-582,302				50
51	Total liabilities (sum of lines 45 and 50)	3,686,802				51
CAPITAL ACCOUNTS						
52	General fund balance	1,153,548				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					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 thru 58)	1,153,548				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	4,840,350				60

CENTRAL INDIANA-AMG SPECIALTY HOSPIT Provider CCN: 15-2025	In Lieu of Form CMS-2552-10	Period : From: 09/01/2016 To: 08/31/2017	Run Date: 01/31/2018 Run Time: 09:40 Version: 2017.10 (12/05/2017)
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STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	Fund balances at beginning of period		1,638,508			1
2	Net income (loss) (from Worksheet G-3, line 29)		-484,955			2
3	Total (sum of line 1 and line 2)		1,153,553			3
4	Additions (credit adjustments) (specify)					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)		1,153,553			11
12	Deductions (debit adjustments) (specify)					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)		1,153,553			19

		ENDOWMENT FUND		PLANT FUND		
		5	6	7	8	
1	Fund balances at beginning of period					1
2	Net income (loss) (from Worksheet G-3, line 29)					2
3	Total (sum of line 1 and line 2)					3
4	Additions (credit adjustments) (specify)					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)					11
12	Deductions (debit adjustments) (specify)					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)					19

CENTRAL INDIANA-AMG SPECIALTY HOSPIT Provider CCN: 15-2025	In Lieu of Form CMS-2552-10	Period : From: 09/01/2016 To: 08/31/2017	Run Date: 01/31/2018 Run Time: 09:40 Version: 2017.10 (12/05/2017)
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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	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	13,371,795		13,371,795	1
2	Subprovider IPF				2
3	Subprovider IRF				3
5	Swing Bed - SNF				5
6	Swing Bed - NF				6
7	Skilled nursing facility				7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	13,371,795		13,371,795	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit				11
12	Coronary Care Unit				12
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit				14
15	Other Special Care (specify)				15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)				16
17	Total inpatient routine care services (sum of lines 10 and 16)	13,371,795		13,371,795	17
18	Ancillary services	21,856,407		21,856,407	18
19	Outpatient services				19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency				22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	Other (specify)				27
27.01	PART B PHYSICIAN REVENUE	150,866		150,866	27.01
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	35,379,068		35,379,068	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		15,272,589	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 Worksheet G-3, line 4)		15,272,589	43

CENTRAL INDIANA-AMG SPECIALTY HOSPIT Provider CCN: 15-2025	In Lieu of Form CMS-2552-10	Period : From: 09/01/2016 To: 08/31/2017	Run Date: 01/31/2018 Run Time: 09:40 Version: 2017.10 (12/05/2017)
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STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	35,379,068	1
2	Less contractual allowances and discounts on patients' accounts	20,597,167	2
3	Net patient revenues (line 1 minus line 2)	14,781,901	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	15,272,589	4
5	Net income from service to patients (line 3 minus line 4)	-490,688	5

OTHER INCOME

6	Contributions, donations, bequests, etc.		6
7	Income from investments	1,103	7
8	Revenues from telephone and other miscellaneous communication services		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 medical and surgical supplies to otehr than patients		16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts	1,292	18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines		21
22	Rental of hosptial space		22
23	Governmental appropriations		23
24	Other (OTHER INCOME)	3,338	24
25	Total other income (sum of lines 6-24)	5,733	25
26	Total (line 5 plus line 25)	-484,955	26
29	Net income (or loss) for the period (line 26 minus line 28)	-484,955	29