near th i manci a	ai bystellis	CENTRAL TRUITARA-ARRO SI	LCIALII 1103111	III LI C	1 01 1 01 III 0W3-2332-10
This report is	required by law (42 USC 1395g;	42 CFR 413.20(b)). Fail	lure to report can re	esult in all interim	FORM APPROVED
payments made	since the beginning of the cost	reporting period being	deemed overpayments	(42 USC 1395g).	OMB NO. 0938-0050
					EXPIRES 05-31-2019
HOSPITAL AND H	OSPITAL HEALTH CARE COMPLEX COST	REPORT CERTIFICATION	Provi der CCN: 15-202	Peri od:	Worksheet S
AND SETTLEMENT	SUMMARY				
				To 08/31/2019	Date/Time Prepared: 1/27/2020 11:28 am
PART I - COST	REPORT STATUS				172772020 11.20 dill
Provi der	1. [X] Electronically filed cos	st report		Date: 1/27/202	20 Time: 11:28 am
use only	2. [] Manually submitted cost	report			
	3. [0] If this is an amended re	port enter the number	of times the provider	r resubmitted this co	ost report
	4. [F] Medicare Utilization. En	iter "F" for full or "L	" for low.		·
Contractor	5. [1] Cost Report Status 6.	Date Received:	1	10. NPR Date:	
use only		Contractor No.		11. Contractor's Vendo	
•	(2) Settled without Audit 8.	[N] Initial Report fo	or this Provider CCN 1	12.[0]If line 5, co	lumn 1 is 4: Enter
	(3) Settled with Audit 9.	[N] Final Report for	this Provider CCN	number of tim	es reopened = 0-9.
	(4) Reopened				
	(5) Amended				

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by CENTRAL INDIANA-AMG SPECIALTY HOSPIT (15-2025) for the cost reporting period beginning 09/01/2018 and ending 08/31/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Si gned)	
	Officer or Administrator of Provider(s)
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	ate

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	-52, 215	0	0	0	1. 00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovi der - I RF	0	0	0		0	3. 00
5.00	Swing bed - SNF	0	0	0		0	5. 00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	-52, 215	0	0	0	200. 00

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boul evard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-2025 Peri od: Worksheet S-2 From 09/01/2018 Part I Date/Time Prepared: 08/31/2019 1/27/2020 11:28 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: 1.00 Street: 2401 W. UNIVERSITY AVE, 8TH FLOOR N PO Box: 1.00 State: IN 2.00 City: MUNCIE Zip Code: 47303 County: DELAWARE 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N)

/ XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal CENTRAL INDIANA-AMG 152025 34620 02/16/2005 N 3.00 SPECIALTY HOSPIT Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 Subprovi der - (Other) 6.00 6.00 Swing Beds - SNF 7 00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 14.00 Hospi tal -Based Hospi ce 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 17. 10 Hospi tal -Based (CORF) I 17.10 17. 20 Hospi tal -Based (OPT) I 17.20 17.30 Hospital-Based (00T) I 17.30 17. 40 Hospi tal -Based (OSP) I 17.40 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 2.00 1.00 20.00 Cost Reporting Period (mm/dd/yyyy) 09/01/2018 08/31/2019 20.00 21.00 Type of Control (see instructions) 21.00 1. 00 2. 00 3.00 Inpatient PPS Information 22. 00 Does this facility qualify and is it currently receiving payments for N N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. 22. 01 Did this hospital receive interim uncompensated care payments for this Ν Ν 22.01 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)
Is this a newly merged hospital that requires final uncompensated care 22.02 Ν Ν 22.02 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. 22.03 Did this hospital receive a geographic reclassification from urban to N Ν Ν 22.03 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. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 Ν 23.00 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.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-2025 Peri od: Worksheet S-2 From 09/01/2018 Part I Date/Time Prepared: 08/31/2019 1/27/2020 11:28 am In-State In-State Out-of Out-of Medi cai d 0ther Medi cai d Medi cai d State State HMO days Medi cai d paid days el i gi bl e Medi cai d Medi cai d days paid days unpai d el i gi bl e days unpai d 1.00 2. 00 3. 00 4. 00 5. 00 6.00 24.00 If this provider is an IPPS hospital, enter the 0 24.00 \cap n 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. 25.00 If this provider is an IRF, enter the in-state 0 0 0 0 0 25.00 Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5. Urban/Rural S Date of Geogr 1. 00 2.00 26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural. 26.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, 27.00 enter the effective date of the geographic reclassification in column 2. If this is a sole community hospital (SCH), enter the number of periods SCH status in 35.00 effect in the cost reporting period. Endi ng: Begi nni ng: 1.00 2.00 36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number 36, 00 of periods in excess of one and enter subsequent dates. If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 37.00 0 is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see 37.01 37.01 instructions) If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is 38.00 greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. Y/N Y/N 1.00 2.00 39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume 39. 00 hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or Ν Ν 40.00 '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) XVIII XIX 1.00 2.00 3.00 Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance 45.00 with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment exception for extraordinary circumstances Ν N Ν 46,00 pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through 47.00 | Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. 47.00 Ν 48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. 48.00 Ν Ν Ν Teaching Hospitals Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes 56.00 Ν 56.00 or "N" for no. If line 56 is yes, is this the first cost reporting period during which residents in approved Ν 57.00 GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. 58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as Ν 58.00 defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I. 59.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-2025 Peri od: Worksheet S-2 From 09/01/2018 Part I Date/Time Prepared: 08/31/2019 1/27/2020 11:28 am NAHE 413.85 Worksheet A Pass-Through Qualification Y/N Line # Criterion Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for 60.00 Ν any programs that meet the criteria under §413.85? (see instructions) Direct GME IME Y/N Direct GME 2. 00 3. 00 1.00 4.00 5.00 61.00 Did your hospital receive FTE slots under ACA 0.00 61.00 Ν section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 61.01 Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) Enter the current year total unweighted primary care 61.02 61.02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61.03 Enter the base line FTE count for primary care 61 03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) 61.04 Enter the number of unweighted primary care/or 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period (see instructions). 61.05 Enter the difference between the baseline primary 61.05 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) Enter the amount of ACA §5503 award that is being 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Code Unweighted IME Unweighted Program Name Direct GME FTE FTE Count Count 1.00 2.00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0 00 0.00 61.10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 61.20 0 00 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 during in this cost_reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions) 63.00 N Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. 0.000000 64.00 64.00 Enter in column 1, if line 63 is yes, or your facility trained residents 0 00 0 00 n 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)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-2025 Peri od: Worksheet S-2 From 09/01/2018 Part I Date/Time Prepared: 08/31/2019 1/27/2020 11:28 am Program Code Unwei ghted Unwei ghted Program Name Ratio (col. 3/ (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0. 00 0. 00 0.000000 65.00 trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0. 00 0.000000 66.00 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) Program Name Unwei ghted Ratio (col. 3/ Program Code Unwei ahted FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)) (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most O 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF N 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)

Miscellaneous Cost Reporting Information						
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no i			N		0 11	15. 00
is yes, enter the method used (A, B, or E only) in column 2. If column 2	is "E", enter i	n column				
3 either "93" percent for short term hospital or "98" percent for long te	rm care (includ	es				
psychiatric, rehabilitation and long term hospitals providers) based on t	he definition i	n CMS				
Pub. 15-1, chapter 22, §2208. 1.						
116.00 s this facility classified as a referral center? Enter "Y" for yes or "N	" for no.		N		111	16. 00
117.00 s this facility legally-required to carry malpractice insurance? Enter "		N" for	N	1 1	11	17. 00
no.						
118.00 s the malpractice insurance a claims-made or occurrence policy? Enter 1	if the policy i	s	0	1 1	11-	18. 00
claim-made. Enter 2 if the policy is occurrence.	o pooj .		Ū			
jerariii iiidde. Eriter 2 11 the porrey 13 decurrence.	Premi ums	Losses		Insurar	nce	
	1 T Cilli Gills	L033C3		i iisai ai		
	4.00	0.00		2 22		
	1. 00	2. 00		3. 00		10.01
118.01 List amounts of malpractice premiums and paid losses:	0		0		0 11	18. 01
		1. 00		2. 00		
118.02 Are mal practice premiums and paid losses reported in a cost center other	than the	N			11	18. 02
Administrative and General? If yes, submit supporting schedule listing o	ost centers					
and amounts contained therein.						
119. OO DO NOT USE THIS LINE			I		11	19. 00
120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless pro	vision in ACA	N	İ	N	112	20. 00
§3121 and applicable amendments? (see instructions) Enter in column 1, "Y					"	20.00
"N" for no. Is this a rural hospital with < 100 beds that qualifies for t						
Hold Harmless provision in ACA §3121 and applicable amendments? (see inst						
Enter in column 2, "Y" for yes or "N" for no.	i ucti ons)					
121.00 Did this facility incur and report costs for high cost implantable device	a abangad ta	N			1.	21. 00
	s charged to	IN				21.00
patients? Enter "Y" for yes or "N" for no.	() (0) () (00 00
122.00 Does the cost report contain healthcare related taxes as defined in \$1903		N				22. 00
Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", ente	r in column 2					
the Worksheet A line number where these taxes are included.						
Transplant Center Information						
125.00 Does this facility operate a transplant center? Enter "Y" for yes and "N"	for no. If	N			12	25. 00
yes, enter certification date(s) (mm/dd/yyyy) below.						
126.00 If this is a Medicare certified kidney transplant center, enter the certi	fication date				12	26. 00
in column 1 and termination date, if applicable, in column 2.						
127.00 If this is a Medicare certified heart transplant center, enter the certif	ication date				12	27. 00
in column 1 and termination date, if applicable, in column 2.						
128.00 If this is a Medicare certified liver transplant center, enter the certif	ication date				12	28. 00
in column 1 and termination date, if applicable, in column 2.						
129.00 f this is a Medicare certified lung transplant center, enter the certifie	cation date in				12	29. 00
column 1 and termination date, if applicable, in column 2.						
130.00 If this is a Medicare certified pancreas transplant center, enter the cer	tification				13	30. 00
date in column 1 and termination date, if applicable, in column 2.						
131.00 If this is a Medicare certified intestinal transplant center, enter the co	ertification				111	31. 00
date in column 1 and termination date, if applicable, in column 2.	or trirication				'`	01.00
132.00 If this is a Medicare certified islet transplant center, enter the certif	ication data				111	32. 00
in column 1 and termination date, if applicable, in column 2.	i cati on date				'`	32.00
133.00 f this is a Medicare certified other transplant center, enter the certif	ication data				111	33. 00
	ication date					33.00
in column 1 and termination date, if applicable, in column 2.						04.00
134.00 If this is an organ procurement organization (0P0), enter the 0P0 number	in column i				13	34. 00
and termination date, if applicable, in column 2.						
All Providers						
140.00 Are there any related organization or home office costs as defined in CMS		Y		HB004	3 14	40. 00
chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home						
are claimed, enter in column 2 the home office chain number. (see instruc	tions)					

In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-2025 Peri od: Worksheet S-2 From 09/01/2018 Part I 08/31/2019 Date/Time Prepared: To 1/27/2020 11:28 am 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number 141. 00 Name: ACADIANA MANAGEMENT Contractor's Name: NOVITAS Contractor's Number: 07201 141 00 GROUP 142.00 Street: STREET: 101 LA RUE FRANCE, PO Box: 142.00 SUITE 50 143.00 Ci ty: LAFAYETTE State: LA Zip Code: 70508 143.00 1.00 144.00 Are provider based physicians' costs included in Worksheet A? 144. 00 2.00 1 00 145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for 145.00 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. 146.00 Has the cost allocation methodology changed from the previously filed cost report? Ν 146,00 Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.
148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.
149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. 147. 00 N N 148 00 149.00 N Part A Part B Title V Title XIX 1.00 2.00 3.00 4.00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal 155.00 156.00 Subprovi der - IPF Ν Ν Ν N 156 00 157.00 Subprovi der - IRF Ν Ν Ν N 157.00 158. 00 SUBPROVI DER 158. 00 159.00 SNF Ν Ν Ν Ν 159.00 160.00 HOME HEALTH AGENCY 160 00 N N N Ν 161. 00 CMHC Ν Ν Ν 161. 00 161. 10 CORF Ν Ν Ν 161. 10 161. 20 OUTPATIENT PHYSICAL THERAPY Ν Ν 161. 20 Ν 161. 30 OUTPATIENT OCCUPATIONAL THERAPY Ν Ν Ν 161. 30 161. 40 OUTPATIENT SPEECH PATHOLOGY Ν N Ν 161. 40 1 00 Mul ti campus 165.00 s this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 Enter "Y" for yes or "N" for no. CBSA FTE/Campus Name County State Zip Code 0 1.00 2.00 3.00 4.00 5.00 0.00166.00 166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) 1.00 Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00|Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no. N 167.00 168.00 of this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the d168. 00 reasonable cost incurred for the HIT assets (see instructions) 168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions) 168.01 169.00|If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the 0.00169.00 transition factor. (see instructions) Begi nni ng Endi ng 1.00 2.00 170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting 170. 00 period respectively (mm/dd/yyyy)

Health Financial Systems	PECIALTY HOSPIT	In Lie	u of Form CMS-	2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE	OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-2025				
			From 09/01/2018 To 08/31/2019	Date/Time Pre	nared.
			10 00/31/201/	1/27/2020 11:	
			1. 00	2. 00	
171.00 If line 167 is "Y", does th			N	(171. 00
section 1876 Medicare cost					
1876 Medicare days in colum	"				
,	•		1	1	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 15-2025 Peri od: Worksheet S-2 From 09/01/2018 Part II Date/Time Prepared: 08/31/2019 1/27/2020 11:28 am Date 1. 00 2.00 General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation Has the provider changed ownership immediately prior to the beginning of the cost N 1.00 reporting period? If yes, enter the date of the change in column 2. (see instructions) V/I Y/N Date 1.00 2.00 3.00 Has the provider terminated participation in the Medicare Program? If 2.00 2 00 yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary. Is the provider involved in business transactions, including management 3.00 3.00 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/N Date Type 1. 00 2. 00 3.00 Financial Data and Reports Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, 4.00 N 4.00 or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues different from 5.00 those on the filed financial statements? If yes, submit reconciliation. Y/N Legal Oper 1.00 2.00 Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is Ν 6.00 6.00 the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see instructions. 7.00 N 7.00 8.00 Were nursing school and/or allied health programs approved and/or renewed during the N 8.00 cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education 9 00 N 9.00 program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or renewed in the current 10.00 N 10.00 cost reporting period? If yes, see instructions. 11.00 Are GME cost directly assigned to cost centers other than I & R in an Approved N 11.00 Teaching Program on Worksheet A? If yes, see instructions Y/N 1.00 Bad Debts 12.00 Is the provider seeking reimbursement for bad debts? If yes, see instructions. 12.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting Ν 13.00 period? If yes, submit copy. 14.00 If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions Ν 14.00 Bed Complement 15.00 Did total beds available change from the prior cost reporting period? If yes, Ν 15.00 see instructions Part B Part A Y/N Date Y/N Date 1.00 2.00 3.00 4.00 PS&R Data Was the cost report prepared using $\overline{\text{the PS\&R Report onl y?}}$ 12/11/2019 12/11/2019 16.00 Υ 16.00 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) 17.00 Was the cost report prepared using the PS&R Report for Ν N 17.00 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) 18.00 If line 16 or 17 is yes, were adjustments made to PS&R Ν N 18.00 Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R 19.00 N Ν Report data for corrections of other PS&R Report information? If yes, see instructions.

	Financial Systems CENTRAL INDIANA-AMG AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der CC	CN: 15-2025 I	Period: From 09/01/2018	of Form CMS- Worksheet S-: Part II			
				To 08/31/2019	Date/Time Pro 1/27/2020 11			
		Descri		Y/N	Y/N			
20.00	If line 16 or 17 is yes, were adjustments made to PS&R	C)	1. 00 N	3. 00 N	20.00		
	Report data for Other? Describe the other adjustments:					20.00		
		Y/N 1. 00	2. 00	Y/N 3. 00	<u>Date</u> 4. 00			
21. 00	Was the cost report prepared only using the provider's	N N	2.00	3. 00 N	4.00	21. 00		
	records? If yes, see instructions.							
				-	1. 00			
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS HO	OSPI TALS)					
	Capital Related Cost							
22. 00 23. 00	Have assets been relifed for Medicare purposes? If yes, see Have changes occurred in the Medicare depreciation expense		als made duri	na the cost		22. 00		
23.00	reporting period? If yes, see instructions.	due to apprais	ars made durin	ig the cost		23.00		
24. 00	Were new leases and/or amendments to existing leases entere	d into during	this cost repo	orting period?		24. 00		
25. 00	If yes, see instructions O Have there been new capitalized leases entered into during the cost reporting period? If yes, see							
20.00	instructions.	2031 1 cp01	ig poi i ou: i	. , , 500, 500		25. 00		
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during th	e cost reporti	ng period? If	yes, see		26. 00		
27 00	instructions. Has the provider's capitalization policy changed during the	cost reportin	a period? If v	ves submit		27. 00		
27.00	copy.		g po ou	,00, 000 1				
20.00	Interest Expense	tonod into dun	ing the east i	conomting		1 20 00		
28.00	Were new loans, mortgage agreements or letters of credit en period? If yes, see instructions.	iterea into auri	ing the cost i	reporting		28. 00		
29. 00	Did the provider have a funded depreciation account and/or		bt Service Res	serve Fund)		29. 00		
20.00	treated as a funded depreciation account? If yes, see instr		dob+2 l£ voo			20.00		
30. 00	Has existing debt been replaced prior to its scheduled matu instructions.	irity with new o	debt? II yes,	see		30.00		
31.00	Has debt been recalled before scheduled maturity without is	suance of new	debt? If yes,	see		31. 00		
	instructions. Purchased Services							
32. 00	Have changes or new agreements occurred in patient care ser	vi ces furni she	d through con	tractual		32. 00		
	arrangements with suppliers of services? If yes, see instru							
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.	olied pertaining	g to competiti	ve bidding? If		33. 00		
	Provi der-Based Physi ci ans							
34. 00	Are services furnished at the provider facility under an ar	rangement with	provi der-base	ed physi ci ans?		34. 00		
35 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended exi	sting agreemen	ts with the n	rovi der-based		35. 00		
	physicians during the cost reporting period? If yes, see in		to with the pi	ovi dei based		00.00		
				Y/N	Date			
	Home Office Costs			1. 00	2. 00			
	Were home office costs claimed on the cost report?					36. 00		
37. 00	If line 36 is yes, has a home office cost statement been pr	epared by the I	home office?			37. 00		
38. 00	If yes, see instructions. If line 36 is yes , was the fiscal year end of the home off	ice different	from that of			38. 00		
	the provider? If yes, enter in column 2 the fiscal year end	of the home o	ffi ce.					
	If line 36 is yes, did the provider render services to othe	r chain compon	ents? If yes,			39. 00		
39. 00								
	see instructions.	home office?	If yes, see			40. 00		
		home office?	If yes, see			40. 00		
	see instructions. If line 36 is yes, did the provider render services to the			2.0	0	40.00		
	see instructions. If line 36 is yes, did the provider render services to the	home office?		2.0	0	40. 00		
40. 00	see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position			2. 0	0	40.00		
40. 00	see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	1. (0			
40. 00	see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	1. (00		0			
40. 00 41. 00 42. 00	see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report preparer.	1. (MI CHAEL	00			41.00		

Heal th	Financial Systems CENTRAL IN	NDI ANA-AMG	SPECIALTY HOSPIT	In Lieu of Form CMS-2552-10		
HOSPI T	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTION	INAI RE	Provider CCN: 15-202	eriod: rom 09/01/2018	Worksheet S-2 Part II	
					Date/Time Pre 1/27/2020 11:	pared: 28 am
			3. 00			
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/posi	ition	MANAGING DIRECTOR			41. 00
	held by the cost report preparer in columns 1, 2,	and 3,				
	respecti vel y.					
42.00	Enter the employer/company name of the cost report	t				42. 00
	preparer.					
43.00	Enter the telephone number and email address of the	he cost				43.00
	report preparer in columns 1 and 2, respectively.					

						10	00/31/2019	1/27/2020 11		
								I/P Days / 0/		<u> </u>
								Visits / Trip		
	Component	Worksheet A	No.	of Beds	Bed Days		CAH Hours	Title V	_	
		Line Number			Avai I abl e					
		1. 00		2. 00	3.00		4. 00	5. 00	\top	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		41		65	0.00		o	1. 00
	8 exclude Swing Bed, Observation Bed and									
	Hospice days) (see instructions for col. 2									
	for the portion of LDP room available beds)									
2.00	HMO and other (see instructions)									2.00
3.00	HMO IPF Subprovider									3.00
4.00	HMO IRF Subprovider									4.00
5.00	Hospital Adults & Peds. Swing Bed SNF								0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF								0	6.00
7.00	Total Adults and Peds. (exclude observation			41	14, 9	65	0.00		0	7.00
	beds) (see instructions)									
8.00	INTENSIVE CARE UNIT									8. 00
9. 00	CORONARY CARE UNIT									9. 00
10. 00	BURN INTENSIVE CARE UNIT									10.00
11. 00	SURGICAL INTENSIVE CARE UNIT									11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)									12. 00
13. 00	NURSERY									13. 00
14. 00	Total (see instructions)			41	14, 9	65	0. 00		0	14. 00
15. 00	CAH visits								0	15. 00
16. 00	SUBPROVI DER - I PF								-	16.00
17. 00	SUBPROVI DER - I RF								-	17. 00
18.00	SUBPROVI DER								-	18.00
19.00	SKILLED NURSING FACILITY								-	19. 00
20.00	NURSING FACILITY OTHER LONG TERM CARE									20. 00 21. 00
21. 00 22. 00	HOME HEALTH AGENCY								-	22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)								-	23. 00
24. 00	HOSPI CE								-	24. 00
24. 10	HOSPICE (non-distinct part)	30. 00							-	24. 10
25. 00	CMHC - CMHC	30.00							1	25. 00
25. 10	CMHC - CORF	99. 10							ol	25. 10
25. 20	CMHC - OUTPATIENT PHYSICAL THERAPY	99. 20							ŏ	25. 20
25. 30	CMHC - OUTPATIENT OCCUPATIONAL THERAPY	99. 30							o	25. 30
25. 40	CMHC - OUTPATIENT SPEECH PATHOLOGY	99. 40							ŏ	25. 40
26. 00	RURAL HEALTH CLINIC								1	26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00							ol	26. 25
27. 00	Total (sum of lines 14-26)			41	ıİ					27. 00
28. 00	Observation Bed Days								ol	28. 00
29. 00	Ambul ance Trips									29. 00
30.00	Employee discount days (see instruction)								- [30.00
31.00	Employee discount days - IRF									31.00
32.00	Labor & delivery days (see instructions)			(0				32.00
32. 01	Total ancillary labor & delivery room									32. 01
	outpatient days (see instructions)									
33. 00	LTCH non-covered days									33.00
33. 01	LTCH site neutral days and discharges									33. 01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-2025

Peri od: Worksheet S-3 From 09/01/2018 Part I To 08/31/2019 Date/Time Prepared:

1/27/2020 11:28 am Full Time Equivalents I/P Days / O/P Visits / Trips Title XVIII Component Title XIX Total All Total Interns Employees On Pati ents & Residents Payrol I 7.00 6.00 8.00 9.00 10.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 5, 854 7, 731 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2 00 HMO and other (see instructions) 2 00 0 81 3.00 HMO IPF Subprovider 0 C 3.00 HMO IRF Subprovider 4.00 0 4.00 Hospital Adults & Peds. Swing Bed SNF 0 0 5.00 5.00 Hospital Adults & Peds. Swing Bed NF 6.00 0 0 6.00 7.00 Total Adults and Peds. (exclude observation 5,854 7,731 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 8.00 CORONARY CARE UNIT 9.00 9.00 10.00 BURN INTENSIVE CARE UNIT 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 13.00 NURSERY 13.00 67.00 14.00 Total (see instructions) 5,854 7,731 0.00 14.00 CAH visits 15.00 15.00 SUBPROVIDER - IPF 16.00 16.00 SUBPROVIDER - IRF 17.00 17.00 18.00 SUBPROVI DER 18.00 19.00 SKILLED NURSING FACILITY 19.00 20 00 NURSING FACILITY 20 00 21.00 OTHER LONG TERM CARE 21.00 22.00 HOME HEALTH AGENCY 22.00 23.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 HOSPI CE 24.00 24 00 24. 10 HOSPICE (non-distinct part) 0 24.10 CMHC - CMHC 25.00 25.00 25. 10 CMHC - CORF 0.00 0.00 25. 10 0 0 0 CMHC - OUTPATIENT PHYSICAL THERAPY 0 0.00 0 0.00 25. 20 25 20 25. 30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY 0 0 0.00 0.00 25.30 CMHC - OUTPATIENT SPEECH PATHOLOGY 0 0.00 0.00 25.40 RURAL HEALTH CLINIC 26, 00 26, 00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0 Ω 0 0.00 0.00 26.25 27.00 Total (sum of lines 14-26) 0.00 67.00 27.00 28.00 Observation Bed Days 0 C 28.00 Ambulance Trips 0 29 00 29 00 30.00 Employee discount days (see instruction) 30.00 Employee discount days - IRF 0 31.00 31.00 Labor & delivery days (see instructions) 32.00 32.00 0 0 0 32.01 Total ancillary labor & delivery room 0 32.01 outpatient days (see instructions) 33.00 LTCH non-covered days 33.00 33.01 LTCH site neutral days and discharges 777 33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-2025

Worksheet S-3 From 09/01/2018 Part I Date/Time Prepared: 08/31/2019

Peri od:

1/27/2020 11:28 am Full Time Di scharges Equi val ents Title XVIII Total All Component Nonpai d Title V Title XIX Workers Pati ents 12.00 13.00 14.00 11.00 15.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 236 310 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2 00 HMO and other (see instructions) O 2 00 3.00 HMO IPF Subprovider 0 3.00 HMO IRF Subprovider 4.00 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 5.00 Hospital Adults & Peds. Swing Bed NF 6.00 6.00 7.00 Total Adults and Peds. (exclude observation 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 8.00 CORONARY CARE UNIT 9.00 9.00 BURN INTENSIVE CARE UNIT 10.00 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 13.00 NURSERY 13.00 14.00 Total (see instructions) 0.00 0 236 0 310 14.00 CAH visits 15.00 15.00 SUBPROVIDER - IPF 16.00 16.00 SUBPROVIDER - IRF 17.00 17.00 18.00 SUBPROVI DER 18.00 19.00 SKILLED NURSING FACILITY 19.00 20 00 NURSING FACILITY 20 00 21.00 OTHER LONG TERM CARE 21.00 22.00 HOME HEALTH AGENCY 22.00 23.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 HOSPI CE 24.00 24 00 24. 10 HOSPICE (non-distinct part) 24. 10 25. 00 CMHC - CMHC 25.00 25. 10 CMHC - CORF 0.00 25. 10 CMHC - OUTPATIENT PHYSICAL THERAPY 0.00 25 20 25. 20 CMHC - OUTPATIENT OCCUPATIONAL THERAPY 25. 30 0.00 25.30 CMHC - OUTPATIENT SPEECH PATHOLOGY 0.00 25.40 RURAL HEALTH CLINIC 26.00 26, 00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0 00 26 25 27. 00 Total (sum of lines 14-26) 0.00 27.00 28.00 Observation Bed Days 28.00 Ambulance Trips 29 00 29 00 30.00 Employee discount days (see instruction) 30.00 Employee discount days - IRF 31.00 31.00 Labor & delivery days (see instructions) 32.00 32.00 Total ancillary labor & delivery room 32.01 32.01 outpatient days (see instructions) 33.00 LTCH non-covered days 0 33.00 33.01 LTCH site neutral days and discharges 36 33.01

Health Financial Systems CENTRAL INDIANA-AMG SPECIALTY HOSPIT In Lieu of Form CMS-2552-10

HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-2025 From 09/01/2018 Part II

To 08/31/2019 Date/Time Prepared: 1/27/2020 11: 28 am

					10	08/31/2019	Date/lime Prep 1/27/2020 11:	
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst.	Salaries (col.2 ± col.	Related to Salaries in	Average Hourly Wage (col. 4 ÷ col. 5)	e um
		1. 00	2.00	A-6) 3. 00	3) 4. 00	<u>col . 4</u> 5. 00	6. 00	
	PART II - WAGE DATA							
1. 00	SALARIES Total salaries (see	200. 00	3, 963, 490	0	3, 963, 490	140, 018. 00	28. 31	1. 00
1.00	instructions)	200.00	3, 703, 470	0	3, 703, 470	140, 018. 00	20. 31	1.00
2.00	Non-physician anesthetist Part		0	0	0	0. 00	0. 00	2. 00
3.00	Non-physician anesthetist Part		0	0	0	0.00	0. 00	3. 00
	В							
4. 00	Physician-Part A - Administrative		0	0	0	0. 00	0. 00	4. 00
4. 01	Physicians - Part A - Teaching		0	0	0	0.00		
5. 00	Physician and Non Physician-Part B		0	0	0	0. 00	0. 00	5. 00
6.00	Non-physician-Part B for		0	0	0	0.00	0. 00	6. 00
	hospital-based RHC and FQHC							
7. 00	services Interns & residents (in an	21. 00	0	О	0	0.00	0. 00	7. 00
7.04	approved program)					2 22	0.00	7.04
7. 01	Contracted interns and residents (in an approved		0	0	0	0. 00	0. 00	7. 01
	programs)							
8. 00	Home office and/or related organization personnel		0	0	0	0. 00	0. 00	8. 00
9.00	SNF	44. 00	0	0	0	0.00		
10. 00	Excluded area salaries (see instructions)		0	0	0	0. 00	0. 00	10. 00
	OTHER WAGES & RELATED COSTS							
11. 00	Contract labor: Direct Patient Care		0	0	0	0. 00	0. 00	11. 00
12. 00	Contract Labor: Top Level		0	0	0	0.00	0.00	12. 00
	management and other							
	management and administrative services							
13. 00	Contract Labor: Physician-Part		0	0	0	0.00	0. 00	13. 00
14. 00	A - Administrative Home office and/or related		0	0	0	0.00	0.00	14. 00
	organization salaries and			-				
14. 01	wage-related costs Home office salaries		0	0	0	0.00	0.00	14. 01
14. 02	Related organization salaries		0	0	0	0.00	0. 00	14. 02
15. 00	Home office: Physician Part A - Administrative		0	0	0	0. 00	0. 00	15. 00
16. 00	Home office and Contract		0	0	0	0.00	0. 00	16. 00
	Physicians Part A - Teaching WAGE-RELATED COSTS							
17. 00	Wage-related costs (core) (see		0	0	0			17. 00
18. 00	instructions)		0	0	0			18. 00
16.00	Wage-related costs (other) (see instructions)		U	0				16.00
19. 00	Excluded areas		0	0	-			19.00
20. 00	Non-physician anesthetist Part A		Ü	0	0			20. 00
21. 00	Non-physician anesthetist Part		0	0	0			21. 00
22. 00	Physician Part A -		0	0	0			22. 00
22 01	Administrative		2	_				22 01
22. 01 23. 00	Physician Part A - Teaching Physician Part B		0	0 0	-			22. 01 23. 00
24. 00	Wage-related costs (RHC/FQHC)		0	0	1			24. 00
25. 00	Interns & residents (in an approved program)		0	0	0			25. 00
25. 50	Home office wage-related		0	0	0			25. 50
25. 51	(core) Related organization		Ω	0	0			25. 51
	wage-related (core)		0					
25. 52	Home office: Physician Part A - Administrative -		0	0	0			25. 52
	wage-related (core)							a= - ·
25. 53	Home office & Contract Physicians Part A - Teaching -		0	0	0			25. 53
	wage-related (core)							
26. 00	OVERHEAD COSTS - DIRECT SALARIE Employee Benefits Department	ES 4. 00	0	0	O	0.00	0.00	26. 00
27. 00	Administrative & General	5. 00	647, 077			25, 811. 00		27. 00
		,			,			

HOSPITAL WAGE INDEX INFORMATION

Provi der CCN: 15-2025

Peri od: Worksheet S-3 From 09/01/2018 Part II To 08/31/2019 Date/Time Prepared:

1/27/2020 11:28 am Wkst. A Line Amount Recl assi fi cati Adj usted Pai d Hours Average Hourly Number Reported on of Salaries Sal ari es Related to Wage (col. 4 (col . 2 ± col . (from Wkst. Salaries in col . 5) 3) col. 4 A-6) 1.00 2.00 5. 00 6.00 3.00 4.00 28.00 Administrative & General under 0 0 0.00 0.00 28.00 contract (see inst.) 29.00 Maintenance & Repairs 6.00 0.00 0.00 29.00 0 0 0 0 Operation of Plant 30.00 7.00 0 0 0.00 0.00 30.00 0 0 0.00 31.00 Laundry & Linen Service 8.00 0.00 31.00 32.00 Housekeepi ng 9.00 0 0 0.00 0.00 32.00 33.00 Housekeeping under contract 0 0 0.00 0.00 33.00 (see instructions) 34.00 28, 800 0 28, 800 0.00 34.00 10.00 0.00 Di etary 35.00 Di etary under contract (see 0 0.00 0.00 35.00 instructions) 36.00 Cafeteri a 11.00 0 0 0.00 0.00 36.00 0.00 Maintenance of Personnel 0 37.00 12.00 0 0 0.00 37.00 38.00 Nursing Administration 13.00 0 0 0 0.00 0.00 38.00 39.00 Central Services and Supply 14.00 0 0 0 0.00 0.00 39.00 Pharmacy 0 0 0.00 40.00 15.00 0 0.00 40.00 Medical Records & Medical 0 41.00 16.00 120, 130 120, 130 4, 247. 00 28. 29 41.00 Records Library Social Service 0 0.00 42.00 42.00 17.00 0 0 0.00 0.00 43.00 43.00 Other General Service 18.00 0 0.00

Total overhead cost (see

instructions)

7.00

26. 48

7.00

HOSPITAL WAGE INDEX INFORMATION Worksheet S-3 Part III Date/Time Prepared: Provi der CCN: 15-2025 Peri od: From 09/01/2018 To 08/31/2019 1/27/2020 11:28 am Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours Average Hourly Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 (col . 2 ± col . col. 5) (from Salaries in Works<u>heet A-6)</u> 3) col. 4 1.00 4.00 5.00 6.00 2.00 3.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 3, 963, 490 3, 963, 490 140, 018. 00 28. 31 1.00 instructions) 2.00 Excluded area salaries (see 0 0.00 0.00 2.00 0 0 instructions) 3.00 Subtotal salaries (line 1 3, 963, 490 0 3, 963, 490 140, 018. 00 28. 31 3.00 minus line 2) 4.00 Subtotal other wages & related 0.00 0.00 4.00 costs (see inst.) Subtotal wage-related costs 5.00 0 0 0 0.00 0.00 5.00 (see inst.) Total (sum of lines 3 thru 5) 6.00 6.00 3, 963, 490 0 3, 963, 490 140, 018. 00 28 31

796,007

796,007

30, 058. 00

Health Financial Systems CENTRAL INDIANA-AMG SPECIALTY HOSPIT In Lieu of Form CMS-2552-10 HOSPITAL WAGE RELATED COSTS Provider CCN: 15-2025 Peri od: Worksheet S-3 From 09/01/2018 Part IV 08/31/2019 Date/Time Prepared: 1/27/2020 11:28 am Amount Reported 1.00 PART IV - WAGE RELATED COSTS Part A - Core List RETIREMENT COST 401K Employer Contributions 38, 803 1.00 Tax Sheltered Annuity (TSA) Employer Contribution 2.00 0 Nonqualified Defined Benefit Plan Cost (see instructions) 0 3.00 Qualified Defined Benefit Plan Cost (see instructions) 0 4.00 PLAN ADMINISTRATIVE COSTS (Paid to External Organization) 5.00 401K/TSA Plan Administration fees 0 Legal /Accounting/Management Fees-Pension Plan 0 6.00 Employee Managed Care Program Administration Fees 0 7.00 HEALTH AND INSURANCE COST Health Insurance (Purchased or Self Funded) 0 8.00 Health Insurance (Self Funded without a Third Party Administrator) 0 8.01 Health Insurance (Self Funded with a Third Party Administrator) 8.02 0 Health Insurance (Purchased) 153, 844 8.03 Prescription Drug Plan 0 9.00 Dental, Hearing and Vision Plan 10.00

	i Financiai Systems Centr					u or Form CWS-2	2552-10
RECLA	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der C	CN: 15-2025 P	eri od:	Worksheet A	
					rom 09/01/2018 o 08/31/2019		narodi
				1	o 08/31/2019	Date/Time Pre 1/27/2020 11:	
	Cost Contor Doscription	Sal ari es	Other	Total (col 1	Recl assi fi cati	Reclassi fi ed	20 alli
	Cost Center Description	Sai ai i es	Other	,			
				+ col . 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
		1.00			4.00	col . 4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1. 00	00100 CAP REL COSTS-BLDG & FIXT		977, 312			977, 312	1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		0) C	0	0	2. 00
3.00	00300 OTHER CAP REL COSTS		0) C	0	0	3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	615, 937	615, 937	0	615, 937	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	647, 077	2, 717, 664	3, 364, 741	0	3, 364, 741	5. 00
6.00	00600 MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700 OPERATION OF PLANT	o	129, 049	129, 049	0	129, 049	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	ol	31, 671			31, 671	8. 00
9. 00	00900 HOUSEKEEPI NG	0	201, 511			201, 511	9. 00
10. 00	01000 DI ETARY	28, 800	173, 538			202, 338	
11. 00	01100 CAFETERI A	20,000	170,000) 202, 000		0	11. 00
12. 00	1 1		0		-	0	12. 00
13. 00	01300 NURSING ADMINISTRATION		0		-	0	13. 00
			0	1	_	0	
14. 00	1 1	0	U		_	0	14. 00
15. 00		0	0	0	_	0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	120, 130	30, 002		. 0	150, 132	16. 00
17. 00	l l	0	0	0	0	0	17. 00
18. 00	01850 RECREATIONAL THERAPY	0	0) C	0	0	18. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0) C	0	0	19. 00
20.00	02000 NURSI NG SCHOOL	0	0	0	0	0	20.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21. 00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	o	0) c	0	0	22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	ol	0		0	0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	-1					
30.00		2, 759, 872	1, 145, 611	3, 905, 483	0	3, 905, 483	30. 00
00.00	ANCI LLARY SERVI CE COST CENTERS	2//0//0/2	.,	0,700,100		0,700,100	00.00
50. 00	05000 OPERATI NG ROOM	٥	188, 675	188, 675	0	188, 675	50. 00
54. 00	1 1	4, 362	143, 905			148, 267	
60. 00	06000 LABORATORY	4, 302	252, 875				
		0	252, 675				
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	2/0 527	-	1	_	742.072	62. 30
65. 00	06500 RESPI RATORY THERAPY	369, 527	374, 445			743, 972	65. 00
66. 00	06600 PHYSI CAL THERAPY	773	102, 871			103, 644	66. 00
67. 00		0	144, 227			144, 227	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	95, 713			95, 713	
71. 00	1	32, 949	0	1,		32, 949	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	1, 111, 426	1, 111, 426	0	1, 111, 426	73. 00
74.00	07400 RENAL DIALYSIS	0	301, 409	301, 409	0	301, 409	74. 00
76. 97	07697 CARDIAC REHABILITATION	0	0	0	0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0) C	0	0	76. 98
76. 99	07699 LI THOTRI PSY	o	0		0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS			•			
92 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS			1		I.	
99. 10		0	0	0	0	0	99. 10
99. 20	l l		0	1		1	99. 20
99. 30			0				
		- 1		1		1	
99. 40		0	0) C	0	0	99. 40
440.0	SPECIAL PURPOSE COST CENTERS	0.0(0.100	0.707.011	40.704.004		40 704 001	440.00
118. 0		3, 963, 490	8, 737, 841	12, 701, 331	0	12, 701, 331	118.00
0.5-	NONREI MBURSABLE COST CENTERS			10			
200. 0	TOTAL (SUM OF LINES 118 through 199)	3, 963, 490	8, 737, 841	12, 701, 331	0	12, 701, 331	J200. 00

Heal th FinancialSystemsCENTRAL INDIANA-AMGSPECIALTY HOSPITRECLASSIFICATIONAND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSESProvider CCN: 1

Provi der CCN: 15-2025

| Period: | Worksheet A | From 09/01/2018 | To 08/31/2019 | Date/Time Prepared: 1/27/2020 11: 28 am

			1/27/2020 11:	28 am
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For Allocation		
	6. 00	7. 00		
GENERAL SERVICE COST CENTERS				
1.00 O0100 CAP REL COSTS-BLDG & FLXT	-393	976, 919		1. 00
2.00 O0200 CAP REL COSTS-MVBLE EQUIP	0	0		2. 00
3.00 00300 OTHER CAP REL COSTS	0	0		3. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	615, 937		4. 00
5.00 00500 ADMINISTRATIVE & GENERAL	-987, 699	2, 377, 042		5. 00
6.00 00600 MAINTENANCE & REPAIRS	0	o		6. 00
7.00 00700 OPERATION OF PLANT	o	129, 049		7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	o	31, 671		8. 00
9. 00 00900 HOUSEKEEPI NG	0	201, 511		9. 00
10. 00 01000 DI ETARY	O	202, 338		10.00
11. 00 01100 CAFETERI A	0	202,000		11.00
12. 00 01200 MAI NTENANCE OF PERSONNEL	0	0		12. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	o	0		13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	0		14.00
15. 00 01500 PHARMACY		0		15. 00
l l	1	-1		
16. 00 01600 MEDI CAL RECORDS & LI BRARY	-667	149, 465		16.00
17. 00 01700 SOCIAL SERVICE	0	0		17. 00
18. 00 01850 RECREATIONAL THERAPY	0	0		18. 00
19. 00 01900 NONPHYSI CI AN ANESTHETI STS	0	0		19. 00
20. 00 02000 NURSI NG SCHOOL	0	0		20. 00
21.00 02100 1 &R SERVI CES-SALARY & FRINGES APPRV	0	0		21. 00
22.00 02200 1 &R SERVICES-OTHER PRGM COSTS APPRV	0	0		22. 00
23.00 O2300 PARAMED ED PRGM-(SPECIFY)	0	0		23. 00
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS	0	3, 905, 483		30.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	188, 675		50. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	148, 267		54.00
60. 00 06000 LABORATORY	0	252, 875		60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62. 30
65. 00 06500 RESPIRATORY THERAPY	0	743, 972		65. 00
66. 00 06600 PHYSI CAL THERAPY	0	103, 644		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	144, 227		67. 00
68. 00 06800 SPEECH PATHOLOGY	0	95, 713		68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	32, 949		71. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	1, 111, 426		73. 00
74.00 07400 RENAL DIALYSIS	o	301, 409		74. 00
76. 97 07697 CARDI AC REHABILI TATI ON	Ö	0		76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	ő	o		76. 98
76. 99 07699 LI THOTRI PSY	o	0		76. 99
OUTPATIENT SERVICE COST CENTERS		U		10.99
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART				92. 00
OTHER REIMBURSABLE COST CENTERS				42.00
99. 10 09910 CORF	0	0		99. 10
99. 10 09910 CORF 99. 20 09920 OUTPATI ENT PHYSI CAL THERAPY	0	0		99. 10
· · · · · · · · · · · · · · · · · · ·	- 1	-1		
99. 30 09930 OUTPATI ENT OCCUPATI ONAL THERAPY	0	0		99. 30
99. 40 O9940 OUTPATIENT SPEECH PATHOLOGY	0	0		99. 40
SPECIAL PURPOSE COST CENTERS				4
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	988, 759	11, 712, 572		118. 00
NONREI MBURSABLE COST CENTERS	1 1			4
200.00 TOTAL (SUM OF LINES 118 through 199)	-988, 759	11, 712, 572		200. 00

Heal th Financial Systems CENTRAL INDIANA-AMG SPECIALTY HOSPIT In Lieu of Form CMS-2552-10

RECLASSIFICATIONS Provider CCN: 15-2025 Period: From 09/01/2018 To 08/31/2019 Date/Time Prepared: 1/27/2020 11:28 am

						lo 08/31/2019	Date/lime Pr	
							1/27/2020 1	:28 am
	Cost Center	Li ne #	Sal ary	Other				
	2. 00	3. 00	4. 00	5. 00				
	A - DEFAULT							
1.00	L	0.00	0	0				1. 00
	0		0	0				
500.00	Grand Total: Increases		0	0				500.00

Health Financial Systems RECLASSIFICATIONS

CENTRAL INDIANA-AMG SPECIALTY HOSPIT

In Lieu of Form CMS-2552-10

Provider CCN: 15-2025 Peri od: Worksheet A-6 From 09/01/2018 To 08/31/2019 Date/Time Prepared:

						1/27/2020 11	:28 am
	Decreases						
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
	A - DEFAULT						
1.00		0.00	0	() (0	1.00
	0		0	(
500.00	Grand Total: Decreases		0	(500.00

Subtotal (sum of lines 1-7)

Reconciling Items

10.00 Total (line 8 minus line 9)

8.00

9.00

8.00

9.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 15-2025 Peri od: Worksheet A-7 From 09/01/2018 Part I Date/Time Prepared: 08/31/2019 1/27/2020 11:28 am Acqui si ti ons Begi nni ng Purchases Total Di sposal s and Donati on Bal ances Retirements 2.00 3.00 4. 00 5. 00 1 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 0 1.00 0 0 0 2.00 Land Improvements 0 2.00 0 3. 00 3.00 Buildings and Fixtures Ω 0 Building Improvements 0 4.00 110, 439 0 0 0 4.00 5.00 Fixed Equipment 0 0 5.00 0 6.00 Movable Equipment 963, 632 50, 281 50, 281 0 6.00 0 7.00 HIT designated Assets 0 7.00 0 0 8.00 Subtotal (sum of lines 1-7) 1,074,071 50, 281 50, 281 0 8.00 9.00 Reconciling Items 0 0 9.00 Total (line 8 minus line 9) 1,074,071 50, 281 0 50, 281 10.00 10.00 0 Endi ng Bal ance Fully Depreci ated Assets 6.00 7. 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 0 1.00 2.00 Land Improvements 0 0 2.00 3.00 Buildings and Fixtures 0 3.00 0) 4.00 Building Improvements 110, 439 4.00 5.00 Fi xed Equipment 0 5.00 Movable Equipment 0 6.00 1, 013, 913 6.00 7.00 HIT designated Assets 0 7.00

1, 124, 352

1, 124, 352

0

Health Financial Systems	CENTRAL INDIANA-AMG SPECIALTY HOSPIT	In Lie	u of Form CMS-2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS	Provi der CCN: 15-2025	Peri od:	Worksheet A-7

RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider Co		Period: From 09/01/2018		
					To 08/31/2019	Date/Time Prep 1/27/2020 11:2	
			SUMMARY OF CAPITAL				
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12. 00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	321, 869	639, 031	5, 91	3 21, 859	-11, 360	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		o o	0	2.00
3.00	Total (sum of lines 1-2)	321, 869	639, 031	5, 91	3 21, 859	-11, 360	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM					
1. 00	CAP REL COSTS-BLDG & FIXT	0	977, 312				1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2. 00
3.00	Total (sum of lines 1-2)	0	977, 312				3. 00

Health Financial Systems CENTR	_ INDIANA-AMG SPECIALTY HOSPIT	In Lieu of Form CMS-2552-10			
RECONCILIATION OF CAPITAL COSTS CENTERS		Peri od: From 09/01/2018 To 08/31/2019	Worksheet A-7 Part III Date/Time Pre 1/27/2020 11:		
	COMPUTATION OF RATIOS	ALLOCATION OF	OTHER CAPITAL		

					rom 09/01/2018 o 08/31/2019	Part III Date/Time Prep	oorod:
				1	0 00/31/2019	1/27/2020 11: 2	
		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
	Cost Center Description	Gross Assets	Capi tali zed	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio	instructions)		
				(col. 1 - col.			
		1.00	2.00	2) 3. 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C		2.00	3.00	4.00	5.00	
1.00	CAP REL COSTS-BLDG & FLXT	1 0	0	1 0	1. 000000	0	1. 00
2. 00	CAP REL COSTS-MVBLE EQUIP	0	٥	0	0. 000000	ő	2. 00
3. 00	Total (sum of lines 1-2)	0	l o	ō	1. 000000	ol	3. 00
		ALLOCA ⁻	TION OF OTHER (CAPI TAL	SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)	0.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	6. 00	7. 00	8. 00	9. 00	10. 00	
1. 00	CAP REL COSTS-BLDG & FIXT	INTERS 0			321, 476	639, 031	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0			321, 470	037, 031	2. 00
3. 00	Total (sum of lines 1-2)	0	0	0	321, 476	639, 031	3. 00
0.00	Tretar (Sam of Trinse 1 2)	J	Sl	JMMARY OF CAPIT		0077001	0.00
	Cost Center Description	Interest	Insurance (see			Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate		
					d Costs (see	through 14)	
		11.00	10.00	10.00	instructions)	45.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	11.00	12.00	13.00	14. 00	15. 00	
1. 00	CAP REL COSTS-BLDG & FIXT	5, 913	21, 859	-11, 360	O	976, 919	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	3, 713	21,037	-11, 300	0	970, 919	2. 00
3.00	Total (sum of lines 1-2)	5, 913	21, 859	-11, 360	0	976, 919	3. 00
		-, -, -			-1	,	

| Period: | Worksheet A-8 | From 09/01/2018 | To 08/31/2019 | Date/Time Prepared: Health Financial Systems
ADJUSTMENTS TO EXPENSES CENTRAL INDIANA-AMG SPECIALTY HOSPIT
Provider CCN: 15-2025

				To	08/31/2019	Date/Time Prep 1/27/2020 11:2	
	Expense Classification on Worksheet A					1/2//2020 11.2	20 alli
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
1.00	Investment income - CAP REL	1. 00 B	2. 00	3.00 CAP REL COSTS-BLDG & FIXT	4. 00 1. 00	5. 00	1. 00
	COSTS-BLDG & FIXT (chapter 2)						
2. 00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
3.00	Investment income - other (chapter 2)		0		0. 00	0	3. 00
4.00	Trade, quantity, and time		0		0. 00	0	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of		0		0. 00	0	5. 00
	expenses (chapter 8)						
6. 00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6. 00
7. 00	Tel ephone services (pay stations excluded) (chapter		0		0. 00	0	7. 00
	21)		_			_	
8. 00	Television and radio service (chapter 21)		0		0. 00	0	8. 00
9.00	Parking Lot (chapter 21)	4.0.2	751 740		0. 00	0	9.00
10. 00	Provider-based physician adjustment	A-8-2	-751, 769			0	10. 00
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0. 00	0	11. 00
12. 00	Related organization	A-8-1	-178, 527			0	12. 00
13. 00	transactions (chapter 10) Laundry and linen service		0		0. 00	0	13. 00
14.00	Cafeteria-employees and guests	1	0		0.00	0	14.00
15. 00	Rental of quarters to employee and others	·	U		0. 00	0	15. 00
16. 00	Sale of medical and surgical supplies to other than		0		0. 00	0	16. 00
47.00	pati ents				0.00		47.00
17. 00	Sale of drugs to other than patients		U		0. 00	0	17. 00
18. 00	Sale of medical records and abstracts	В	-667	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	Nursing and allied health		0		0. 00	0	19. 00
	education (tuition, fees, books, etc.)						
20. 00 21. 00	Vending machines Income from imposition of		0		0. 00 0. 00	0	20. 00 21. 00
21.00	interest, finance or penalty		O		0.00	Ŭ	21.00
22. 00	charges (chapter 21) Interest expense on Medicare		0		0. 00	0	22. 00
	overpayments and borrowings to repay Medicare overpayments						
23. 00	Adjustment for respiratory	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
000	(chapter 21)			04B BEL 000TO BLBO & ELVE			0.4 00
26. 00	Depreciation - CAP REL COSTS-BLDG & FLXT		0	CAP REL COSTS-BLDG & FIXT	1. 00	0	26. 00
27. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
28. 00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19. 00		28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	0. 00 67. 00	0	29. 00 30. 00
	therapy costs in excess of limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00	instructions) 0 Adjustment for speech A-8-3 OS		SPEECH PATHOLOGY	68. 00		31. 00	
	pathology costs in excess of			22.00			
32. 00	1		0		0. 00	0	32. 00
33. 00	Depreciation and Interest ADVERTISING	A	-57. 403	ADMINISTRATIVE & GENERAL	5. 00	O	33. 00
	1		37, 100	, J	3. 30	<u> </u>	

Heal th	Financial Systems	CENTR	AL INDIANA-AMG	In Lieu of Form CMS-2552-10			
ADJUST	MENTS TO EXPENSES				Period: From 09/01/2018	Worksheet A-8	
					To 08/31/2019		
				Expense Classification on	Worksheet A		
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3. 00	4. 00	5. 00	
34. 00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	34. 00
	(3)						
35.00	OTHER ADJUSTMENTS (SPECIFY)		o		0.00	0	35. 00
	(3)						
50.00			-988, 759				50.00

- column 6, line 200.) (1) Description - all chapter references in this column pertain to CMS Pub. 15-1. (2) Basis for adjustment (see instructions).

(Transfer to Worksheet A,

- A. Costs if cost, including applicable overhead, can be determined.

 B. Amount Received if cost cannot be determined.

 (3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
- Note: See instructions for column 5 referencing to Worksheet A-7.

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

Provi der CCN: 15-2025 | Peri od: From 09/01/2018

Worksheet A-8-1

002	00010			To 08/31/2019	Date/Time Pre 1/27/2020 11:				
	Li ne No.	Cost Center	Expense Items	Amount of	Amount				
				Allowable Cost	Included in				
					Wks. A, column				
					5				
	1. 00	2. 00	3. 00	4. 00	5. 00				
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED								
	HOME OFFICE COSTS:								
1.00	5. 00	ADMINISTRATIVE & GENERAL	HO OPERATING	1, 069, 214	1, 247, 741	1.00			
2.00	0.00			0	0	2.00			
3.00	0.00			0	0	3.00			
4.00	0.00			0	0	4.00			
5.00	TOTALS (sum of lines 1-4).			1, 069, 214	1, 247, 741	5.00			
	Transfer column 6, line 5 to								
	Worksheet A-8, column 2,								
	line 12.								

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

has not been posted to not kendet his ordinals i and or 2, the amount arronable should be that dated in ordinal i or this part.									
				Related Organization(s) and/	or Home Office				
	Symbol (1)	Name	Percentage of	Name	Percentage of				
	•		Ownershi p		Ownershi p				
	1. 00	2. 00	3.00	4. 00	5. 00				
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:								

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

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

6. 00	F	0.00 ACADI ANA MANAGEMENT GROUP 0.00	6. 00
7.00		0.00	7. 00
8.00		0.00	8. 00
9.00		0.00	9. 00
10.00		0.00	10.00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

Не	al th	Financial Syste	ems	CEN	NTRAL INDIANA-AMG	SPECIALTY I	HOSPI T		In Lie	u of Form C	MS-25	552-10
ST	TATEME	NT OF COSTS OF	SERVICES FROM	RELATED ORGAN	IZATIONS AND HOME	Provi der	CCN: 15-2025	Peri		Worksheet	A-8-1	1
OF	FICE	COSTS							09/01/2018	D . (T)		
								lo	08/31/2019			
										1/27/2020	11: 28	<u>3 am</u>
		Net	Wkst. A-7 Ref.									
		Adjustments										
		(col. 4 minus										
		col. 5)*										
		6. 00	7. 00									
		A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED										
		HOME OFFICE CO	STS:									
1.	00	-178, 527	C)								1. 00

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

2.00

3.00

4.00

5.00

nas i	ot been posted to worksheet A,	cordinins i and/or 2, the amount arrowable should be find cated in cordinin 4 or this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	6. 00		
	B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S) AND/OR HOME OFFICE:	
-			

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

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

6.00	MANAGEMENT COMPANY	6. 00
7.00		7. 00
8.00		8. 00
9.00		9. 00
10.00		10.00
100.00		100.00

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- Corporation, partnership, or other organization has financial interest in provider.
- 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 organi zati on.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der

2.00

3.00

4.00

o

0

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Health Financial Systems CENTRAL INDIANA-AMG SPECIALTY HOSPIT In Lieu of Form CMS-2552-10 PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-2025 Peri od: Worksheet A-8-2 From 09/01/2018 Date/Time Prepared: 1/27/2020 11: 28 am 08/31/2019 Wkst. A Line # Cost Center/Physician Total Professi onal Provi der RCE Amount Physi ci an/Prov Identi fi er Component Component ider Component Remuneration Hours 7.00 1. 00 2.00 3.00 4.00 5. 00 6. 00 1.00 5. OO AGGREGATE-ADMINISTRATIVE & 751, 769 751, 769 1.00 GENERAL 2.00 0.00 2.00 3.00 0.00 3.00 0 0 0.00 4.00 0 0 4.00 0.00 0 5.00 5.00 0 6.00 0.00 0 0 0 6.00 7.00 0.00 7.00 0 0.00 0 8.00 8.00 0.00 9.00 0 9.00 10.00 0.00 0 10.00 751, 769 751, 769 200.00 200.00 Provi der Wkst. A Line # Cost Center/Physician Unadjusted RCE 5 Percent of Cost of Physician Cost I denti fi er Limit Unadjusted RCE Memberships & Component of Malpractice Conti nui ng Share of col. Insurance Educati on 12 1. 00 2. 00 8. 00 9. 00 13.00 14.00 12. 00 5. OO AGGREGATE-ADMINISTRATIVE & 1.00 Ω 0 1.00 GENERAL 2.00 0.00 0 2.00 0.00 0 3.00 0 0 0 0 3.00 0 0 0 4.00 0.00 4.00 0.00 0 5.00 0 5.00 6.00 0.00 6.00 0.00 0 0 7.00 0 0 7.00 0.00 0 8.00 0 8.00 9.00 0.00 0 0 0 9.00 0 10.00 0.00 10.00 200.00 200.00 Cost Center/Physician Adjusted RCE RCE Wkst. A Line # Provi der Adjustment I denti fi er Component Limit Di sal I owance

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-2025 Peri od: Worksheet B From 09/01/2018 Part I Date/Time Prepared: 08/31/2019 1/27/2020 11:28 am CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Subtotal for Cost **BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 1 00 1 00 00100 CAP REL COSTS-BLDG & FLXT 976, 919 976, 919 2.00 00200 CAP REL COSTS-MVBLE EQUIP 0 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 615, 937 0 615, 937 4.00 00500 ADMINISTRATIVE & GENERAL 0 2, 579, 049 5 00 2, 377, 042 101, 449 100, 558 5 00 0 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 129, 049 129, 049 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 31, 671 0 0 o 31, 671 8.00 00900 HOUSEKEEPI NG 201, 511 9 00 201.511 9 00 Ω 0 10.00 01000 DI ETARY 202, 338 4, 476 206, 814 10.00 01100 CAFETERI A 11.00 0 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 0 0 0 01300 NURSING ADMINISTRATION 0 13.00 13.00 Ω 0 0 14.00 01400 CENTRAL SERVICES & SUPPLY 0 0 0 0 14.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 149, 465 186, 805 18, 669 16, 00 16.00 18, 671 17 00 01700 SOCIAL SERVICE 0 0 17 00 18.00 01850 RECREATIONAL THERAPY 0 18.00 0 19.00 01900 NONPHYSICIAN ANESTHETISTS 0 0 0 0 0 19.00 0 02000 NURSING SCHOOL 0 20.00 0 20.00 0 0 02100 I &R SERVICES-SALARY & FRINGES APPRV 0 0 21.00 0 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 0 22.00 22.00 0 02300 PARAMED ED PRGM-(SPECIFY) 0 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 3, 905, 483 0 5, 078, 335 30.00 743, 962 428, 890 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 188, 675 0 188, 675 50.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 148, 267 0 678 148, 945 54.00 06000 LABORATORY 60.00 252, 875 252, 875 60.00 0 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 06500 RESPIRATORY THERAPY 743, 972 17 400 0 818, 798 65.00 57, 426 65 00 0 66.00 06600 PHYSI CAL THERAPY 103, 644 9, 422 120 113, 186 66.00 06700 OCCUPATIONAL THERAPY 144, 227 9, 422 0 67.00 0 153, 649 67.00 06800 SPEECH PATHOLOGY 95, 713 9, 365 0 105, 078 68.00 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 32, 949 0 67, 228 105, 297 71.00 5, 120 71.00 73.00 07300 DRUGS CHARGED TO PATIENTS 1, 111, 426 C 0 0 1, 111, 426 73.00 74.00 07400 RENAL DIALYSIS 301, 409 0 0 301, 409 74.00 0 o 07697 CARDIAC REHABILITATION 76. 97 76 97 0 Ω 0 07698 HYPERBARIC OXYGEN THERAPY 0 76.98 0 C 0 0 76.98 76. 99 07699 LI THOTRI PSY 0 76. 99 OUTPATIENT SERVICE COST CENTERS 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0 92.00 OTHER REIMBURSABLE COST CENTERS 99. 10 0 0 0 0 0 99.10 09910 CORF 09920 OUTPATIENT PHYSICAL THERAPY 99. 20 0 0 0 0 0 99. 20 09930 OUTPATIENT OCCUPATIONAL THERAPY 0 99 30 99 30 0 C 0 0 09940 OUTPATIENT SPEECH PATHOLOGY 99.40 0 0 99.40 SPECIAL PURPOSE COST CENTERS | SUBTOTALS (SUM OF LINES 1 through 117) | NONREI MBURSABLE COST CENTERS 11, 712, 572 976, 919 0 615, 937 11, 712, 572 118. 00 118.00 200.00 Cross Foot Adjustments 0 200. 00 201.00 Negative Cost Centers 0 0 201.00 0 202.00 TOTAL (sum lines 118 through 201) 11, 712, 572 976, 919 615, 937 11, 712, 572 202. 00

0 201, 00

258, 412 202. 00

COST ALLOCATION - GENERAL SERVICE COSTS

Provi der CCN: 15-2025

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40.614

165, 489

Peri od: Worksheet B From 09/01/2018 Part I To 08/31/2019 Date/Time Prepared:

1/27/2020 11:28 am Cost Center Description ADMINISTRATIVE MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG & GENERAL **REPAIRS PLANT** LINEN SERVICE 9.00 5.00 6.00 8.00 GENERAL SERVICE COST CENTERS 1.00 1.00 00100 CAP REL COSTS-BLDG & FLXT 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 2, 579, 049 5 00 5 00 6.00 00600 MAINTENANCE & REPAIRS 6.00 00700 OPERATION OF PLANT 7.00 36, 440 165, 489 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8, 943 0 40, 614 8.00 C 00900 HOUSEKEEPI NG 56, 901 258, 412 9.00 0 9 00 10.00 01000 DI ETARY 58, 398 0 10.00 11.00 01100 CAFETERI A 0 0 0 0 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 0 0 0 12 00 0 13.00 01300 NURSING ADMINISTRATION 0 0 0 0 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 0 0 0 0 14.00 0 01500 PHARMACY 15.00 15.00 0 0 0 5, 511 01600 MEDICAL RECORDS & LIBRARY 16.00 52.749 0 3.529 16.00 0 17.00 01700 SOCIAL SERVICE 0 C 0 17.00 01850 RECREATIONAL THERAPY 0 18.00 18 00 0 0 01900 NONPHYSICIAN ANESTHETISTS 0 0 19.00 0 0 19.00 0 02000 NURSING SCHOOL 0 0 20 00 C 0 20.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 0 0 21.00 21.00 0 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 0 C 0 0 0 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 0 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 1, 433, 976 0 140, 631 40, 614 219, 595 30.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 53.277 Λ 50.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 42,058 0 0 0 0 54.00 06000 LABORATORY 0 60.00 71, 405 0 0 0 60.00 0 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62.30 0 0 62.30 06500 RESPIRATORY THERAPY 0 0 65.00 231, 206 3, 289 5, 136 65.00 0 66.00 06600 PHYSI CAL THERAPY 31, 961 1,781 2, 781 66.00 06700 OCCUPATIONAL THERAPY 2, 781 67.00 43, 386 1, 781 0 67.00 68 00 06800 SPEECH PATHOLOGY 29, 671 1.770 2.764 68 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 29, 733 12, 708 19,844 71.00 07300 DRUGS CHARGED TO PATIENTS 313, 836 0 0 73.00 73.00 C 0 07400 RENAL DIALYSIS 74.00 85.109 0 74.00 0 07697 CARDI AC REHABILI TATI ON 0 76.97 0 C 0 76.97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 76.98 76. 99 07699 LI THOTRI PSY 0 0 0 76.99 OUTPATIENT SERVICE COST CENTERS 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 99.10 09910 CORF 0 0 0 0 0 99.10 09920 OUTPATIENT PHYSICAL THERAPY 99. 20 99 20 0 0 0 Ω 0 99.30 09930 OUTPATIENT OCCUPATIONAL THERAPY 0 C 0 0 0 99.30 99.40 09940 OUTPATIENT SPEECH PATHOLOGY 0 99.40 SPECIAL PURPOSE COST CENTERS 165, 489 SUBTOTALS (SUM OF LINES 1 through 117) 0 258, 412 118. 00 118.00 2, 579, 049 40, 614 NONREI MBURSABLE COST CENTERS 200.00 Cross Foot Adjustments 200. 00

2, 579, 049

201.00

202.00

Negative Cost Centers

TOTAL (sum lines 118 through 201)

| Peri od: | Worksheet B | From 09/01/2018 | Part | | To 08/31/2019 | Date/Time Prepared: | Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-2025

					To 08/31/2019	Date/lime Pre 1/27/2020 11:	
	Cost Center Description	DI ETARY	CAFETERI A	MAI NTENANCE	OF NURSI NG	CENTRAL	ZO dili
	'			PERSONNEL	ADMI NI STRATI ON	SERVICES &	
						SUPPLY	
	JOSUS DA LA CONTROL DE LA CONT	10. 00	11. 00	12.00	13. 00	14. 00	
1. 00	GENERAL SERVICE COST CENTERS			I			1 00
2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00	00500 ADMI NI STRATI VE & GENERAL						5. 00
6. 00	00600 MAINTENANCE & REPAIRS						6. 00
7. 00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY	265, 212					10.00
11. 00	01100 CAFETERI A	0	0				11. 00
12. 00	01200 MAINTENANCE OF PERSONNEL	0	0		0		12. 00
13. 00	01300 NURSING ADMINISTRATION	0	0	1	0		13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	0	i .	0 0	0	
15.00	01500 PHARMACY	0	0		0	0	
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0		0 0	0	
17. 00 18. 00	01700 SOCI AL SERVI CE 01850 RECREATI ONAL THERAPY	U O	0	•	0 0	0	17. 00 18. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	i .	0 0	0	
20. 00	02000 NURSI NG SCHOOL	0	0		0 0	0	
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRV	0	0		0 0	0	
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	Ö	0		0 0	0	
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	o	0		0 0	0	
	INPATIENT ROUTINE SERVICE COST CENTERS						1
30. 00	03000 ADULTS & PEDI ATRI CS	265, 212	0		0 0	0	30. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0		0 0	0	
54.00	05400 RADI OLOGY - DI AGNOSTI C	0	0		0 0	0	
60.00	06000 LABORATORY	U O	0		0 0	0	
62. 30 65. 00	06250 BLOOD CLOTTING FOR HEMOPHILIACS 06500 RESPIRATORY THERAPY	U O	0	1	0 0	0	
66. 00	06600 PHYSI CAL THERAPY	0	0		0 0	0	
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	1
68. 00	06800 SPEECH PATHOLOGY	Ö	0		0 0	0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	ol	0		0 0	0	1
73.00	07300 DRUGS CHARGED TO PATIENTS	o	0		0 0	0	73. 00
74.00	07400 RENAL DIALYSIS	o	0		0 0	0	74. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0		0	0	
76. 99	07699 LI THOTRI PSY	0	0		0 0	0	76. 99
00.00	OUTPATIENT SERVICE COST CENTERS			ı			00.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92. 00
99. 10	09910 CORF	0	0		0 0	0	99. 10
99. 10	09920 OUTPATIENT PHYSICAL THERAPY	0	0	•	0 0	0	
99. 30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	•	0 0	0	
99. 40	09940 OUTPATIENT SPEECH PATHOLOGY	Ö	0		0 0	0	
	SPECIAL PURPOSE COST CENTERS	<u> </u>			-,		1
118.00		265, 212	0		0 0	0	118. 00
	NONREI MBURSABLE COST CENTERS						1
200.00							200. 00
201.00		0	0		0 0		201. 00
202.00	TOTAL (sum lines 118 through 201)	265, 212	0	1	0 0	0	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-2025

				1	0 08/31/2019	1/27/2020 11:	
					OTHER GENERAL	172772020 111	20 4
					SERVI CE		
	Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVICE		NONPHYSI CI AN	
	'		RECORDS &		THERAPY	ANESTHETI STS	
			LI BRARY				
		15. 00	16. 00	17. 00	18. 00	19. 00	
	GENERAL SERVICE COST CENTERS			1	<u> </u>		
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
6. 00	00600 MAI NTENANCE & REPAI RS						6. 00
7. 00	00700 OPERATION OF PLANT						7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10. 00
11. 00	01100 CAFETERI A						11. 00
12. 00	01200 MAINTENANCE OF PERSONNEL						12. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON						13. 00
14. 00	01400 CENTRAL SERVI CES & SUPPLY						14. 00
15. 00	01500 PHARMACY	0					15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	248, 594	1			16. 00
17. 00	01700 SOCIAL SERVICE	0	240, 374				17. 00
18. 00		0					18.00
19. 00	01850 RECREATIONAL THERAPY	0			0	1	•
	01900 NONPHYSI CI AN ANESTHETI STS	0			0	0	19.00
20.00	02000 NURSI NG SCHOOL	0		0	_		20.00
21. 00	02100 &R SERVICES-SALARY & FRINGES APPRV	U	C	0	_		21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	U	C			l	22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	Ų	C) 0	0		23. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	240 504			0	20.00
30. 00	03000 ADULTS & PEDIATRICS ANCILLARY SERVICE COST CENTERS	0	248, 594	l 0	0	U	30. 00
50. 00	05000 OPERATING ROOM	٥	C		0	0	E0 00
		0	C				50.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0				1	54.00
60.00	06000 LABORATORY	0		0		1	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		1	_	0	62.30
65. 00	06500 RESPI RATORY THERAPY	0	C	0		0	65. 00
66. 00	06600 PHYSI CAL THERAPY	U	C	0	_	0	66.00
67. 00	06700 OCCUPATIONAL THERAPY	U	C	0		0	67.00
68. 00	06800 SPEECH PATHOLOGY	U	C	0	0	0	68. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	U	C		0	0	71.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	C	0		0	73. 00
74.00	07400 RENAL DI ALYSI S	0	C	0	_	0	74. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	C	0		0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	C	1			76. 98
76. 99	07699 LI THOTRI PSY	U	C) 0	0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	OTHER REIMBURSABLE COST CENTERS				ı		
	09910 CORF	0	C	1		l	99. 10
	09920 OUTPATIENT PHYSICAL THERAPY	0	C				
	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	C				99. 30
99. 40	09940 OUTPATIENT SPEECH PATHOLOGY	0	C	0	0	0	99. 40
	SPECIAL PURPOSE COST CENTERS				1		
118.00		0	248, 594	l 0	0	0	118. 00
	NONREI MBURSABLE COST CENTERS						
200.00							200. 00
201.00		0	C			0	201. 00
202.00	TOTAL (sum lines 118 through 201)	0	248, 594	l 0	0	0	202. 00

Provider CCN: 15-2025

Peri od:

11, 712, 572 202. 00

Part I

From 09/01/2018 08/31/2019 Date/Time Prepared: 1/27/2020 11:28 am INTERNS & RESIDENTS NURSING SCHOOL SERVICES-SALAR SERVICES-OTHER PARAMED ED Cost Center Description Subtotal Y & FRINGES PRGM COSTS PRGM **APPRV APPRV** 23.00 20.00 21.00 22.00 24.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10 00 01100 CAFETERI A 11.00 11.00 12. 00 01200 MAINTENANCE OF PERSONNEL 12.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14 00 14 00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 01700 SOCIAL SERVICE 17 00 17 00 18.00 01850 RECREATIONAL THERAPY 18.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 19.00 02000 NURSI NG SCHOOL 20.00 20.00 02100 I &R SERVICES-SALARY & FRINGES APPRV 21 00 21 00 C 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 0 0 0 7, 426, 957 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 241, 952 50.00 0 0 0 0 05400 RADI OLOGY-DI AGNOSTI C 54.00 0 0 191,003 54.00 60.00 0 06000 LABORATORY 0 324, 280 60.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 00000000 0 0 0 0 62.30 06500 RESPIRATORY THERAPY 1, 058, 429 65 00 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 149, 709 66, 00 06700 OCCUPATIONAL THERAPY 0 67 00 0 201.597 67 00 0 06800 SPEECH PATHOLOGY 139, 283 68.00 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 0 0 0 167, 582 71.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0 1, 425, 262 73.00 0 07400 RENAL DIALYSIS 0 74.00 0 386, 518 74.00 0 76. 97 07697 CARDIAC REHABILITATION 0 0 0 0 76.97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 76. 98 0 0 07699 LI THOTRI PSY 0 0 0 76. 99 76.99 OUTPATIENT SERVICE COST CENTERS 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 OTHER REIMBURSABLE COST CENTERS 99.10 09910 CORF 0 0 0 0 0 99.10 99. 20 09920 OUTPATIENT PHYSICAL THERAPY 0 0 0 99. 20 09930 OUTPATIENT OCCUPATIONAL THERAPY 0 0 o 99. 30 0 99.30 0 09940 OUTPATIENT SPEECH PATHOLOGY 99.40 99.40 0 0 0 0 0 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 11, 712, 572 118. 00 118.00 0 0 0 0 NONREI MBURSABLE COST CENTERS 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 201. 00

202.00

TOTAL (sum lines 118 through 201)

From 09/01/2018 Part I 08/31/2019 Date/Time Prepared: 1/27/2020 11:28 am Cost Center Description Intern & Total Residents Cost & Post Stepdown Adjustments 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10 00 01100 CAFETERI A 11.00 11.00 12. 00 01200 MAINTENANCE OF PERSONNEL 12.00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14 00 15. 00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 17. 00 01700 SOCIAL SERVICE 17 00 18.00 01850 RECREATIONAL THERAPY 18.00 19.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 02000 NURSI NG SCHOOL 20.00 20.00 02100 I &R SERVICES-SALARY & FRINGES APPRV 21 00 21 00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 0 7, 426, 957 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 241, 952 50.00 0 54. 00 05400 RADI OLOGY-DI AGNOSTI C 191,003 54.00 324, 280 60. 00 | 06000 | LABORATORY 60.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 00000000 62.30 06500 RESPIRATORY THERAPY 1,058,429 65 00 65.00 66.00 06600 PHYSI CAL THERAPY 149, 709 66.00 06700 OCCUPATIONAL THERAPY 201, 597 67.00 67 00 68.00 06800 SPEECH PATHOLOGY 139, 283 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 167, 582 71.00 07300 DRUGS CHARGED TO PATIENTS 73.00 1, 425, 262 73.00 07400 RENAL DIALYSIS 74.00 386, 518 74.00 76.97 07697 CARDIAC REHABILITATION 0 0 76.97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 76. 98 0 07699 LI THOTRI PSY 76. 99 0 76.99 OUTPATIENT SERVICE COST CENTERS 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92.00 OTHER REIMBURSABLE COST CENTERS 99. 10 99.10 09910 CORF 0 0 99. 20 09920 OUTPATIENT PHYSICAL THERAPY 0 0 99. 20 09930 OUTPATIENT OCCUPATIONAL THERAPY 0 99. 30 0 99.30 09940 OUTPATIENT SPEECH PATHOLOGY 99.40 0 0 99.40 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 11, 712, 572 118.00 0 118.00 NONREI MBURSABLE COST CENTERS 200.00 Cross Foot Adjustments 0 200. 00 0 201.00 Negative Cost Centers Ω 201.00 202.00 TOTAL (sum lines 118 through 201) 11, 712, 572 202.00

	Assigned New				BENEFITS	
	Capi tal				DEPARTMENT	
	Related Costs					
	0	1. 00	2. 00	2A	4. 00	
GENERAL SERVICE COST CENTERS						1
1.00 O0100 CAP REL COSTS-BLDG & FLXT						1.00
2.00 O0200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5. 00 00500 ADMINISTRATIVE & GENERAL	o	101, 449	0	101, 449	0	5. 00
6.00 00600 MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00 00700 OPERATION OF PLANT	0	0	0	0	0	
8.00 00800 LAUNDRY & LINEN SERVICE	o	0	l o	0	0	
9. 00 00900 HOUSEKEEPI NG		0	٥	0	0	
10. 00 01000 DI ETARY	0	0		0	0	
	0	0		0	0	
11. 00 01100 CAFETERI A	0	0	0	U		
12. 00 01200 MAI NTENANCE OF PERSONNEL	0	0	0	0	0	
13. 00 01300 NURSI NG ADMINI STRATI ON	0	0	0	0	0	
14.00 01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	
15. 00 01500 PHARMACY	0	0	0	0	0	
16.00 01600 MEDICAL RECORDS & LIBRARY	0	18, 671	0	18, 671	0	16. 00
17.00 01700 SOCIAL SERVICE	0	0	0	0	0	17. 00
18. 00 01850 RECREATIONAL THERAPY	0	0	0	0	0	18.00
19.00 01900 NONPHYSICIAN ANESTHETISTS	o	0	0	0	0	19.00
20. 00 02000 NURSI NG SCHOOL	o	0	0	0	0	20.00
21. 00 02100 &R SERVICES-SALARY & FRINGES APPRV	0	0	l o	0	0	
22. 00 02200 &R SERVICES-OTHER PRGM COSTS APPRV	ő	n	o o	0	0	
23. 00 02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS) U	U	0	U	0	23.00
		742.0/2	1 0	742.0/2		20.00
30. 00 03000 ADULTS & PEDIATRICS ANCILLARY SERVICE COST CENTERS	0	743, 962	0	743, 962	0	30.00
			1 0			
50. 00 05000 OPERATI NG ROOM	0	0		· ·	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	
60. 00 06000 LABORATORY	0	0	0	0	0	
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	
65. 00 06500 RESPIRATORY THERAPY	0	17, 400	0	17, 400	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	9, 422	0	9, 422	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	9, 422	0	9, 422	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	9, 365	0		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	67, 228		67, 228	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0.,220	ا م	0//220	0	
74. 00 07400 RENAL DIALYSIS	o o	0	١	0	0	1
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	0		0	0	
	0	0	0	U		
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	
76. 99 07699 LI THOTRI PSY	0	0	0	0	0	76. 99
OUTPATIENT SERVICE COST CENTERS						
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
OTHER REIMBURSABLE COST CENTERS						
99. 10 09910 CORF	0	0	0	0	0	99. 10
99. 20 09920 OUTPATIENT PHYSICAL THERAPY	o	0	0	o	0	99. 20
99. 30 09930 OUTPATIENT OCCUPATIONAL THERAPY	o	0	0	0	0	99. 30
99. 40 09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	
SPECIAL PURPOSE COST CENTERS				<u> </u>		1 // 10
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	976, 919	0	976, 919	0	118. 00
	١	770, 717	l O	770, 717		1110.00
NONREI MBURSABLE COST CENTERS						200 00
200.00 Cross Foot Adjustments		_	_	0	_	200.00
201.00 Negative Cost Centers		0	0			201. 00
202.00 TOTAL (sum lines 118 through 201)	0	976, 919	0	976, 919	0	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-2025

						1/27/2020 11:	28 am_
	Cost Center Description	ADMI NI STRATI VE		OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		& GENERAL	REPAI RS	PLANT	LINEN SERVICE		
		5. 00	6. 00	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	101, 449					5.00
6.00	00600 MAINTENANCE & REPAIRS	0	0				6.00
7. 00	00700 OPERATION OF PLANT	1, 433	0	1, 433			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	352	0	1,	352		8.00
9. 00	00900 HOUSEKEEPI NG	2, 238				2, 238	
10. 00	01000 DI ETARY	2, 297				2, 230	
11. 00	01100 CAFETERI A	2,297	0			0	1
		_	0				1
12.00	01200 MAI NTENANCE OF PERSONNEL	0	0		0	0	
13. 00	01300 NURSING ADMINISTRATION	0	0	C	1	0	
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	0	C	1	0	1
15. 00	01500 PHARMACY	0	0	C	-	0	
16. 00	01600 MEDICAL RECORDS & LIBRARY	2, 075	0	31	0	48	16. 00
17. 00	01700 SOCIAL SERVICE	0	0	C	0	0	17. 00
18. 00	01850 RECREATIONAL THERAPY	0	0	C	0	0	18. 00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	C	0	0	19.00
20.00	02000 NURSI NG SCHOOL	0	0	l c	o	0	20.00
21. 00	02100 I&R SERVICES-SALARY & FRINGES APPRV	0	l o		o	0	21.00
22. 00	02200 &R SERVICES-OTHER PRGM COSTS APPRV	0	0		o	0	
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0		0	0	
20.00	I NPATIENT ROUTINE SERVICE COST CENTERS				·	Ü	20.00
30.00	03000 ADULTS & PEDIATRICS	56, 407	0	1, 219	352	1, 902	30.00
30.00	ANCI LLARY SERVI CE COST CENTERS	30, 407		1,217	332	1, 702	30.00
50. 00	05000 OPERATING ROOM	2, 096	0		ol	0	50.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 654	0		1	0	
60.00					-	0	
	06000 LABORATORY	2, 809	1		-		
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	C	T -	0	
65. 00	06500 RESPI RATORY THERAPY	9, 094	0	28		44	1
66. 00	06600 PHYSI CAL THERAPY	1, 257	0	15	1	24	
67. 00	06700 OCCUPATI ONAL THERAPY	1, 707	0	15		24	1
68. 00	06800 SPEECH PATHOLOGY	1, 167	0	15		24	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 170	0	110	0	172	
73. 00	07300 DRUGS CHARGED TO PATIENTS	12, 345	0	C	0	0	73. 00
74.00	07400 RENAL DIALYSIS	3, 348	0	C	0	0	74.00
76. 97	07697 CARDIAC REHABILITATION	0	0	C	0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	C	o	0	76. 98
76. 99	07699 LI THOTRI PSY	0	0	l c	o	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS		l .				1
99. 10	09910 CORF	0	0	C	0	0	99. 10
99. 20	09920 OUTPATIENT PHYSICAL THERAPY	0	0			0	
99. 30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	Ì		0	
99. 40	09940 OUTPATIENT SPEECH PATHOLOGY	0	l o		1	0	
77. 40	SPECIAL PURPOSE COST CENTERS				1 9	U	77.40
118. 00		101, 449	0	1, 433	352	2 220	118. 00
1 10.00	NONREI MBURSABLE COST CENTERS	101, 447		1,433	. 332	2, 230	1.10.00
200.00							200. 00
200.00		0	0			^	200.00
201.00		101, 449	l e		1 4		201.00
202.00	TIOTAL (Sum Times The Uniough 201)	101, 449	ı	1, 433	332	2, 230	1202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 15-2025

Peri od: Worksheet B From 09/01/2018 Part II To 08/31/2019 Date/Time Prepared:

1/27/2020 11:28 am Cost Center Description DI ETARY CAFETERI A MAINTENANCE OF NURSI NG CENTRAL ADMI NI STRATI ON SERVICES & **PERSONNEL SUPPLY** 10.00 11.00 12.00 13.00 14.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8 00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 2, 297 10.00 01100 CAFETERI A 11.00 11.00 0 01200 MAINTENANCE OF PERSONNEL 0 12.00 12.00 13.00 01300 NURSING ADMINISTRATION 0 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 0000000 0 0 0 0 0 14.00 01500 PHARMACY 0 15.00 0 15.00 01600 MEDICAL RECORDS & LIBRARY 0 16.00 0 16.00 17.00 01700 SOCIAL SERVICE 17.00 0 01850 RECREATIONAL THERAPY 0 18.00 0 0 18.00 0 01900 NONPHYSICIAN ANESTHETISTS 0 19 00 19 00 0 20.00 02000 NURSING SCHOOL 0 0 20.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 0 21.00 21.00 0 0 0 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 22.00 0 22.00 0 02300 PARAMED ED PRGM-(SPECIFY) 0 0 23.00 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 2, 297 0 0 0 30.00 0 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 0 0 0 50.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 0 0 0 0 54.00 06000 LABORATORY 0 60.00 00000000000 0 0 0 0 0 0 0 0 0 0 0 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 62.30 0 62.30 0 65.00 06500 RESPIRATORY THERAPY 0 0 65.00 06600 PHYSI CAL THERAPY 0 66.00 0 0 66.00 06700 OCCUPATIONAL THERAPY 67 00 Ω 0 0 67 00 0 06800 SPEECH PATHOLOGY 0 68.00 0 68.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 71.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0 0 0 73.00 74 00 07400 RENAL DIALYSIS Ω 0 74 00 0 0 76.97 07697 CARDIAC REHABILITATION 0 0 76.97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 76. 98 76.99 07699 LI THOTRI PSY 0 0 76.99 OUTPATIENT SERVICE COST CENTERS 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 99. 10 0 99. 10 09910 CORF 0 0 0 09920 OUTPATIENT PHYSICAL THERAPY 0 99. 20 99. 20 0 C 0 0 99.30 09930 OUTPATIENT OCCUPATIONAL THERAPY 0 0 0 0 0 99.30 99 40 09940 OUTPATIENT SPEECH PATHOLOGY 0 0 0 0 99.40 SPECIAL PURPOSE COST CENTERS 0 SUBTOTALS (SUM OF LINES 1 through 117) 2, 297 0 0 118.00 0 118. 00 NONREI MBURSABLE COST CENTERS 200.00 Cross Foot Adjustments 200.00 Negative Cost Centers 0 201. 00 201.00 0 0 0 202.00 TOTAL (sum lines 118 through 201) 2, 297 0 202. 00

Health Financial Systems CENTRAL INDIANA-AMG SPECIALTY HOSPIT In Lieu of Form CMS-2552-10 ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-2025 Peri od: Worksheet B From 09/01/2018 Part II 08/31/2019 Date/Time Prepared: 1/27/2020 11:28 am OTHER GENERAL SERVI CE RECREATI ONAL NONPHYSI CI AN Cost Center Description **PHARMACY** MEDI CAL SOCIAL SERVICE RECORDS & THERAPY **ANESTHETISTS** LI BRARY 18. 00 19.00 15.00 16.00 17.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10 00 01100 CAFETERI A 11.00 11.00 12.00 01200 MAINTENANCE OF PERSONNEL 12.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14 00 14 00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 0000000 20, 825 16.00 01700 SOCIAL SERVICE 17 00 17 00 18.00 01850 RECREATIONAL THERAPY C 0 18.00 01900 NONPHYSICIAN ANESTHETISTS 0 0 0 19.00 19.00 0 02000 NURSI NG SCHOOL 20.00 0 0 20.00 02100 I &R SERVICES-SALARY & FRINGES APPRV 0 21 00 Ω 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 0 22.00 C 22.00 02300 PARAMED ED PRGM-(SPECIFY) 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 0 30.00 20, 825 0 0 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 50.00 0 0 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 0000000000 0 54.00 60.00 0 06000 LABORATORY Ω 60.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 0 0 0 0 0 0 0 62.30 06500 RESPIRATORY THERAPY 0 65 00 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 66.00 06700 OCCUPATIONAL THERAPY 0 67 00 Ω 67 00 06800 SPEECH PATHOLOGY 68.00 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 71.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 73.00 0 07400 RENAL DIALYSIS 74.00 0 74.00 0 0 76. 97 07697 CARDIAC REHABILITATION 0 0 76.97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 76. 98 07699 LI THOTRI PSY 0 0 76. 99 0 76. 99 OUTPATIENT SERVICE COST CENTERS 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 OTHER REIMBURSABLE COST CENTERS 99.10 09910 CORF 0 0 0 0 99.10

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0 202. 00

99. 20

99. 30

99.40

118.00

200.00

201.00

202.00

09920 OUTPATIENT PHYSICAL THERAPY

09940 OUTPATIENT SPEECH PATHOLOGY

Cross Foot Adjustments

Negative Cost Centers

SPECIAL PURPOSE COST CENTERS

NONREI MBURSABLE COST CENTERS

09930 OUTPATIENT OCCUPATIONAL THERAPY

SUBTOTALS (SUM OF LINES 1 through 117)

TOTAL (sum lines 118 through 201)

976, 919 118. 00

976, 919 202. 00

0 200.00

0 201. 00

Health Financial Systems CENTRAL INDIANA-AMG SPECIALTY HOSPIT In Lieu of Form CMS-2552-10 ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-2025 Peri od: Worksheet B From 09/01/2018 Part II 08/31/2019 Date/Time Prepared: 1/27/2020 11:28 am INTERNS & RESIDENTS NURSING SCHOOL SERVICES-SALAR SERVICES-OTHER PARAMED ED Cost Center Description Subtotal Y & FRINGES PRGM COSTS PRGM **APPRV APPRV** 23.00 20.00 21.00 22.00 24.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10 00 01100 CAFETERI A 11.00 11.00 12. 00 01200 MAINTENANCE OF PERSONNEL 12.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14 00 14 00 15. 00 |01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 17. 00 01700 SOCIAL SERVICE 17 00 18.00 01850 RECREATIONAL THERAPY 18.00 19.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 02000 NURSI NG SCHOOL 20.00 20.00 02100 I &R SERVICES-SALARY & FRINGES APPRV 21 00 21 00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 0 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 826, 964 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 2, 096 50.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 1.654 54.00 60. 00 | 06000 | LABORATORY 2,809 60.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62.30 06500 RESPIRATORY THERAPY 65 00 26, 566 65.00 10, 718 66.00 06600 PHYSI CAL THERAPY 66, 00 06700 OCCUPATIONAL THERAPY 67.00 11, 168 67 00 06800 SPEECH PATHOLOGY 10, 571 68.00 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 68, 680 71.00 07300 DRUGS CHARGED TO PATIENTS 12, 345 73.00 73.00 07400 RENAL DIALYSIS 74.00 3, 348 74.00 76.97 07697 CARDIAC REHABILITATION 0 76.97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 76. 98 0 07699 LI THOTRI PSY 76. 99 0 76. 99 OUTPATIENT SERVICE COST CENTERS 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 OTHER REIMBURSABLE COST CENTERS 99. 10 99.10 09910 CORF 0 99. 20 09920 OUTPATIENT PHYSICAL THERAPY 99. 20 09930 OUTPATIENT OCCUPATIONAL THERAPY 99. 30 99.30 0 09940 OUTPATIENT SPEECH PATHOLOGY 99.40 99.40 0

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118.00

200.00

201.00

202.00

SPECIAL PURPOSE COST CENTERS

NONREI MBURSABLE COST CENTERS

Cross Foot Adjustments

Negative Cost Centers

SUBTOTALS (SUM OF LINES 1 through 117)

TOTAL (sum lines 118 through 201)

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-2025

| Peri od: | Worksheet B-1 | To 08/31/2010 | From 09/01/2018 | Worksheet B-1 | To 08/31/2010 | From 09/01/2018 | To 08/31/2010 | From 09/01/2018 | To 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/2010 | From 08/31/

						rom 09/01/2018 o 08/31/2019	Date/Time Pre	
			CAPITAL REL	ATED COSTS			1/27/2020 11:	28 am
		Cost Center Description	BLDG & FLXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconci I i ati on	ADMINISTRATIVE & GENERAL (ACCUM COST)	
			1.00	2.00	4.00	5A	5. 00	
1. 00		AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT	16, 900					1. 00
2. 00	1	CAP REL COSTS-BEBG & TTXT	10, 700	16, 900				2. 00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0				4. 00
5.00	1	ADMINISTRATIVE & GENERAL	1, 755	1, 755	647, 077	-2, 579, 049	9, 133, 523	5. 00
6. 00 7. 00		MAINTENANCE & REPAIRS OPERATION OF PLANT	0	0	0	0	0 129, 049	6. 00 7. 00
8.00	1	LAUNDRY & LINEN SERVICE	0	0	Ō	O	31, 671	8. 00
9.00	1	HOUSEKEEPI NG	0	0	0	0	201, 511	9.00
10. 00 11. 00	1	DI ETARY CAFETERI A	0	0	28, 800 0		206, 814 0	10. 00 11. 00
12. 00	1	MAINTENANCE OF PERSONNEL	Ö	Ö	Ö	o	0	12. 00
13.00		NURSING ADMINISTRATION	0	0	0	0	0	13.00
14. 00 15. 00		CENTRAL SERVICES & SUPPLY PHARMACY	0	0 0	0 0	0	0	14. 00 15. 00
16. 00		MEDICAL RECORDS & LIBRARY	323	323	120, 130	o	186, 805	16. 00
17. 00	1	SOCIAL SERVICE	0	0	0	o	0	17. 00
18. 00 19. 00	1	RECREATIONAL THERAPY NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	18. 00 19. 00
20. 00		NURSI NG SCHOOL	0	0	0	0	0	20.00
21. 00		I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21. 00
22. 00		I &R SERVI CES-OTHER PRGM COSTS APPRV	0	0	0		0	22. 00
23. 00		PARAMED ED PRGM-(SPECIFY) LENT ROUTINE SERVICE COST CENTERS	U	0	0	l O	0	23. 00
30.00		ADULTS & PEDIATRICS	12, 870	12, 870	2, 759, 872	0	5, 078, 335	30. 00
F0 00		LARY SERVICE COST CENTERS	0	_		O	100 /75	F0 00
50. 00 54. 00	1	OPERATING ROOM RADIOLOGY-DIAGNOSTIC	0	0	0 4, 362	-	188, 675 148, 945	50. 00 54. 00
60.00		LABORATORY	0	0	0		252, 875	60. 00
62. 30		BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62. 30
65. 00 66. 00	1	RESPI RATORY THERAPY PHYSI CAL THERAPY	301 163	301 163	369, 527 773	0	818, 798 113, 186	65. 00 66. 00
67. 00	1	OCCUPATI ONAL THERAPY	163	163	0		153, 649	67. 00
68.00	1	SPEECH PATHOLOGY	162	162	0	0	105, 078	
71. 00 73. 00		MEDICAL SUPPLIES CHARGED TO PATIENT DRUGS CHARGED TO PATIENTS	1, 163	1, 163 0	32, 949 0	0	105, 297 1, 111, 426	71. 00 73. 00
74. 00	1	RENAL DIALYSIS	0	0	ő	o	301, 409	
76. 97	1	CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
76. 98 76. 99		HYPERBARI C OXYGEN THERAPY LI THOTRI PSY	0	0	0	0	0	76. 98 76. 99
70. 77		TIENT SERVICE COST CENTERS	J			<u> </u>		70. 77
92. 00		OBSERVATION BEDS (NON-DISTINCT PART						92. 00
99. 10	01HER	REIMBURSABLE COST CENTERS	O	0	0	O	0	99. 10
99. 20	09920	OUTPATIENT PHYSICAL THERAPY	Ö	Ö			0	
99. 30		OUTPATIENT OCCUPATIONAL THERAPY	0	0			0	
99. 40		OUTPATIENT SPEECH PATHOLOGY AL PURPOSE COST CENTERS	0	0	0	0	0	99. 40
118. 00		SUBTOTALS (SUM OF LINES 1 through 117)	16, 900	16, 900	3, 963, 490	-2, 579, 049	9, 133, 523	118. 00
		IMBURSABLE COST CENTERS						
200. 00 201. 00		Cross Foot Adjustments Negative Cost Centers						200. 00 201. 00
201.00		Cost to be allocated (per Wkst. B,	976, 919	0	615, 937		2, 579, 049	
		Part I)						
203. 00 204. 00	1	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	57. 805858	0. 000000	0. 155403		0. 282372 101, 449	
204.00	,	Part II)					101, 449	204.00
205.00)	Unit cost multiplier (Wkst. B, Part			0. 000000		0. 011107	205. 00
206.00								206. 00
200.00		(per Wkst. B-2)						200.00
207. 00		NAHE unit cost multiplier (Wkst. D,						207. 00
	1	Parts III and IV)		I	I	ı l		l

Provider CCN: 15-2025

Peri od:

From 09/01/2018

COST ALLOCATION - STATISTICAL BASIS

08/31/2019 Date/Time Prepared: 1/27/2020 11:28 am Cost Center Description MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY LINEN SERVICE (SQUARE FEET) (MEALS SERVED) REPAIRS PLANT (SQUARE FEET) (SQUARE FEET) (POUNDS OF LAUNDRY) 7.00 6.00 9.00 10.00 8.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00600 MAINTENANCE & REPAIRS 6.00 15, 145 6.00 00700 OPERATION OF PLANT 7.00 7.00 15, 145 00800 LAUNDRY & LINEN SERVICE 8.00 0 7,731 8.00 9.00 00900 HOUSEKEEPI NG 0 15, 145 9.00 0 01000 DI ETARY 23, 193 10.00 10.00 0 01100 CAFETERI A 0 11.00 C 0 Λ 11.00 01200 MAINTENANCE OF PERSONNEL 0 12.00 C 0 0 0 12.00 13.00 01300 NURSING ADMINISTRATION 0 0 13.00 0 01400 CENTRAL SERVICES & SUPPLY 0 0 14.00 0 14.00 0 01500 PHARMACY 0 0 15.00 C 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 323 323 323 16.00 01700 SOCIAL SERVICE 17.00 0 0 0 0 17.00 0 0 01850 RECREATIONAL THERAPY 18 00 Ω 0 18 00 0 01900 NONPHYSICIAN ANESTHETISTS 19.00 C 0 0 19.00 02000 NURSING SCHOOL 0 0 0 20.00 20.00 C 0 21.00 0 0 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 21.00 0 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 0 0 22 00 22 00 0 23.00 02300 PARAMED ED PRGM-(SPECIFY) 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 12, 870 12, 870 7, 731 12, 870 23, 193 30 00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 0 0 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 o 54.00 0 0 06000 LABORATORY 0 60 00 0 0 60 00 C 0 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62.30 0 0 62.30 06500 RESPIRATORY THERAPY 301 0 301 65.00 65.00 301 66.00 06600 PHYSI CAL THERAPY 163 163 0 163 0 66, 00 06700 OCCUPATIONAL THERAPY 0 67.00 67.00 163 163 163 0 68.00 06800 SPEECH PATHOLOGY 162 162 0 162 0 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 1, 163 1, 163 1, 163 71.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0 C 0 0 07400 RENAL DIALYSIS 0 74.00 0 C 0 0 74.00 76.97 07697 CARDIAC REHABILITATION 0 0 0 76.97 0 76.98 07698 HYPERBARIC OXYGEN THERAPY 0 0 0 0 76. 98 07699 LI THOTRI PSY 76.99 0 0 76.99 0 0 OUTPATIENT SERVICE COST CENTERS 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 OTHER REIMBURSABLE COST CENTERS 99.10 09910 CORF 0 0 0 0 0 99.10 09920 OUTPATIENT PHYSICAL THERAPY 99.20 0 C 0 0 0 99.20 99.30 09930 OUTPATIENT OCCUPATIONAL THERAPY 0 0 0 99.30 99. 40 09940 OUTPATIENT SPEECH PATHOLOGY 0 99.40 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 15, 145 15, 145 7, 731 15, 145 23, 193 118. 00 118.00 NONREI MBURSABLE COST CENTERS Cross Foot Adjustments 200.00 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 165, 489 40, 614 258, 412 265, 212 202. 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 0.000000 10. 926973 5. 253395 17.062529 11. 435002 203. 00 Cost to be allocated (per Wkst. B, 2, 297 204. 00 204.00 1, 433 352 2.238 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.000000 0.094619 0.045531 0. 147772 0. 099039 205. 00 II)206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207.00 207. 00 Parts III and IV)

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-2025 Peri od: Worksheet B-1 From 09/01/2018 08/31/2019 Date/Time Prepared: 1/27/2020 11:28 am Cost Center Description CAFETERI A MAINTENANCE OF NURSI NG CENTRAL **PHARMACY** PERSONNEL ADMI NI STRATI ON (MEALS SERVED) SERVICES & (COSTED (NUMBER **SUPPLY** REQUIS.) (DIRECT NRSING HOUSED) (COSTED REQUIS.) HRS) 15.00 11.00 12.00 13.00 14.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10 00 01100 CAFETERI A 11.00 23, 193 11.00 12.00 01200 MAINTENANCE OF PERSONNEL 12.00 13.00 01300 NURSING ADMINISTRATION 0 87, 252 13.00 0 01400 CENTRAL SERVICES & SUPPLY 7, 731 14 00 14 00 15.00 01500 PHARMACY 0 7, 731 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 00000 0 0 0 16.00 01700 SOCIAL SERVICE 0 17 00 0 17 00 0 18.00 01850 RECREATIONAL THERAPY 0 0 0 18.00 01900 NONPHYSICIAN ANESTHETISTS 0 0 19.00 19.00 0 0 20.00 02000 NURSING SCHOOL 0 20.00 0 02100 I &R SERVICES-SALARY & FRINGES APPRV 0 0 21 00 21 00 Ω 0 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 C 0 0 0 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 23.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 7, 731 7, 731 30.00 03000 ADULTS & PEDIATRICS 23, 193 0 87, 252 30.00 ANCILLARY SERVICE COST CENTERS 50.00 50.00 05000 OPERATING ROOM 0 0 0 0 0 0 0 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 0 0 54.00 0 06000 LABORATORY 60.00 Ω 0 60.00 0 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 62.30 62.30 0 0 0 0 0 0 0 06500 RESPIRATORY THERAPY 65 00 65.00 66.00 06600 PHYSI CAL THERAPY 00000 0 0 0 66,00 06700 OCCUPATIONAL THERAPY 0 67 00 Ω 0 67 00 06800 SPEECH PATHOLOGY 68.00 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 0 71.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0 73.00 C 0 0 74.00 07400 RENAL DIALYSIS C 0 74.00 0 76. 97 07697 CARDIAC REHABILITATION 0 0 0 76.97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 o 76. 98 0 07699 LI THOTRI PSY 0 ol 76. 99 76.99 OUTPATIENT SERVICE COST CENTERS 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 OTHER REIMBURSABLE COST CENTERS 99.10 09910 CORF 0 0 0 0 0 99.10 99. 20 09920 OUTPATIENT PHYSICAL THERAPY 0 0 0 99. 20 09930 OUTPATIENT OCCUPATIONAL THERAPY 99. 30 0 C 0 0 99.30 0 09940 OUTPATIENT SPEECH PATHOLOGY 99.40 0 0 0 0 99.40 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 7, 731 118. 00 118.00 23, 193 0 87, 252 7, 731 NONREI MBURSABLE COST CENTERS 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 0 202.00 0 Part I) 203 00 Unit cost multiplier (Wkst. B, Part I) 0.000000 0.000000 0.000000 0.000000 0.000000 203.00 204.00 Cost to be allocated (per Wkst. B, 0 204. 00 Part II) 0.000000 0.000000 0.000000 0.000000 205.00 205.00 Unit cost multiplier (Wkst. B, Part 0.000000 II) 206. 00 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207. 00 Parts III and IV)

Provider CCN: 15-2025

Peri od:

Health Financial Systems

COST ALLOCATION - STATISTICAL BASIS

In Lieu of Form CMS-2552-10
Worksheet B-1

From 09/01/2018 08/31/2019 Date/Time Prepared: 1/27/2020 11:28 am OTHER GENERAL SERVI CE MEDI CAL SOCIAL SERVICE RECREATI ONAL NONPHYSICIAN NURSING SCHOOL Cost Center Description THERAPY RECORDS & **ANESTHETISTS** (TIME SPENT) (ASSI GNED LIBRARY (TIME SPENT) (ASSI GNED (TIME SPENT) TIME) TIME) 16.00 17.00 18.00 19.00 20.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FLXT 1.00 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00600 MAINTENANCE & REPAIRS 6.00 6 00 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9 00 9 00 01000 DI ETARY 10.00 10.00 11.00 01100 CAFETERI A 11.00 12.00 01200 MAINTENANCE OF PERSONNEL 12.00 01300 NURSING ADMINISTRATION 13 00 13 00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 4, 247 16,00 16,00 01700 SOCIAL SERVICE 17.00 17.00 7, 731 18.00 01850 RECREATIONAL THERAPY 0 18.00 01900 NONPHYSICIAN ANESTHETISTS 0 19.00 19.00 02000 NURSING SCHOOL 0 0 0 20.00 0 20.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 0 21.00 Ω 21.00 22. 00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 0 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 0 30.00 03000 ADULTS & PEDIATRICS 4, 247 7, 731 0 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM C 0 50.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 54.00 0 54.00 0 0 0 60.00 06000 LABORATORY 0 0 0 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62.30 0 0 0 62.30 65.00 06500 RESPIRATORY THERAPY 0 0 0 0 0 65.00 06600 PHYSI CAL THERAPY 0 66.00 0 Λ 66,00 0 67.00 06700 OCCUPATIONAL THERAPY 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 0 O 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 71.00 0 0 07300 DRUGS CHARGED TO PATIENTS 0 73.00 C 0 73.00 0 0 74.00 07400 RENAL DIALYSIS 0 0 74.00 76. 97 07697 CARDIAC REHABILITATION 0 76. 97 0 07698 HYPERBARI C OXYGEN THERAPY 0 0 76.98 n 76.98 Λ 76. 99 07699 LI THOTRI PSY 0 0 76.99 OUTPATIENT SERVICE COST CENTERS 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 OTHER REIMBURSABLE COST CENTERS 99. 10 09910 CORF 0 0 0 0 0 99.10 09920 OUTPATIENT PHYSICAL THERAPY 0 99. 20 0 C 0 0 99. 20 99 30 09930 OUTPATIENT OCCUPATIONAL THERAPY 0 0 0 99.30 Ω 0 99.40 09940 OUTPATIENT SPEECH PATHOLOGY 0 0 0 99.40 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 4, 247 7, 731 0 0 0 118. 00 118.00 NONREI MBURSABLE COST CENTERS 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201. 00 202.00 Cost to be allocated (per Wkst. B, 248.594 0 0 202. 00 0 Part I) 0.000000 203.00 203 00 Unit cost multiplier (Wkst. B, Part I) 58 534024 0.000000 0.000000 0.000000 204.00 Cost to be allocated (per Wkst. B, 0 204.00 20,825 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 4. 903461 0.000000 0.000000 0.000000 0.000000 205.00 II)0 206, 00 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 0.000000 207.00 Parts III and IV)

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

					To 08/31/2019 Date/Time	
		INTERNS &	RESI DENTS		1/27/2020	11. 20 dili
	Cost Center Description	SERVI CES-SALARS Y & FRI NGES APPRV	SERVICES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM (ASSIGNED		
		(ASSI GNED	(ASSI GNED	TIME)		
		TI ME) 21. 00	TI ME) 22. 00	23. 00		
	GENERAL SERVICE COST CENTERS					
1. 00 2. 00	OO100 CAP REL COSTS-BLDG & FLXT OO200 CAP REL COSTS-MVBLE EQUIP					1. 00 2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5.00	00500 ADMINISTRATIVE & GENERAL					5. 00
6.00	00600 MAI NTENANCE & REPAI RS					6. 00
7. 00 8. 00	OO7OO OPERATION OF PLANT OO8OO LAUNDRY & LINEN SERVICE					7. 00 8. 00
9.00	00900 HOUSEKEEPI NG					9. 00
10.00	01000 DI ETARY					10.00
11. 00 12. 00	01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL					11. 00 12. 00
	01300 NURSING ADMINISTRATION					13. 00
14.00	01400 CENTRAL SERVI CES & SUPPLY					14. 00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY					15. 00 16. 00
	01700 SOCI AL SERVI CE					17. 00
	01850 RECREATIONAL THERAPY					18. 00
	01900 NONPHYSI CLAN ANESTHETI STS					19. 00 20. 00
	02000 NURSING SCHOOL 02100 I&R SERVICES-SALARY & FRINGES APPRV	o				21.00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV		0			22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)			C)	23. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	O	0	C		30.00
	ANCILLARY SERVICE COST CENTERS					
50. 00 54. 00	05000 OPERATI NG ROOM 05400 RADI OLOGY-DI AGNOSTI C	0 0	0	0		50. 00 54. 00
60. 00	06000 LABORATORY	0	0	0		60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	C		62. 30
65. 00	06500 RESPIRATORY THERAPY	0	0	C		65. 00
66. 00 67. 00	O6600 PHYSI CAL THERAPY O6700 OCCUPATI ONAL THERAPY		0	0		66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	o	0	C		68. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	O		71. 00
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	0	0		73. 00 74. 00
74. 00	07697 CARDI AC REHABI LI TATI ON	0	0	0		76. 97
76. 98	07698 HYPERBARIC OXYGEN THERAPY	O	0	C		76. 98
76. 99	07699 LITHOTRIPSY OUTPATIENT SERVICE COST CENTERS	0	0	C)	76. 99
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART					92. 00
	OTHER REIMBURSABLE COST CENTERS					
99. 10 99. 20	09910 CORF 09920 OUTPATI ENT PHYSI CAL THERAPY	0 0	0	0		99. 10 99. 20
99. 20	09930 OUTPATIENT PHYSICAL THERAPY		0	0		99. 30
	09940 OUTPATIENT SPEECH PATHOLOGY	Ō	0	C		99. 40
110 00	SPECIAL PURPOSE COST CENTERS		0		sl	110.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	0	0	C	<u> </u>	118. 00
200.00	Cross Foot Adjustments					200. 00
201.00						201. 00
202.00	Cost to be allocated (per Wkst. B, Part I)	0	0	C)	202. 00
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	0. 000000	0.000000		203. 00
204.00		0	0	C		204. 00
205.00	Part II) Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000	0. 000000		205. 00
		1. 000000	27 000000			
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)			C		206. 00
207.00	1 1 7			0. 000000		207. 00
	Parts III and IV)					

near the Financial Systems Cent	RAL TINDI ANA-AWG	SPECIALIT HUS	PII	III LI E	u or Form CMS	2332-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der Co		Peri od:	Worksheet C	
				rom 09/01/2018		
			T	o 08/31/2019		pared:
					1/27/2020 11:	28 am_
		litle	XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)					
	1. 00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	7, 426, 957		7, 426, 957	0	7, 426, 957	30. 00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	241, 952		241, 952	0	241, 952	50. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	191, 003		191, 003	0	191, 003	54.00
60. 00 06000 LABORATORY	324, 280		324, 280	0	324, 280	60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		l	0	0	62. 30
65. 00 06500 RESPIRATORY THERAPY	1, 058, 429	l o	1, 058, 429	0	1, 058, 429	
66. 00 06600 PHYSI CAL THERAPY	149, 709		149, 709		149, 709	1
67. 00 06700 OCCUPATI ONAL THERAPY	201, 597		201, 597		201, 597	
68. 00 06800 SPEECH PATHOLOGY	139, 283		139, 283		139, 283	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	167, 582		167, 582		167, 582	
73. 00 07300 DRUGS CHARGED TO PATIENTS	1, 425, 262		1, 425, 262		1, 425, 262	
74. 00 07400 RENAL DIALYSIS	386, 518		386, 518		386, 518	
76. 97 07697 CARDI AC REHABI LI TATI ON	300, 310		300, 310		0 300, 310	1
76. 98 07698 HYPERBARI C OXYGEN THERAPY					0	1
76. 99 07699 LITHOTRIPSY					0	76. 99
OUTPATIENT SERVICE COST CENTERS	1 0) 0	U	70.99
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	1		\	0	92. 00
OTHER REIMBURSABLE COST CENTERS	1 0			/	0	92.00
			1	\	0	00 10
	0				0	
99. 20 09920 OUTPATIENT PHYSICAL THERAPY	0)	0	
99. 30 09930 OUTPATIENT OCCUPATIONAL THERAPY	0		[C)	0	
99. 40 09940 OUTPATIENT SPEECH PATHOLOGY	0		[C)	0	, , , , , ,
200.00 Subtotal (see instructions)	11, 712, 572	0	11, 712, 572	0		
201.00 Less Observation Beds	0		[C)		201. 00
202.00 Total (see instructions)	11, 712, 572	0	11, 712, 572	2 0	11, 712, 572	202. 00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-2025 Peri od: Worksheet C From 09/01/2018 Part I 08/31/2019 Date/Time Prepared: 1/27/2020 11:28 am Title XVIII Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA I npati ent + col . 7) Ratio Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDI ATRI CS 30.00 10, 669, 995 10, 669, 995 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 351223 0.000000 50.00 688, 885 688, 885 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 585, 302 0 1, 585, 302 0.120484 0.000000 54.00 06000 LABORATORY 0.248618 0.000000 60.00 1.304.330 0 1, 304, 330 60.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 0.000000 62.30 65.00 06500 RESPIRATORY THERAPY 10, 134, 240 10, 134, 240 0.104441 0.000000 65.00 06600 PHYSI CAL THERAPY 0. 542326 66.00 276,050 276,050 0.000000 66.00 06700 OCCUPATIONAL THERAPY 0 0. 949603 0.000000 67.00 212, 296 212, 296 67 00 68.00 06800 SPEECH PATHOLOGY 488, 098 488, 098 0. 285359 0.000000 68.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 1, 919, 152 1, 919, 152 0.087321 0.000000 71.00 07300 DRUGS CHARGED TO PATIENTS 1, 481, 548 73.00 0 1, 481, 548 0.000000 0.962009 73.00 74.00 07400 RENAL DIALYSIS 653, 449 0 653, 449 0.591504 0.000000 74.00 76. 97 07697 CARDIAC REHABILITATION 0 0.000000 0.000000 76.97 07698 HYPERBARI C OXYGEN THERAPY 0 76. 98 0 0 0.000000 0.000000 76. 98 07699 LI THOTRI PSY 76. 99 0 0 76. 99 0 0.000000 0.000000 OUTPATIENT SERVICE COST CENTERS 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 0.000000 0.000000 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 99.10 09910 CORF 0 Ω 0 99.10 09920 OUTPATIENT PHYSICAL THERAPY 99. 20 0 0 0 99. 20 09930 OUTPATIENT OCCUPATIONAL THERAPY 99. 30 99. 30 0 0 0 99. 40 09940 OUTPATIENT SPEECH PATHOLOGY 0 O 99.40 0 200.00 Subtotal (see instructions) 29, 413, 345 0 29, 413, 345 200.00 201.00 Less Observation Beds 201. 00 202.00 Total (see instructions) 29, 413, 345 0 29, 413, 345 202.00 | Peri od: | Worksheet C | From 09/01/2018 | Part | To 08/31/2019 | Date/Time Prepared:

			10 00/31/2017	1/27/2020 11: 28 am
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 351223			50. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 120484			54.00
60. 00 06000 LABORATORY	0. 248618			60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			62. 30
65. 00 06500 RESPI RATORY THERAPY	0. 104441			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 542326			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 949603			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 285359			68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 087321			71. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 962009			73. 00
74.00 07400 RENAL DIALYSIS	0. 591504			74. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000			76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000			76. 98
76. 99 07699 LI THOTRI PSY	0. 000000			76. 99
OUTPATIENT SERVICE COST CENTERS				
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92. 00
OTHER REIMBURSABLE COST CENTERS				
99. 10 09910 CORF				99. 10
99. 20 09920 OUTPATIENT PHYSICAL THERAPY				99. 20
99. 30 09930 OUTPATI ENT OCCUPATI ONAL THERAPY				99. 30
99. 40 09940 OUTPATIENT SPEECH PATHOLOGY				99. 40
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-2025 Peri od: Worksheet C From 09/01/2018 Part I 08/31/2019 Date/Time Prepared: 1/27/2020 11:28 am Title XIX Hospi tal PPS Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs Di sal I owance from Wkst. B, Adj Part I, col. 26) 2.00 4. 00 5.00 1.00 3.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 7, 426, 957 7, 426, 957 0 30.00 7, 426, 957 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 241, 952 241, 952 0 241, 952 50.00 05400 RADI OLOGY-DI AGNOSTI C 0 191,003 54.00 191,003 191,003 54.00 06000 LABORATORY 60.00 324, 280 324, 280 324, 280 60.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 0 0 0 0 0 62.30 65.00 06500 RESPIRATORY THERAPY 1, 058, 429 1, 058, 429 1, 058, 429 65.00 149, 709 149, 709 149, 709 66.00 06600 PHYSI CAL THERAPY 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 201, 597 C 201, 597 201, 597 67.00 68.00 06800 SPEECH PATHOLOGY 139, 283 139, 283 139, 283 68.00 167, 582 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 167, 582 167, 582 71.00 07300 DRUGS CHARGED TO PATIENTS 1, 425, 262 1, 425, 262 1, 425, 262 73.00 73.00 74.00 07400 RENAL DIALYSIS 386, 518 386, 518 386, 518 74.00 07697 CARDIAC REHABILITATION 0 76. 97 76. 97 0 0 0 07698 HYPERBARI C OXYGEN THERAPY 76. 98 76 98 0 0 0 07699 LI THOTRI PSY 0 76. 99 0 0 76. 99 OUTPATIENT SERVICE COST CENTERS 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0 0 0 92.00 OTHER REIMBURSABLE COST CENTERS 99. 10 09910 CORF 0 0 0 99. 10 09920 OUTPATIENT PHYSICAL THERAPY 99. 20 99. 20 0 0 0 99. 30 09930 OUTPATIENT OCCUPATIONAL THERAPY 0 0 99.30 0 99. 40 09940 OUTPATIENT SPEECH PATHOLOGY 99. 40 0 Λ 200.00 Subtotal (see instructions) 11, 712, 572 0 11, 712, 572 11, 712, 572 200. 00 201.00 Less Observation Beds 0 201. 00 0 11, 712, 572 o 202.00 Total (see instructions) 11, 712, 572 11, 712, 572 202. 00 COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-2025 Peri od: Worksheet C From 09/01/2018 Part I 08/31/2019 Date/Time Prepared: 1/27/2020 11:28 am Title XIX Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA I npati ent + col . 7) Ratio Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDI ATRI CS 30.00 10, 669, 995 10, 669, 995 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 351223 0.000000 50.00 688, 885 688, 885 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 585, 302 0 1, 585, 302 0.120484 0.000000 54.00 06000 LABORATORY 0.248618 0.000000 60.00 1.304.330 0 1, 304, 330 60.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 0.000000 62.30 65.00 06500 RESPIRATORY THERAPY 10, 134, 240 10, 134, 240 0.104441 0.000000 65.00 06600 PHYSI CAL THERAPY 0. 542326 66.00 276,050 276,050 0.000000 66.00 06700 OCCUPATIONAL THERAPY 0 0. 949603 0.000000 67.00 212, 296 212, 296 67 00 68.00 06800 SPEECH PATHOLOGY 488, 098 488, 098 0. 285359 0.000000 68.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 1, 919, 152 1, 919, 152 0.087321 0.000000 71.00 07300 DRUGS CHARGED TO PATIENTS 1, 481, 548 73.00 0 1, 481, 548 0.000000 0.962009 73.00 74.00 07400 RENAL DIALYSIS 653, 449 0 653, 449 0.591504 0.000000 74.00 76. 97 07697 CARDIAC REHABILITATION 0 0.000000 0.000000 76.97 07698 HYPERBARI C OXYGEN THERAPY 0 76. 98 0 0 0.000000 0.000000 76. 98 07699 LI THOTRI PSY 76. 99 0 0 76. 99 0 0.000000 0.000000 OUTPATIENT SERVICE COST CENTERS 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 0.000000 0.000000 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 99.10 09910 CORF 0 Ω 0 99.10 09920 OUTPATIENT PHYSICAL THERAPY 99. 20 0 0 0 99. 20 09930 OUTPATIENT OCCUPATIONAL THERAPY 99. 30 99. 30 0 0 0 99. 40 09940 OUTPATIENT SPEECH PATHOLOGY 0 O 99.40 0 200.00 Subtotal (see instructions) 29, 413, 345 0 29, 413, 345 200.00 201.00 Less Observation Beds 201. 00 202.00 Total (see instructions) 29, 413, 345 0 29, 413, 345 202.00 Peri od: Worksheet C From 09/01/2018 Part I To 08/31/2019 Date/Time Prepared:

			00,01,201,	1/27/2020 11:28 am
		Title XIX	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 351223			50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 120484			54.00
60. 00 06000 LABORATORY	0. 248618			60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			62. 30
65. 00 06500 RESPI RATORY THERAPY	0. 104441			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 542326			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 949603			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 285359			68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 087321			71. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 962009			73.00
74.00 07400 RENAL DI ALYSI S	0. 591504			74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000			76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000			76. 98
76. 99 07699 LI THOTRI PSY	0. 000000			76. 99
OUTPATIENT SERVICE COST CENTERS				
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92. 00
OTHER REIMBURSABLE COST CENTERS				
99. 10 09910 CORF				99. 10
99. 20 09920 OUTPATIENT PHYSICAL THERAPY				99. 20
99. 30 09930 OUTPATI ENT OCCUPATI ONAL THERAPY				99. 30
99. 40 09940 OUTPATIENT SPEECH PATHOLOGY				99. 40
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00

 Heal th Financial Systems
 CENTRAL INDIANA-AMG
 SPECIALTY HOSPIT

 CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF
 Provider CCN: 1

 REDUCTIONS FOR MEDICALD ONLY
 Provi der CCN: 15-2025

					1/27/2020 11:	28 am
			e XIX	Hospi tal	PPS	
Cost Center Description	Total Cost		Operating Cost		Operating Cost	
			Net of Capital	Reducti on	Reduction	
	I, col. 26)	II col. 26)	Cost (col. 1 -		Amount	
			col . 2)			
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS			1			
50. 00 05000 OPERATI NG ROOM	241, 952	2, 096		0	0	00.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	191, 003	1, 654		0	0	54. 00
60. 00 06000 LABORATORY	324, 280	2, 809	321, 471	0	0	
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62. 30
65. 00 06500 RESPIRATORY THERAPY	1, 058, 429	26, 566		0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	149, 709	10, 718		0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	201, 597	11, 168		0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	139, 283	10, 571		0	0	68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	167, 582	68, 680		0	0	,
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 425, 262	12, 345		0	0	73. 00
74. 00 07400 RENAL DI ALYSI S	386, 518	3, 348	383, 170	0	0	74.00
76.97 O7697 CARDIAC REHABILITATION	0	0	0	0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76. 98
76. 99 07699 LI THOTRI PSY	0	0	0	0	0	76. 99
OUTPATIENT SERVICE COST CENTERS						
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92. 00
OTHER REIMBURSABLE COST CENTERS	,					
99. 10 09910 CORF	0	0	0	0	0	
99. 20 09920 OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99. 20
99. 30 09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99. 30
99. 40 09940 OUTPATI ENT SPEECH PATHOLOGY	0	0	0	0	0	99. 40
200.00 Subtotal (sum of lines 50 thru 199)	4, 285, 615	149, 955	4, 135, 660	0		200. 00
201.00 Less Observation Beds	0	0	0	0	0	201.00
202.00 Total (line 200 minus line 201)	4, 285, 615	149, 955	4, 135, 660	0	0	202. 00

Health Financial Systems CENTRAL INDIANA-AMG SPECIALTY HOSPIT CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF Provider CCN: 1 Peri od: Worksheet C From 09/01/2018 Part II To 08/31/2019 Date/Time Prepared: 1/27/2020 11: 28 am Provi der CCN: 15-2025 REDUCTIONS FOR MEDICALD ONLY

					1/2//2020 11:2	28 alli
			e XIX	Hospi tal	PPS	
Cost Center Description	Cost Net of	Total Charges				
	Capital and		Cost to Charge			
		Part I, column				
	Reduction	8)	/ col . 7)			
	6.00	7. 00	8. 00			
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	241, 952	688, 885	0. 351223			50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	191, 003	1, 585, 302	0. 120484			54.00
60. 00 06000 LABORATORY	324, 280	1, 304, 330	0. 248618			60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000			62.30
65. 00 06500 RESPIRATORY THERAPY	1, 058, 429	10, 134, 240	0. 104441			65.00
66. 00 06600 PHYSI CAL THERAPY	149, 709	276, 050	0. 542326			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	201, 597	212, 296	0. 949603			67.00
68.00 06800 SPEECH PATHOLOGY	139, 283	488, 098	0. 285359			68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	167, 582	1, 919, 152	0. 087321			71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 425, 262	1, 481, 548	0. 962009			73.00
74. 00 07400 RENAL DI ALYSI S	386, 518	653, 449	0. 591504			74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	0.000000			76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0. 000000			76. 98
76. 99 07699 LI THOTRI PSY	0	0	0. 000000			76. 99
OUTPATIENT SERVICE COST CENTERS			•			
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS			,			
99. 10 09910 CORF	0	0	0.000000			99. 10
99. 20 09920 OUTPATIENT PHYSICAL THERAPY	0	0	0. 000000			99. 20
99. 30 09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0. 000000			99. 30
99. 40 09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0. 000000			99. 40
200.00 Subtotal (sum of lines 50 thru 199)	4, 285, 615	18, 743, 350	1			200.00
201.00 Less Observation Beds	0					201. 00
202.00 Total (line 200 minus line 201)	4, 285, 615	18, 743, 350				202. 00
	1, ===, =		I .	Į.	ı.	

Health Financial Systems CENT	RAL INDIANA-AMG	SPECIALTY HOS	PIT	In Lieu of Form CMS-2552-10			
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Period: From 09/01/2018 To 08/31/2019			
		Titl∈	XVIII	Hospi tal	PPS		
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.		
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)		
	(from Wkst. B,		Related Cost				
	Part II, col.		(col. 1 - col				
	26)		2)				
	1.00	2.00	3.00	4. 00	5. 00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00 ADULTS & PEDI ATRI CS	826, 964	0	826, 96	4 7, 731	106. 97	30.00	
200.00 Total (lines 30 through 199)	826, 964		826, 96	4 7, 731		200.00	
Cost Center Description	I npati ent	I npati ent					
	Program days	Program					
		Capital Cost					
		(col. 5 x col.					
		6)					
	6.00	7. 00					
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00 ADULTS & PEDIATRICS	5, 854	626, 202				30.00	
200.00 Total (lines 30 through 199)	5, 854	626, 202				200. 00	

In Lieu of Form CMS-2552-10 Health Financial Systems CENTRAL INDIANA-AMG SPECIALTY HOSPIT APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS Provider CCN: 15-2025 Peri od: Worksheet D From 09/01/2018 Part II Date/Time Prepared: 08/31/2019 1/27/2020 11:28 am Title XVIII Hospi tal PPS Cost Center Description Total Charges Ratio of Cost Inpati ent Capital Costs Capi tal to Charges Related Cost (from Wkst. C, Program (column 3 x (from Wkst. B, Part I, col. (col. 1 ÷ col column 4) Charges Part II, col. 8) 2) 26) 1.00 2.00 3.00 4.00 5.00 ANCILLARY SERVICE COST CENTERS 2, 096 50.00 05000 OPERATING ROOM 688, 885 0.003043 528, 659 1, 609 50.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 1,654 1, 585, 302 0.001043 1, 159, 407 1, 209 54.00 60.00 06000 LABORATORY 2,809 1, 304, 330 0.002154 1, 074, 264 2, 314 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 62.30 62.30 0 06500 RESPIRATORY THERAPY 26, 566 10, 134, 240 0.002621 7, 943, 679 65.00 20, 820 65.00 66.00 06600 PHYSI CAL THERAPY 10,718 276, 050 0.038826 211, 106 8, 196 66.00 67.00 06700 OCCUPATIONAL THERAPY 11, 168 212, 296 0.052606 158, 501 8, 338 67.00 10, 571 7, 725 68.00 06800 SPEECH PATHOLOGY 488, 098 0.021658 356, 691 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 1, 919, 152 71.00 68, 680 0.035787 1, 463, 562 52, 376 71.00 73.00 07300 DRUGS CHARGED TO PATIENTS 12, 345 1, 481, 548 0.008333 1, 122, 757 9, 356 73.00 07400 RENAL DIALYSIS 3, 348 0.005124 372, 926 74.00 653, 449 1, 911 74.00 07697 CARDIAC REHABILITATION 76. 97 76. 97 0.000000 0 0 Ω 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0.000000 0 0 76. 98 07699 LI THOTRI PSY 0 76. 99 76. 99 0.000000 OUTPATIENT SERVICE COST CENTERS 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.000000 O 92.00 200.00 Total (lines 50 through 199) 149, 955 18, 743, 350 14, 391, 552 113, 854 200. 00

Health Financial Systems (CENTRAL INDIANA-AMG	SPECIALTY HOS	PIT	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHE	R PASS THROUGH COST	TS Provider CO	F	Period: From 09/01/2018 To 08/31/2019	Date/Time Pre	
		Ti +Lo	: XVIII	Hospi tal	1/27/2020 11: PPS	28 am_
Cost Center Description	Nursing School			Allied Health	All Other	
cost center bescription	Post-Stepdown	indi si ng school	Post-Stepdown		Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1, 00	2A	2, 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	<u>'</u>					
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	(0	0	30. 00
200.00 Total (lines 30 through 199)	0	0	(0	0	200. 00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	I npati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
		minus col. 4)				
LUDATI ENT. DOUTLINE OFFICE OF COOT OFFITEDO	4. 00	5. 00	6. 00	7. 00	8. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0		7 70		F 054	00.00
30. 00 03000 ADULTS & PEDIATRICS	0	0	7, 731			1
200.00 Total (lines 30 through 199) Cost Center Description	Innotiont	0	7, 731	I	5, 854	200. 00
Cost Center Description	Inpatient Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS	<u>'</u>					
30. 00 03000 ADULTS & PEDIATRICS	0					30. 00
200.00 Total (lines 30 through 199)	0					200. 00

THROUGH COSTS

					1/27/2020 11:	28 am_
		Ti tl e	xVIII	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
	Anesthetist	Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	C	(0	0	50. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0) (0	0	54.00
60. 00 06000 LABORATORY	0			0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	l		0	0	62. 30
65. 00 06500 RESPIRATORY THERAPY	0	l		0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	l		0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	l		0	0	67. 00
68, 00 06800 SPEECH PATHOLOGY	0			0	0	68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0			0	0	71. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0			0	0	73. 00
74, 00 07400 RENAL DIALYSIS	0	0	,	0	0	74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	,	0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	l o		0	0	76. 98
76. 99 07699 LI THOTRI PSY	0	l o		0	0	76. 99
OUTPATIENT SERVICE COST CENTERS		-		-1	-	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0		1 ()	0	92. 00
200.00 Total (lines 50 through 199)	0	n		0		200. 00
	1	١ ~	1	-1 91	, ,	

Health Financial Systems CEN	TRAL INDIANA-AMG	SPECIALTY HOS	PIT	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		Provi der CO		Period: From 09/01/2018 To 08/31/2019	Worksheet D Part IV Date/Time Prep 1/27/2020 11:2	
		Title	: XVIII	Hospi tal	PPS	
Cost Center Description	All Other Medical	Total Cost	Total Outpatient	Total Charges		

					1/27/2020 11:	28 am
		Title	Title XVIII		PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)			
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	(688, 885	0.000000	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	(1, 585, 302	0.000000	54.00
60. 00 06000 LABORATORY	0	0	(1, 304, 330	0.000000	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	(0	0.000000	62. 30
65. 00 06500 RESPIRATORY THERAPY	0	0	(10, 134, 240	0.000000	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	(276, 050	0.000000	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	C	212, 296	0.000000	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	C	488, 098	0.000000	68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	C	1, 919, 152	0.000000	71. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	C	1, 481, 548	0.000000	73.00
74.00 07400 RENAL DIALYSIS	0	0	C	653, 449	0.000000	74.00
76.97 07697 CARDIAC REHABILITATION	0	0	C	0	0.000000	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	C	0	0.000000	76. 98
76. 99 07699 LI THOTRI PSY	0	0	(0	0.000000	76. 99
OUTPATIENT SERVICE COST CENTERS						
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	(0	0.000000	92.00
200.00 Total (lines 50 through 199)	0	0	(18, 743, 350		200. 00

Heal th	Financial Systems CENT	RAL INDIANA-AMG	SPECIALTY HOS	PIT	In Lie	eu of Form CMS-2	2552-10	
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provi der Co	Provi der CCN: 15-2025		Worksheet D		
THROU	GH COSTS				From 09/01/2018 To 08/31/2019	Date/Time Pre		
				\0.41.1		1/27/2020 11:	28 am_	
				XVIII	Hospi tal	PPS		
	Cost Center Description	Outpati ent	Inpati ent	Inpatient	Outpati ent	Outpati ent		
		Ratio of Cost	Program	Program	Program	Program		
		to Charges	Charges	Pass-Through		Pass-Through		
		(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9		
		7)		x col. 10)		x col. 12)		
		9. 00	10. 00	11. 00	12.00	13.00		
	ANCILLARY SERVICE COST CENTERS	,						
50. 00	05000 OPERATING ROOM	0. 000000	528, 659	l .	0	0	50. 00	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	1, 159, 407		0	0	54.00	
60.00	06000 LABORATORY	0. 000000	1, 074, 264		0 0	0	60.00	
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0		0 0	0	62. 30	
65.00	06500 RESPI RATORY THERAPY	0. 000000	7, 943, 679		0 0	0	65.00	
66.00	06600 PHYSI CAL THERAPY	0. 000000	211, 106		0	0	66. 00	
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	158, 501		0	0	67. 00	
68.00	06800 SPEECH PATHOLOGY	0. 000000	356, 691		0	0	68. 00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	1, 463, 562		0 0	0	71. 00	
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 122, 757		0 0	0	73. 00	
74.00	07400 RENAL DIALYSIS	0. 000000	372, 926	l .	0 0	0	74.00	
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 000000	0		ol o	0	76. 97	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0		ol o	0	76. 98	
76. 99	07699 LI THOTRI PSY	0. 000000	0		0	0	76. 99	

0. 000000

14, 391, 552

0

0

0 92.00 0 200.00

76. 99 07699 LI THOTRI PSY
0UTPATIENT SERVICE COST CENTERS
92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART

Total (lines 50 through 199)

200.00

0.000000

0

0

0

0

0

0

0

0

0 92.00

0 200.00

0 202. 00

201.00

92. 00 OUTPATIENT SERVICE COST CENTERS
92. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART

Only Charges

Subtotal (see instructions)

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

200.00

201.00

202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provi der CCN: 15-2025 Peri od: Worksheet D From 09/01/2018 To 08/31/2019 Part V Date/Time Prepared: 1/27/2020 11:28 am Title XVIII Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Reimbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 0 0 0 0 0 0 0 0 0 0 54.00 60. 00 06000 LABORATORY 0 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62.30 62.30 65. 00 06500 RESPIRATORY THERAPY 0 65.00 06600 PHYSI CAL THERAPY 0 66.00 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 0 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 71.00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 73 00 74.00 07400 RENAL DIALYSIS 0 74.00 76. 97 07697 CARDIAC REHABILITATION 0 76. 97 07698 HYPERBARI C OXYGEN THERAPY 76.98 0 76.98 76. 99 07699 LI THOTRI PSY 0 76. 99 OUTPATIENT SERVICE COST CENTERS 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 92.00 0 200.00 Subtotal (see instructions) 0 200. 00 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges

0

202.00

202.00

Net Charges (line 200 - line 201)

Health Financial Systems CENT	AL INDIANA-AMG SPECIALTY HOSPIT					2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der Co		Period: From 09/01/2018 To 08/31/2019		pared: 28 am
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	826, 964	0	826, 96	4 7, 731	106. 97	30.00
200.00 Total (lines 30 through 199)	826, 964		826, 96	4 7, 731		200.00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(coi. 5 x col.				
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS	•					
30. 00 ADULTS & PEDIATRICS	0	0				30. 00
200.00 Total (lines 30 through 199)	0	0				200. 00

In Lieu of Form CMS-2552-10 Health Financial Systems CENTRAL INDIANA-AMG SPECIALTY HOSPIT APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS Provi der CCN: 15-2025 Peri od: Worksheet D From 09/01/2018 To 08/31/2019 Part II Date/Time Prepared: 1/27/2020 11:28 am Title XIX Hospi tal PPS Cost Center Description Total Charges Ratio of Cost Inpati ent Capital Costs Capi tal to Charges (column 3 x Related Cost (from Wkst. C, Program (from Wkst. B, Part I, col. (col. 1 ÷ col Charges column 4) 2) Part II, col. 8) 26) 1.00 2.00 3.00 4.00 5.00 ANCILLARY SERVICE COST CENTERS 2, 096 50.00 05000 OPERATING ROOM 688, 885 0.003043 0 50.00 0 54. 00 | 05400 | RADI OLOGY-DI AGNOSTI C 1,654 1, 585, 302 0.001043 0 54.00 60.00 06000 LABORATORY 2,809 1, 304, 330 0.002154 0 60.00 0 0 0 0 0 0 0 0 0 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 0 62.30 62.30 06500 RESPIRATORY THERAPY 26, 566 10, 134, 240 0.002621 65.00 0 65.00 66.00 06600 PHYSI CAL THERAPY 10,718 276, 050 0.038826 0 66.00 67. 00 06700 OCCUPATIONAL THERAPY 11, 168 212, 296 0.052606 0 67.00 68.00 06800 SPEECH PATHOLOGY 10, 571 488, 098 0.021658 0 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 68, 680 1, 919, 152 0.035787 71.00 71.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 12, 345 1, 481, 548 0.008333 0 73.00 07400 RENAL DIALYSIS 3, 348 653, 449 0.005124 74.00 74.00 0 07697 CARDIAC REHABILITATION 76. 97 76. 97 0.000000 0 0 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0.000000 0 76. 98 76. 99 07699 LI THOTRI PSY 0 76. 99 0.000000 OUTPATIENT SERVICE COST CENTERS 92.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.000000 0 Ol

149, 955

18, 743, 350

0 200.00

200.00

Total (lines 50 through 199)

Health Financial Systems	CENTRAL INDIANA-AMG	SPECIALTY HOS	PIT	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHE	R PASS THROUGH COST	TS Provider CO	F	Period: From 09/01/2018 To 08/31/2019		pared:
					1/27/2020 11:	
			e XIX	Hospi tal	PPS	
Cost Center Description		Nursing School		Allied Health	All Other	
	Post-Stepdown		Post-Stepdown		Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1. 00	2A	2. 00	3. 00	
I NPATIENT ROUTI NE SERVI CE COST CENTERS		_	1	.1	_	
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	(0	0	00.00
200.00 Total (lines 30 through 199)	0	0	(0		200. 00
Cost Center Description	Swi ng-Bed	Total Costs		Per Diem (col.	Inpati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
		minus col. 4)				
	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						1
30.00 03000 ADULTS & PEDIATRICS	0	0	7, 731			
200.00 Total (lines 30 through 199)		0	7, 731		0	200. 00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9. 00					
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		Г				
30. 00 03000 ADULTS & PEDI ATRI CS	0					30. 00
200.00 Total (lines 30 through 199)	0					200. 00

THROUGH COSTS

						1/2//2020 11: 2	28 am
			Titl	e XIX	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursing School	Nursing School	I Allied Health	Allied Health	
		Anesthetist	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	C		0	0	50. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0)	0 0	0	54.00
60.00	06000 LABORATORY	0	0)	0 0	0	60. 00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0)	0 0	0	62. 30
65.00	06500 RESPI RATORY THERAPY	0	0)	0 0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0)	0 0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0)	0 0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0	0	1	o o	0	68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1	o o	0	71. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	l o	1	o o	0	73. 00
74.00	07400 RENAL DIALYSIS	0	l o	1	o o	0	74. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	l o	1	o o	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	l o)	o o	0	76. 98
76. 99	07699 LI THOTRI PSY	0	l)	o o	0	76. 99
	OUTPATIENT SERVICE COST CENTERS	•			'		
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00
200.00	Total (lines 50 through 199)	0	0		o o	0	200. 00
		•	•	•	•		,

Health Financial Systems	CENTRAL INDIANA-AMG SF	PECIALTY HOSPIT	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-2025	Period: From 09/01/2018	Worksheet D Part IV Date/Time Prepared:

					Date/Time Prep 1/27/2020 11:	
		Titl	e XIX	Hospital PPS		
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)			
	4.00	5. 00	6. 00	7. 00	8. 00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	(688, 885	0.000000	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	(1, 585, 302		
60. 00 06000 LABORATORY	0	0	(1, 304, 330		
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	(0	0.000000	
65. 00 06500 RESPIRATORY THERAPY	0	0	(10, 134, 240		
66. 00 06600 PHYSI CAL THERAPY	0	0	(276, 050	0.000000	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	(212, 296	0.000000	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	(488, 098	0.000000	68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(1, 919, 152	0.000000	71. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	(1, 481, 548	0.000000	73. 00
74. 00 07400 RENAL DI ALYSI S	0	0	(653, 449	0.000000	74. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	(0	0.000000	76. 97
76. 98 07698 HYPERBARIC OXYGEN THERAPY	0	0	(0	0.000000	76. 98
76. 99 07699 LI THOTRI PSY	0	0	(0	0.000000	76. 99
OUTPATIENT SERVICE COST CENTERS						
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	(0	0.000000	92.00
200.00 Total (lines 50 through 199)	0	0	(18, 743, 350		200. 00

	SPECIALTY HOS			eu of Form CMS-2	2552-10	
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	Provi der Co	CN: 15-2025	Peri od: From 09/01/2018	Worksheet D Part IV	
THROUGH COSTS				To 08/31/2019		nared:
				10 00/31/201/	1/27/2020 11:	28 am
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Outpati ent	I npati ent	Inpatient	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	3	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9. 00	10.00	11. 00	12. 00	13. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0. 000000	0		0	0	50. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	0		0	0	54. 00
60. 00 06000 LABORATORY	0. 000000	0		0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0		0	0	62. 30
65. 00 06500 RESPI RATORY THERAPY	0. 000000	0		0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	0		0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	0		0 0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	0		0 0	0	71. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	0		0 0	0	73. 00
74.00 07400 RENAL DI ALYSI S	0. 000000	0		0 0	0	74. 00
76. 97 O7697 CARDIAC REHABILITATION	0. 000000	0		0 0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0		0 0	0	76. 98
76. 99 07699 LI THOTRI PSY	0. 000000	0		0 0	0	76. 99
OUTPATIENT SERVICE COST CENTERS						
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0 0	0	92. 00
200.00 Total (lines 50 through 199)		0		0 0	0	200. 00

0.591504

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0 92.00

76. 99

0 200.00

0 202. 00

201.00

74.00

76. 97

76.98

76. 99

200.00

201.00

202.00

07400 RENAL DIALYSIS

07699 LI THOTRI PSY

07697 CARDIAC REHABILITATION

Only Charges

07698 HYPERBARI C OXYGEN THERAPY

OUTPATIENT SERVICE COST CENTERS 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Subtotal (see instructions)

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

Health Financial Systems CENTR			RAL INDIANA-AMG SPECIALTY HOSPIT				In Lieu of Form CMS-2552-10			
APPORT	APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND		VACCINE COST	Provi		CN: 15-2025		Date/Time Pro 1/27/2020 11:		
					Ti tl	e XIX	Hospi tal	PPS		
				sts						
		Cost Center Description	Cost	Cos						
			Rei mbursed	Rei mbui						
			Servi ces	Servi ces						
			Subject To	Subj ec						
			Ded. & Coins.	Ded. & C	-					
			(see inst.) 6.00	(see in						
	ANCLLI	ARY SERVICE COST CENTERS	6.00	7.00)					
50. 00		OPERATING ROOM			0				50.00	
		RADI OLOGY-DI AGNOSTI C			0				54.00	
		LABORATORY			0				60.00	
		BLOOD CLOTTING FOR HEMOPHILIACS			0				62. 30	
		RESPIRATORY THERAPY			0				65. 00	
		PHYSI CAL THERAPY			0				66. 00	
		OCCUPATIONAL THERAPY			0				67. 00	
		SPEECH PATHOLOGY			0				68.00	
		MEDICAL SUPPLIES CHARGED TO PATIENT			0				71.00	
		DRUGS CHARGED TO PATIENTS			0				73. 00	
		RENAL DIALYSIS	0		0				74. 00	
		CARDI AC REHABI LI TATI ON	0		o				76. 97	
76. 98	07698	HYPERBARI C OXYGEN THERAPY	0		o				76. 98	
76. 99	07699	LI THOTRI PSY	0		0				76. 99	
	OUTPAT	TIENT SERVICE COST CENTERS		•						
92. 00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0				92. 00	
200.00		Subtotal (see instructions)	0		o				200. 00	
201.00		Less PBP Clinic Lab. Services-Program	0						201. 00	
		Only Charges								
202.00		Net Charges (line 200 - line 201)	0		0				202. 00	

Health Financial Systems	CENTRAL INDIANA-AMG SF	PECIALTY HOSPIT	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST			Peri od:	Worksheet D-1
			From 09/01/2018	Date/Time Prepared:
			10 00/31/2019	1/27/2020 11: 28 am
'		Title XVIII	Hospi tal	DDS

		Title XVIII	Hospi tal	1/27/2020 11: PPS	28 am
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS				
1. 00 2. 00 3. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-bervate room days (excluding swing-bed and observation bed day do not complete this line.	ped and newborn days)	vate room days,	7, 731 7, 731 0	1. 00 2. 00 3. 00
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private roof reporting period		r 31 of the cost	7, 731 0	4. 00 5. 00
6. 00	Total swing-bed SNF type inpatient days (including private roof reporting period (if calendar year, enter 0 on this line)	om days) after December :	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	n days) through December	31 of the cost	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)			0	8. 00
9. 00	Total inpatient days including private room days applicable to newborn days)	0 1		5, 854	9. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct	tions)	,	0	10.00
11. 00 12. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er Swing-bed NF type inpatient days applicable to titles V or XI)	nter O on this line)	, ,	0	11. 00 12. 00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI)	3	,	0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra	ear, enter O on this line	e) ,	0	14. 00
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0 0	15. 00 16. 00
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of	the cost	0. 00	19. 00
20. 00	Medicald rate for swing-bed NF services applicable to services reporting period	s after December 31 of th	ne cost	0.00	20. 00
21. 00 22. 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through Decembe		ng period (line	7, 426, 957 0	21. 00 22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December $ 7 \times 1 $ ine 19)	31 of the cost reporti	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December (x line 20)	31 of the cost reporting	period (line 8	0	25. 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost ((line 21 minus line 26)		0 7, 426, 957	26. 00 27. 00
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	29. 00
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 -	lino 28)		0. 000000	30. 00 31. 00
32. 00	Average private room per diem charge (line 29 ÷ line 3)	- 111le 20 <i>)</i>		0.00000	32. 00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00	33. 00
34.00	Average per diem private room charge differential (line 32 mir	nus line 33)(see instruc	tions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x lin		,	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	and private room cost di	fferential (line	7, 426, 957	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ICTMENTS			
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU		T	0/0 /7	20.00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see	•		960. 67 5, 623, 762	38.00
40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program	•		5, 623, 762	39. 00 40. 00
	Total Program general inpatient routine service cost (line 39)	,		5, 623, 762	

COMPLIT	Financial Systems CENTI ATION OF INPATIENT OPERATING COST	RAL INDIANA-AM		CN: 15-2025	Peri od:	u of Form CMS-2 Worksheet D-1	
					From 09/01/2018 To 08/31/2019	Date/Time Pre 1/27/2020 11:	pared:
			Ti tl e	e XVIII	Hospi tal	PPS	20 4111
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only)						42. 00
12 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT			1			42.00
43. 00 44. 00	CORONARY CARE UNIT						43. 00 44. 00
15. 00	BURN INTENSIVE CARE UNIT						45. 00
6. 00	SURGICAL INTENSIVE CARE UNIT						46. 00
17. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1.00	
8. 00	Program inpatient ancillary service cost (Wk	st D-3 col	3 line 200)			1. 00 3, 217, 369	48. 00
9. 00	Total Program inpatient costs (sum of lines			ons)		8, 841, 131	
7. 00	PASS THROUGH COST ADJUSTMENTS	Tr till odgir 10)	(300 111311 4011 6	5113)		0,011,101	17.00
0. 00	Pass through costs applicable to Program inp.	atient routine	services (from	m Wkst. D, sur	n of Parts I and	626, 202	50.00
51. 00	Pass through costs applicable to Program inpand IV)	atient ancilla	ry services (fr	rom Wkst. D, s	sum of Parts II	113, 854	51.00
2. 00	Total Program excludable cost (sum of lines	50 and 51)				740, 056	52. 00
53. 00	Total Program inpatient operating cost exclu		elated, non-phy	ysician anestl	netist, and	8, 101, 075	
	medical education costs (line 49 minus line	52)					
	TARGET AMOUNT AND LIMIT COMPUTATION						
4. 00 5. 00	Program discharges Target amount per discharge					0 0. 00	
6. 00	Target amount (line 54 x line 55)					0.00	1
7. 00	Difference between adjusted inpatient operat	ing cost and t	arget amount (I	ine 56 minus	line 53)	0	
8. 00	Bonus payment (see instructions)	3	J		,	0	
9. 00	Lesser of lines $53/54$ or 55 from the cost re	porting period	endi ng 1996, ι	updated and co	ompounded by the	0. 00	59. 00
0 00	market basket					0.00	/0.00
50. 00 51. 00	Lesser of lines 53/54 or 55 from prior year of line 53/54 is less than the lower of line				the amount by	0. 00 0	
71.00	which operating costs (line 53) are less than					0	01.00
	amount (line 56), otherwise enter zero (see		to (o o . x	00), 0. 1.0 0	the target		
52. 00	Relief payment (see instructions)					0	
53. 00	Allowable Inpatient cost plus incentive paym	ent (see instr	uctions)			0	63. 00
54. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dec	ember 31 of the	e cost reporti	na period (See	0	64.00
	instructions) (title XVIII only)	g			(
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decem	per 31 of the d	cost reportin	g period (See	0	65. 00
66. 00	instructions)(title XVIII only)	no costs (lino	44 plus lino 4	4E) (+; + o V/	Lonly) For	0	44 00
36. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (Tine	04 prus rine t	os)(title xvi	i only). For	U	66. 00
57. 00	Title V or XIX swing-bed NF inpatient routing	e costs throug	n December 31 d	of the cost re	eporting period	0	67. 00
	(line 12 x line 19)	9					
58. 00	Title V or XIX swing-bed NF inpatient routing	e costs after	December 31 of	the cost repo	orting period	0	68. 00
59. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient		•			0	69. 00
70.00	PART III - SKILLED NURSING FACILITY, OTHER NI						70.00
'0. 00 '1. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of	-)		70.00
2. 00	Program routine service cost (line 9 x line		THE 70 - TIME	۷)			71.00
3. 00	Medically necessary private room cost applications		m (line 14 x li	ne 35)			73. 00
74. 00	Total Program general inpatient routine serv						74. 00
75. 00	Capital -related cost allocated to inpatient	routine servic	e costs (from V	Worksheet B, I	Part II, column		75. 00
	26, line 45)						
76. 00	Per diem capital-related costs (line 75 ÷ li						76. 00

76.00 Per diem capital-related costs (line 75 ÷ line 2) 76.00 77.00 Program capital-related costs (line 9 x line 76)
78.00 Inpatient routine service cost (line 74 minus line 77) 77.00 78.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 79.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 80.00 Inpatient routine service cost per diem limitation 81.00 81.00 82.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 83.00 Reasonable inpatient routine service costs (see instructions) 83.00 84.00 Program inpatient ancillary services (see instructions) 84.00 Utilization review - physician compensation (see instructions)
Total Program inpatient operating costs (sum of lines 83 through 85)
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 85. 00 85.00 86.00 86.00 87.00 Total observation bed days (see instructions)
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 88. 00 0.00 0 89.00 89.00 Observation bed cost (line 87 x line 88) (see instructions)

Health Financial Systems CENTI	RAL INDIANA-AMG	SPECIALTY HOSI	PLT	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Peri od:	Worksheet D-1	
				From 09/01/2018 To 08/31/2019		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	826, 964	7, 426, 957	0. 11134	6 0	0	90.00
91.00 Nursing School cost	0	7, 426, 957	0.00000	0	0	91.00
92.00 Allied health cost	0	7, 426, 957	0.00000	0	0	92. 00
93.00 All other Medical Education	0	7, 426, 957	0. 00000	0 0	0	93. 00

Health Financial Systems	CENTRAL INDIANA-AMG SF	PECIALTY HOSPIT	In Lieu	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-2025	Peri od: From 09/01/2018 To 08/31/2019	Worksheet D-1 Date/Time Prepared: 1/27/2020 11:28 am
		Title YIY	Hospi tal	DDC

		Ti +Lo VIV	Hospi tal	1/27/2020 11: PPS	28 am
	Cost Center Description	Title XIX	Hospi tal	PPS	
	·			1. 00	
	PART I - ALL PROVIDER COMPONENTS				
1. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days	excluding newborn)		7, 731	1.00
2. 00	Inpatient days (including private room days, excluding swing-k			7, 731	2.00
3.00	Private room days (excluding swing-bed and observation bed day	/s). If you have only pr	ivate room days,	0	3. 00
	do not complete this line.			7 704	
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private roo		r 21 of the cost	7, 731 0	4. 00 5. 00
5.00	reporting period	on days) through becembe	i si di the cost	U	3.00
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)				
7. 00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room	n days) after December 3	1 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	days) arter becomber o	i or the cost	· ·	0.00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	0	9. 00
40.00	newborn days)				40.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct		oom days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, er	nter O on this line)	,		
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI)	only (including private	e room days)	0	12. 00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI)	(only (including privat	e room days)	0	13. 00
13.00	after December 31 of the cost reporting period (if calendar ye			O	13.00
14.00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed	days)	0	14. 00
15. 00	Total nursery days (title V or XIX only)			0	15.00
16. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17. 00
	reporting period	3			
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	through Docombor 21 of	the cost	0.00	19. 00
19.00	reporting period	s through becember 31 or	the cost	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	he cost	0.00	20. 00
	reporting period				
21. 00 22. 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through Decembe		ing ported (line	7, 426, 957 0	21. 00 22. 00
22.00	5 x line 17)	or 31 or the cost report	ing period (inte	O	22.00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00
	x line 18)				
24. 00	Swing-bed cost applicable to NF type services through December 7×1 ine 19)	31 of the cost reporti	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
	x line 20)	. 0			
26. 00	Total swing-bed cost (see instructions)	(1: 21 -: 1: 2/)		7 424 057	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(Tine 21 minus Tine 26)		7, 426, 957	27. 00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)		J ,	0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27	- line 28)		0. 000000	31.00
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00	32. 00 33. 00
34. 00	Average per diem private room charge differential (line 32 mir	nus line 33)(see instruc	tions)	0.00	•
35. 00	Average per diem private room cost differential (line 34 x lin			0.00	35. 00
36.00	Private room cost differential adjustment (line 3 x line 35)		66	0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	rrerential (line	7, 426, 957	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			960. 67	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	•		0	39.00
40. 00 41. 00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39			0	40. 00 41. 00
55	1.112 13. dai. 30.10. dapat. 5t Toutino 301 vi 00 005t (11110 07		ı	O	

		RAL INDIANA-AMO				eu of Form CMS-	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der C	CN: 15-2025	Period: From 09/01/2018	Worksheet D-1	
					To 08/31/2019		
			T: +1	a VIV	Hooni tal	1/27/2020 11:	28 am
	Cost Center Description	Total	Total	e XIX Average Per	Hospital Program Days	PPS Program Cost	
	oost conten bosci i pti on		Inpatient Days			(col. 3 x col.	
				col . 2)		4)	
12.00	NUDCEDY (+: +1 - V o VIV1)	1.00	2. 00	3. 00	4. 00	5. 00	42.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units						42. 00
43. 00	INTENSIVE CARE UNIT						43. 00
14. 00	CORONARY CARE UNIT						44.00
	BURN INTENSIVE CARE UNIT						45. 00
	SURGICAL INTENSIVE CARE UNIT						46. 00
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
	cost center bescription					1.00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	3, line 200)			0	48. 00
49. 00		41 through 48)	(see instructio	ons)		0	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS	ationt routing	comiless (from	» Wkat D au	m of Donto L and	0	50.00
30. 00	III)	atrent routine	services (110	II WKSt. D, Su	III OI PAILS I AIIU	0	30.00
51. 00		atient ancilla	y services (fr	om Wkst. D,	sum of Parts II	0	51.00
	and IV)						
52. 00	Total Program excludable cost (sum of lines	vice cost (Wkst. D-3, col. 3, line 200) sum of lines 41 through 48)(see instructions) o Program inpatient routine services (from Wkst. D, sum of Parts I ar o Program inpatient ancillary services (from Wkst. D, sum of Parts II sum of lines 50 and 51) ng cost excluding capital related, non-physician anesthetist, and 9 minus line 52) TION 5) atient operating cost and target amount (line 56 minus line 53)) m the cost reporting period ending 1996, updated and compounded by the m prior year cost report, updated by the market basket lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by are less than expected costs (lines 54 x 60), or 1% of the target er zero (see instructions) s) ncentive payment (see instructions) BED COST t routine costs through December 31 of the cost reporting period (See		L-4!-4	0		
53. 00	medical education costs (line 49 minus line		erated, non-pny	ysician anest	netist, and	0	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION	02)					
	Program di scharges					0	
	Target amount per discharge					0.00	1
	Target amount (line 54 x line 55)	ing coot and to	wast smount (ino E/ minuo	line E2)	0	
	Bonus payment (see instructions)	ing cost and ta	arget amount (i	The 56 minus	11 ne 53)	0	1
59. 00		porting period	endi ng 1996, u	updated and c	ompounded by the	-	
	market basket		3				
60.00						0.00	1
61.00						0	61. 00
	amount (line 56), otherwise enter zero (see		.5 (TITIES 54 X	00), 01 1% 0	i the target		
	Relief payment (see instructions)	•				0	62. 00
63. 00	Allowable Inpatient cost plus incentive paym	ent (see instru	uctions)			0	63. 00
64 00	PROGRAM INPATIENT ROUTINE SWING BED COST	ts through Doc	mbor 21 of the	cost roport	ing pariod (Saa	0	64. 00
04.00	instructions) (title XVIII only)	is through become	elliber 31 of the	e cost report	ing period (see	0	04.00
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	oer 31 of the o	cost reportin	g period (See	0	65. 00
	instructions)(title XVIII only)						
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	65)(title XVI	ll only). For	0	66. 00
57. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 o	of the cost r	eporting period	0	67. 00
37.00	(line 12 x line 19)	o ocoto tili odg.	. 200020. 0. 0		opor tring por rou		07.00
68. 00	Title V or XIX swing-bed NF inpatient routin	e costs after [December 31 of	the cost rep	orting period	0	68. 00
0.00	(line 13 x line 20)	noutine costs	lina (7 . lina	. (0)			40.00
59. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N		•			0	69. 00
70. 00	Skilled nursing facility/other nursing facil)		70.00
	Adjusted general inpatient routine service c	-					71. 00
	Program routine service cost (line 9 x line			>			72. 00
	Medically necessary private room cost applic						73.00
4. 00 5. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•			Part II column		74. 00 75. 00
5.00	26, line 45)	TOUTTHE SET VICE	COSES (TIOHIV	TO KSHEEL D,	rart II, COTUIIII		/ 3.00
7/ 00	Por diam capital related costs (line 75 : li					i .	

Health Financial Systems CENTI	RAL INDIANA-AMG	SPECIALTY HOSI	PI T	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Peri od:	Worksheet D-1	
				From 09/01/2018 To 08/31/2019	Date/Time Pre 1/27/2020 11:	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	826, 964	7, 426, 957	0. 11134	6 0	0	90. 00
91.00 Nursing School cost	0	7, 426, 957	0.00000	0	0	91.00
92.00 Allied health cost	0	7, 426, 957	0.00000	0	0	92.00
93.00 All other Medical Education	0	7, 426, 957	0. 00000	0 0	0	93. 00

Health Fina	nncial Systems CENTRAL INDIANA-AMG SI	PECIALTY HOS	PIT	In Lie	u of Form CMS-2	2552-10
I NPATI ENT	ANCILLARY SERVICE COST APPORTIONMENT	Provi der Co	CN: 15-2025	Peri od:	Worksheet D-3	
				From 09/01/2018 To 08/31/2019	Date/Time Pre 1/27/2020 11:	
		Title	XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos	The state of the s	I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
	THE POLITIME OF DIVINE CONT. OF LITERS		1. 00	2. 00	3. 00	
	TIENT ROUTINE SERVICE COST CENTERS			0.405.400		
	O ADULTS & PEDI ATRI CS			8, 195, 600		30. 00
	LLARY SERVICE COST CENTERS O OPERATING ROOM		0. 35122	23 528, 659	185, 677	50.00
	O RADI OLOGY-DI AGNOSTI C		0. 35122			ł
	IO RADI OLOGY-DI AGNOSTI C IO LABORATORY		0. 12048			60.00
	O BLOOD CLOTTING FOR HEMOPHILIACS		0. 2488		207,001	62. 30
	O RESPIRATORY THERAPY		0. 10444		829. 646	65.00
	O PHYSI CAL THERAPY		0. 10442		114, 488	
	O OCCUPATI ONAL THERAPY		0. 94960		150, 513	1
	O SPEECH PATHOLOGY		0. 28535		101, 785	1
	O MEDICAL SUPPLIES CHARGED TO PATIENT		0. 08732	·	127, 800	
	O DRUGS CHARGED TO PATIENTS		0. 96200			
	O RENAL DI ALYSI S		0. 59150		220, 587	1
	7 CARDI AC REHABI LI TATI ON		0.00000		0	
	8 HYPERBARI C OXYGEN THERAPY		0.00000		0	
	9 LI THOTRI PSY		0.00000		0	
	ATIENT SERVICE COST CENTERS					
92.00 0920	O OBSERVATION BEDS (NON-DISTINCT PART		0.00000	00	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)			14, 391, 552	3, 217, 369	200. 00
201. 00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201. 00
202.00	Net charges (line 200 minus line 201)	·		14, 391, 552		202. 00

Health Financial Systems CENTRAL INDIANA-AMG SPE	CLALTY HOSPLT	In Lie	eu of Form CMS-:	2552-10
· · · · · · · · · · · · · · · · · · ·	Provi der CCN: 15-2025	Peri od:	Worksheet D-3	
		From 09/01/2018		
		To 08/31/2019		
	T: +1 - VI V	11! +-1	1/27/2020 11:	28 am
Cook Cooker Doored at the	Title XIX Ratio of C	Hospi tal	PPS	
Cost Center Description			Inpatient	
	To Charge	9	Program Costs	
		Charges	(col. 1 x col. 2)	
	1.00	2. 00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS		C	i	30.00
ANCI LLARY SERVI CE COST CENTERS	<u>'</u>			00.00
50. 00 05000 OPERATI NG ROOM	0. 351	223 C	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 120)484 C	o o	54.00
60. 00 06000 LABORATORY	0. 248		o o	
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000	0000	0	62. 30
65. 00 06500 RESPI RATORY THERAPY	0. 104	441	o o	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 542	326	0	66, 00
67. 00 06700 OCCUPATI ONAL THERAPY	0.949	603	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 285	359	0	68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.087	321 0	o o	1
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 962	2009	o o	73. 00
74. 00 07400 RENAL DI ALYSI S	0. 591	504 C	0	74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0.000	0000	0	76, 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0.000		0	76, 98
76. 99 07699 LI THOTRI PSY	0.000	0000	o o	76. 99
OUTPATIENT SERVICE COST CENTERS		•		
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART	0.000	0000	0	92. 00
200.00 Total (sum of lines 50 through 94 and 96 through 98)		C	0	200. 00
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)	C		201. 00
202.00 Net charges (Line 200 minus Line 201)			J	202.00

0 92.00 0 200.00 201.00 202.00

202.00

Net charges (line 200 minus line 201)

Part I

Peri od:

From 09/01/2018 08/31/2019 Date/Time Prepared: 1/27/2020 11:28 am Title XVIII Hospi tal PPS Part B Inpatient Part A mm/dd/yyyy mm/dd/yyyy Amount Amount 1.00 2.00 3.00 4.00 1.00 Total interim payments paid to provider 9, 161, 226 1. 00 0 2.00 Interim payments payable on individual bills, either 2.00 submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment 3.00 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) Program to Provider 3.01 ADJUSTMENTS TO PROVIDER 08/31/2019 177, 065 0 3.01 3.02 0 3.02 3.03 0 3.03 0 3.04 0 0 3.04 3.05 0 0 3.05 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 0 0 3.50 0 3.51 0 3.51 0 0 3.52 3.52 3.53 0 3.53 0 3.54 0 0 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 177, 065 0 3.99 3.50-3.98) 9, 338, 291 0 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropri ate) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after 5.00 desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 5.01 TENTATIVE TO PROVIDER 0 0 5.02 0 0 5.02 0 5.03 0 5.03 Provider to Program 5.50 TENTATI VE TO PROGRAM 0 0 5.50 5.51 0 0 5. 51 0 5.52 0 5.52 0 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 5.99 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on 6.00 the cost report. (1) SETTLEMENT TO PROVIDER 6.01 0 6.01 6 02 SETTLEMENT TO PROGRAM 52, 215 0 6.02 7.00 Total Medicare program liability (see instructions) 9, 286, 076 7.00 Contractor NPR Date (Mo/Day/Yr) Number

0

1 00

2 00

8.00

8.00 Name of Contractor

Health Financial Systems	CENTRAL INDIANA-AMG SPE	ECIALTY HOSPIT	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 15-2025	From 09/01/2018	Worksheet E-3 Part IV Date/Time Prepared:

			10 00/31/2019	1/27/2020 11:	
		Title XVIII	Hospi tal	PPS	
	· · · · · · · · · · · · · · · · · · ·				
				1. 00	
	PART IV - MEDICARE PART A SERVICES - LTCH PPS				
1.00	Net Federal PPS Payments (see instructions)			9, 490, 447	1.00
1.01	Full standard payment amount			7, 264, 016	1. 01
1.02	Short stay outlier standard payment amount			2, 020, 203	1. 02
1.03	Site neutral payment amount - Cost			46, 670	1. 03
1.04	Site neutral payment amount - IPPS comparable			159, 558	1. 04
2.00	Outlier Payments			187, 475	2.00
3.00	Total PPS Payments (sum of lines 1 and 2)			9, 677, 922	3. 00
4.00	Nursing and Allied Health Managed Care payments (see instructi	ons)		0	4.00
5.00	Organ acquisition (DO NOT USE THIS LINE)				5. 00
6.00	Cost of physicians' services in a teaching hospital (see instr	ructions)		0	6.00
7.00	Subtotal (see instructions)			9, 677, 922	7. 00
8.00	Primary payer payments			0	8. 00
9.00	Subtotal (line 7 less line 8).			9, 677, 922	9. 00
10.00	Deducti bl es			62, 561	10.00
11.00	Subtotal (line 9 minus line 10)			9, 615, 361	11. 00
12.00	Coinsurance			267, 171	12. 00
13.00	Subtotal (line 11 minus line 12)			9, 348, 190	13. 00
14.00	Allowable bad debts (exclude bad debts for professional service	ces) (see instructions)		195, 997	14. 00
15.00	Adjusted reimbursable bad debts (see instructions)			127, 398	15. 00
16.00	Allowable bad debts for dual eligible beneficiaries (see insti	ructions)		87, 491	16. 00
17.00	Subtotal (sum of lines 13 and 15)			9, 475, 588	17. 00
18.00	Direct graduate medical education payments (from Wkst. E-4, li	ne 49)		0	18. 00
19.00	Other pass through costs (see instructions)			0	19. 00
20.00	Outlier payments reconciliation			0	20. 00
21.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	21. 00
21. 50	Pioneer ACO demonstration payment adjustment (see instructions	s)		0	21. 50
21. 99	Demonstration payment adjustment amount before sequestration			0	21. 99
22. 00	Total amount payable to the provider (see instructions)			9, 475, 588	22. 00
22. 01	Sequestration adjustment (see instructions)			189, 512	
22. 02	Demonstration payment adjustment amount after sequestration			0	22. 02
23.00	Interim payments			9, 338, 291	23. 00
24.00	Tentative settlement (for contractor use only)			0	24. 00
25.00	Balance due provider/program (line 22 minus lines 22.01, 22.02	2, 23 and 24)		-52, 215	25. 00
26.00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2,	chapter 1,	0	26. 00
	§115. 2				
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount from Wkst. E-3, Pt IV, line 2 (see ins	structions)		187, 475	
	Outlier reconciliation adjustment amount (see instructions)			0	
52. 00	, , , , , , , , , , , , , , , , , , , ,	uctions)			52.00
53. 00	Time Value of Money (see instructions)			0	53.00

Health Financial Systems CENTRAL INDIANA-BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column onl y)

Provider CCN: 15-2025

| Period: | Worksheet G | From 09/01/2018 | To 08/31/2019 | Date/Time Prepared: 1/27/2020 11: 28 am

oni y)					1/27/2020 11:	
		General Fund		Endowment Fund		
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS		2.00	0.00	00	
1.00	Cash on hand in banks	-215, 542		0	0	1. 00
2.00	Temporary investments Notes receivable	0	0	0	0	2.00
3. 00 4. 00	Accounts receivable	2, 168, 937	0	0	0	3. 00 4. 00
5. 00	Other recei vable	2, 100, 737	Ö	ő	Ö	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	o	0	6. 00
7.00	Inventory	0	0	0	0	7. 00
8.00	Prepaid expenses	202, 088		0	0	8. 00
9.00	Other current assets		0	0	0	9.00
10. 00 11. 00	Due from other funds Total current assets (sum of lines 1-10)	2, 155, 483		0	0	10. 00 11. 00
11.00	FIXED ASSETS	2, 133, 403		<u> </u>		11.00
12.00	Land	0	0	0	0	12. 00
13.00	Land improvements	C	0	0	0	13. 00
14. 00	Accumulated depreciation	0	0	0	0	14. 00
15. 00 16. 00	Buildings Accumulated depreciation		0	0	0	15. 00 16. 00
17. 00	Leasehold improvements	110, 439		0	0	17. 00
18. 00	Accumul ated depreciation	110, 107	ő	o	Ö	18. 00
19.00	Fi xed equipment	0	0	О	0	19. 00
20. 00	Accumulated depreciation	0	0	0	0	20. 00
21. 00	Automobiles and trucks	0	0	0	0	21. 00
22. 00 23. 00	Accumulated depreciation Major movable equipment	1, 013, 913	0	0	0	22. 00 23. 00
24. 00	Accumulated depreciation	-896, 807	1	0	0	24. 00
25. 00	Mi nor equi pment depreci abl e	0,00,007	ő	o	Ö	25. 00
26.00	Accumulated depreciation	0	0	O	0	26. 00
27. 00	HIT designated Assets	0	0	0	0	27. 00
28. 00	Accumulated depreciation	1 7/7 004	0	0	0	28. 00
29. 00 30. 00	Minor equipment-nondepreciable Total fixed assets (sum of lines 12-29)	1, 767, 984 1, 995, 529		0	0	29. 00 30. 00
30.00	OTHER ASSETS	1, 773, 327	0	<u> </u>	0	30.00
31.00	Investments	0	0	0	0	31. 00
32. 00	Deposits on Leases	180, 200	0	0	0	32. 00
33. 00	Due from owners/officers	0	0	0	0	33. 00
34. 00 35. 00	Other assets Total other assets (sum of Lines 21 24)	180, 200	0	0	0	34. 00 35. 00
36. 00	Total other assets (sum of lines 31-34) Total assets (sum of lines 11, 30, and 35)	4, 331, 212		0	0	36.00
00.00	CURRENT LI ABI LI TI ES	1,001,212		<u>~</u>	0	00.00
37. 00	Accounts payable	2, 784, 308	0	0	0	37. 00
38. 00	Salaries, wages, and fees payable	187, 016	0	0	0	38. 00
39. 00	Payroll taxes payable	0	0	0	0	39. 00
40. 00 41. 00	Notes and Loans payable (short term) Deferred income		0	0	0	40. 00 41. 00
42. 00	Accel erated payments			ď	١	42. 00
43. 00	Due to other funds		0	О	0	
44.00	Other current liabilities	2, 191, 826	0	O	0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	5, 163, 150	0	0	0	45. 00
46 00	LONG TERM LIABILITIES Mortgage payable	T c	0	ol	0	46. 00
46. 00 47. 00	Notes payable	701, 008		0	0	47. 00
48. 00	Unsecured Loans	0	ő	o	Ö	48. 00
49. 00	Other long term liabilities	0	0	О	0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	701, 008		0	0	50. 00
51. 00	Total liabilities (sum of lines 45 and 50)	5, 864, 158	0	0	0	51. 00
52. 00	CAPITAL ACCOUNTS General fund balance	-1, 532, 946				52. 00
53. 00	Specific purpose fund	-1, 532, 940	0			53. 00
54. 00	Donor created - endowment fund balance - restricted			0		54. 00
55.00	Donor created - endowment fund balance - unrestricted			0		55. 00
56.00	Governing body created - endowment fund balance			0		56. 00
57. 00	Plant fund balance - invested in plant				0	57. 00
58. 00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58. 00
59. 00	Total fund balances (sum of lines 52 thru 58)	-1, 532, 946	О	0	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	4, 331, 212		o	0	60. 00
	[59]			ļ		

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-2025

						1/27/2020 11:	28 am
		General	Fund	Speci al F	Purpose Fund	Endowment Fund	
	T=	1.00	2. 00	3. 00	4. 00	5. 00	
1.00	Fund balances at beginning of period		1, 850, 533		C)	1. 00
2. 00	Net income (loss) (from Wkst. G-3, line 29)		317, 587		_		2. 00
3. 00	Total (sum of line 1 and line 2)	_	2, 168, 120		C) _	3. 00
4. 00	Additions (credit adjustments) (specify)	0			0	0	4. 00
5.00		0			0	0	5. 00
6. 00		0			0	0	6. 00
7.00		0			0	0	7. 00
8.00		0			0	0	8. 00
9.00	T-+-1 -	0	0		0	0	9.00
10.00	Total additions (sum of line 4-9)		0 4/0 400				10.00
11.00	Subtotal (line 3 plus line 10)		2, 168, 120)	11.00
12.00	Deductions (debit adjustments) (specify)	0			0	0	12.00
13.00		0			0	0	13.00
14.00		0			0	0	14. 00 15. 00
15. 00 16. 00		0			0	0	16. 00
17. 00		0			0		17. 00
18. 00	Total deductions (sum of lines 12-17)	U					18. 00
19. 00	Fund balance at end of period per balance		2, 168, 120				19. 00
17.00	sheet (line 11 minus line 18)		2, 100, 120			'	17.00
	Torrect (TTTIO TT IIII NAS TTTIO TO)	Endowment Fund	PI ant	Fund			
		6.00	7. 00	8. 00			
1. 00	Fund balances at beginning of period	0.00	7.00	0.00	0		1. 00
2. 00	Net income (loss) (from Wkst. G-3, line 29)	9					
					U .		
							2. 00
3.00	Total (sum of line 1 and line 2)	0	0		0		2. 00 3. 00
3. 00 4. 00		0	0				2. 00 3. 00 4. 00
3.00	Total (sum of line 1 and line 2)	o	0 0				2. 00 3. 00
3. 00 4. 00 5. 00	Total (sum of line 1 and line 2)	0	0 0 0 0				2. 00 3. 00 4. 00 5. 00
3. 00 4. 00 5. 00 6. 00	Total (sum of line 1 and line 2)	O	0 0 0 0				2. 00 3. 00 4. 00 5. 00 6. 00
3. 00 4. 00 5. 00 6. 00 7. 00	Total (sum of line 1 and line 2)	0	0 0 0 0				2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Total (sum of line 1 and line 2)	0	0 0 0 0 0				2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	Š	0 0 0 0 0		0		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9)	0	0 0 0 0 0		0		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	0	0 0 0 0 0 0		0		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00	Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	0	0 0 0 0 0 0		0		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00	Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	0	0 0 0 0 0 0		0		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 11. 00 12. 00 13. 00 14. 00 15. 00
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00	Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	0	0 0 0 0 0 0		0		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0 0	0 0 0 0 0 0 0		0 0 0		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17)	0 0	0 0 0 0 0 0		0 0 0		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance	0 0	0 0 0 0 0 0		0 0 0		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17)	0 0	0 0 0 0 0 0 0		0 0 0		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00

		'	0 00/31/2019	1/27/2020 11:	
	Cost Center Description	Inpati ent	Outpati ent	Total	
		1.00	2.00	3. 00	
PART I - PATIENT REVENUES					
	General Inpatient Routine Services				
1.00	Hospi tal	10, 669, 995		10, 669, 995	1.00
2.00	SUBPROVI DER - I PF				2.00
3.00	SUBPROVI DER - I RF				3.00
4.00	SUBPROVI DER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7. 00
8.00	NURSING FACILITY				8. 00
9.00	OTHER LONG TERM CARE				9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	10, 669, 995		10, 669, 995	10.00
	Intensive Care Type Inpatient Hospital Services				
11. 00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGI CAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16.00	Total intensive care type inpatient hospital services (sum of lines	0		0	16.00
	11-15)				
17.00	Total inpatient routine care services (sum of lines 10 and 16)	10, 669, 995		10, 669, 995	17.00
18.00	Ancillary services	18, 743, 350	0	18, 743, 350	18.00
19.00	Outpati ent servi ces	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22. 00
23.00	AMBULANCE SERVI CES				23.00
24.00	CMHC				24.00
24. 10	CORF	0	0	0	24. 10
24. 20	OUTPATIENT PHYSICAL THERAPY	0	o	0	24. 20
24. 30	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	24. 30
24. 40	OUTPATIENT SPEECH PATHOLOGY	0	o	0	24. 40
25.00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26.00	HOSPI CE				26. 00
27.00	OTHER (SPECIFY)	0	o	0	27. 00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	29, 413, 345	o	29, 413, 345	28. 00
	G-3, line 1)				
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		12, 701, 331		29. 00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38. 00		0			38. 00
39. 00		0			39. 00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		o		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer		12, 701, 331		43.00
	to Wkst. G-3, line 4)				

Health Financial Systems	CENTRAL INDIANA-AMG SF	CENTRAL INDIANA-AMG SPECIALTY HOSPIT		In Lieu of Form CMS-2552-10		
STATEMENT OF REVENUES AND EXPENSES		Provider CCN: 15-2025	Peri od:	Worksheet G-3		

Heal th	Financial Systems CENTRAL INDIANA-AMG	CENTRAL INDIANA-AMG SPECIALTY HOSPIT		u of Form CMS-2552-10	
STATEMENT OF REVENUES AND EXPENSES		Provider CCN: 15-2025	Peri od:	Worksheet G-3	
			From 09/01/2018	D . /T' D	
	To 08/31/2019			Date/Time Prepared: 1/27/2020 11:28 am	
				1/21/2020 11.	20 4111
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, I	ine 28)		29, 413, 345	1. 00
2.00	Less contractual allowances and discounts on patients' accounts			16, 395, 487	2.00
3.00	Net patient revenues (line 1 minus line 2)			13, 017, 858	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)			12, 701, 331	4.00
5.00	Net income from service to patients (line 3 minus line 4)			316, 527	5.00
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			393	7.00
8.00	Revenues from telephone and other miscellaneous communicati	on services		0	8.00
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11.00
12.00	Parking Lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			0	14.00
15.00	Revenue from rental of living quarters			0	15.00
16.00	Revenue from sale of medical and surgical supplies to other	than patients		0	16.00
17. 00	Revenue from sale of drugs to other than patients			0	17.00
18. 00	Revenue from sale of medical records and abstracts			667	18.00
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21.00	Rental of vending machines			0	21.00
22.00	Rental of hospital space			0	22.00
23.00	Governmental appropriations			0	23.00
24.00	OTHER (SPECIFY)			0	24.00
25.00	Total other income (sum of lines 6-24)			1, 060	25.00
26.00	Total (line 5 plus line 25)			317, 587	26.00
27.00	OTHER EXPENSES (SPECIFY)			0	27.00
28. 00	Total other expenses (sum of line 27 and subscripts)			0	28.00
29. 00	Net income (or loss) for the period (line 26 minus line 28)			317, 587	29. 00