near til Fillanci	ai systems	Renabilitation nospital	or nor therm mar	III LI E	u oi foill civis	-2002-10
This report is	required by law (42 USC 1395g;	42 CFR 413.20(b)). Fail	lure to report can r	esult in all interim	FORM APPROVE	D
payments made	since the beginning of the cost	t reporting period being	deemed overpayments	(42 USC 1395g).	OMB NO. 0938	
					EXPIRES 09-3	0-2025
HOSPITAL AND H AND SETTLEMENT	OSPITAL HEALTH CARE COMPLEX COS SUMMARY	ST REPORT CERTIFICATION	Provider CCN: 15-304	From 05/01/2023	Worksheet S Parts I-III Date/Time Pr 9/9/2024 1:5	
PART I - COST	REPORT STATUS					
Provi der	1. [ X ] Electronically prepare	d cost report		Date: 9/9/202	4 Time:	1:53 pm
use only	2. [ ] Manually prepared cost	report				
	3. [ 0 ] If this is an amended 4. [ F ] Medicare Utilization.				ost report	
Contractor use only	(1) As Submitted 7 (2) Settled without Audit 8	o. Date Received: C. Contractor No. B. [ N ] Initial Report fo D. [ N ] Final Report for	or this Provider CCN	10. NPR Date: 11. Contractor's Vendo 12. [ 0 ]If line 5, co number of tim	olumn 1 is 4:	

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

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 submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by Rehabilitation Hospital of Northern Indiana (15-3047) for the cost reporting period beginning 05/01/2023 and ending 04/30/2024 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.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
		1	2	SI GNATURE STATEMENT	
1	Са	leb Reed	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Cal eb Reed			2
3	Signatory Title	EVP FINANCE			3
4	Date	(Dated when report is electronica			4

			Title	XVIII			
		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	72, 496	0	0	0	1. 00
2.00	SUBPROVI DER - I PF	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
7.00	SKILLED NURSING FACILITY	0	0	0		0	7. 00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	TOTAL	0	72, 496	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 number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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

Health Financial Systems Rehabilitation Hospital of Northern Indi In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-3047 Peri od: Worksheet S-2 From 05/01/2023 Part I Date/Time Prepared: 04/30/2024 9/9/2024 1:53 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 4807 Edison Lakes Parkway 1.00 PO Box: 1.00 State: IN 2.00 City: Mishawaka Zip Code: 46545 County: ST. **JOSEPH** 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N)
V 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 Rehabilitation Hospital 153047 43780 5 05/28/2020 Ν 3.00 of Northern Indiana 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 11.00 Hospi tal -Based OLTC 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 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 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: 1. 00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 05/01/2023 04/30/2024 20.00 21.00 Type of Control (see instructions) 21.00 4 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. Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no 22.01 Ν Ν 22.01 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) 22.02 Is this a newly merged hospital that requires a final UCP to be Ν Ν 22.02 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 22.03 N Ν 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. 22.04 Did this hospital receive a geographic reclassification from urban to 22.04 rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? 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, yes or "N" for no. 23 00 Which method is used to determine Medicaid days on lines 24 and/or 25 23 00 3 N 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.

JSPI I	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		<u>f Northern</u> Provider CC			i od:	01/2023	Work	Form Cl sheet I	
					То		30/2024	Date	/Time 2024 1	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	St Medi elig	t-of ate i cai d gi bl e pai d	Medic HMO d	ai d	Other Medica days	i d
		1. 00	2. 00	3. 00	_	. 00	5. 0	0	6. 00	
5. 00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid eligible unpaid 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.	246				0		, 003		0 2
					ι	Jrban/F 1.	Rural S	Date	of Geo 2.00	ogr
. 00	Enter your standard geographic classification (not wa	age) status	at the beg	inning of	the	1.	1		2.00	2
	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi	age) status - "2" for r cation in	ural. If ap column 2.	pl i cabl e,			1			2
. 00	If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	e number of 	periods SC 	н status ir 	1		(			3
						Begi n 1.		Е	ndi ng: 2. 00	
. 00	Enter applicable beginning and ending dates of SCH st		cript line	36 for numb	oer	1.	00		2.00	3
. 00	of periods in excess of one and enter subsequent dates.  On If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status  On If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status									
is in effect in the cost reporting period.									3	
	instructions) If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.	of MDH st	atus. If li	ne 37 is						3
						Υ/			Y/N	
	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet taccordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii) or "N" for no. (see instructions)	, (ii), or the mileage	(iii)? Ent	er in colur its in	mn	1.	V		2. 00 N	3
	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	oer 1. Ente	r "Y" for y			N	N		N	4
	ino The Condition 2, Total di Sondi ges on or di ter october 1.	(300 11131	r de tr ons)				V	XVI		
	Prospective Payment System (PPS)-Capital						1.0	0   2.	00   3.	00
	Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment excepursuant to 42 CFR §412.348(f)? If yes, complete Wkst	eption for	extraordi na	iry circumst	tance	S	N N	N		
. 00	Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS of Is the facility electing full federal capital payment					no.	N N	N		
. 00	Teaching Hospitals Is this a hospital involved in training residents in	approved G	ME programs	? For cost	reno	rtina	l N			
	periods beginning prior to December 27, 2020, enter cost reporting periods beginning on or after December the instructions. For column 2, if the response to convolved in training residents in approved GME programmer are you are impacted by CR 11642 (or applicable ("Y" for yes; otherwise, enter "N" for no in column 2.	TY" for yes 27, 2020, Dlumn 1 is ams in the CRs) MA dir	or "N" for under 42 C "Y", or if prior year	no in colu FR 413.78(b this hospit or penultir	umn 1 o)(2) tal w mate	. For , see as year,				
	For cost reporting periods beginning prior to Decembers this the first cost reporting period during which at this facility? Enter "Y" for yes or "N" for no in residents start training in the first month of this complete West. D, Parts III & IV and D-2, Pt. II, if beginning on or after December 27, 2020, under 42 CFF which month(s) of the cost report the residents were	er 27, 2020 residents n column 1. cost report e Worksheet applicable & 413.77(e on duty, i	in approved If column ing period? E-4. If co . For cost )(1)(iv) an f the respo	I GME progra 1 is "Y", o 2 Enter "Y' Dumn 2 is ' reporting p d (v), rega anse to line	ams t did 'for 'N", perio ardle e 56	yes of series of the series of	r			5
	for yes, enter "Y" for yes in column 1, do not comple If line 56 is yes, did this facility elect cost reimb							- 1	1	5

				oount			
	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	0.00	61. 20		
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 Se							
62.00 Enter the number of FTE residents that your hospital		reporting peri	od for which	0.00	62. 00		
your hospital received HRSA PCRE funding (see instru							
62.01 Enter the number of FTE residents that rotated from			your hospital	0.00	62. 01		
during in this cost reporting period of HRSA THC pro		ns)					
Teaching Hospitals that Claim Residents in Nonprovid							
63.00 Has your facility trained residents in nonprovider s				N	63.00		
"Y" for yes or "N" for no in column 1. If yes, compl	"Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)						

Health Financial Systems	Rehabilitation	Hospital of Northe	ern Indi	In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DA	TA Provi der		eriod: rom 05/01/2023 o 04/30/2024	Worksheet S-2 Part I Date/Time Pre	pared:
			Unwei ghted FTEs Nonprovi der Si te	FTES in Hospital	9/9/2024 1:53 Ratio (col. 1/ (col. 1 + col. 2))	рш
Coation FEOA of the ACA Dage Ve	on FTE Dooldonto in N	anneaui dan Cattinga	1. 00	2.00	3.00	
Section 5504 of the ACA Base Ye period that begins on or after.			sinis base year	is your cost i	eportring	
64.00 Enter in column 1, if line 63 is in the base year period, the nuresident FTEs attributable to resettings. Enter in column 2 the resident FTEs that trained in year of (column 1 divided by (colu	s yes, or your facilit nber of unweighted nor otations occurring in e number of unweighted our hospital. Enter in	ty trained resident n-primary care all nonprovider d non-primary care n column 3 the rati		0. 00	0. 000000	64. 00
	Program Name	Program Code	Unwei ghted	Unweighted	Ratio (col. 3/	
	·	-	FTEs Nonprovi der Si te	FTEs in Hospital	(col. 3 + col. 4))	
	1. 00	2.00	3. 00	4.00	5. 00	
65.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00			65. 00
			Unwei ghted FTEs Nonprovi der	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			Si te 1.00	2.00	3. 00	
Section 5504 of the ACA Current	Year ETE Residents in	n Nonnrovider Setti				
beginning on or after July 1, 2		. Honprovidor docti	95 25515	, oco : . opo. :.	ng pon oue	
66.00 Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospic (column 1 divided by (column 1 divided b	unweighted non-primar occurring in all nonpr unweighted non-primar tal. Enter in column 3 column 2)). (see ins	rovider settings. ry care resident 3 the ratio of structions)	0.00			66. 00
	Program Name	Program Code	Unwei ghted FTEs	Unweighted FTEs in	Ratio (col. 3/ (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 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

Health Financial Systems Rehabilitation Hospital o HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-		eri od:	worksheet S			
			rom 05/01/2023 o 04/30/2024	Part I Date/Time P			
			V	9/9/2024 1: XI X	53 pm		
			1. 00	2.00			
98.00 Does title V or XIX follow Medicare (title XVIII) for the intersection stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for your column 1 for title V, and in column 2 for title XIX.	ns and residents yes or "N" for n	post o in	Y	Y	98. 00		
98.01 Does title V or XIX follow Medicare (title XVIII) for the repor C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title title XIX.			Y	Y	98. 01		
98.02 Does title V or XIX follow Medicare (title XVIII) for the calcubed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "I for title V, and in column 2 for title XIX.	N" for no in col	umn 1	Y	Y	98. 02		
98.03 Does title V or XIX follow Medicare (title XVIII) for a critica reimbursed 101% of inpatient services cost? Enter "Y" for yes o for title V, and in column 2 for title XIX.	reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column for title V, and in column 2 for title XIX.						
	O4 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and						
98.05 Does title V or XIX follow Medicare (title XVIII) and add back Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in colum column 2 for title XIX.	, and in		Y	98. 05			
98.06 Does title V or XIX follow Medicare (title XVIII) when cost rein Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 column 2 for title XIX.  Rural Providers			Y	Y	98. 06		
105.00 Does this hospital qualify as a CAH? 106.00 If this facility qualifies as a CAH, has it elected the all-inc for outpatient services? (see instructions)	lusive method of	payment	N		105. 00 106. 00		
107.00 Column 1: If line 105 is Y, is this facility eligible for cost training programs? Enter "Y" for yes or "N" for no in column 1. Column 2: If column 1 is Y and line 70 or line 75 is Y, do you approved medical education program in the CAH's excluded IPF at Enter "Y" for yes or "N" for no in column 2. (see instructions 107.01 If this facility is a REH (line 3, column 4, is "12"), is it ellowed in the column and the column are included in the column and the column are included in the column and the column are included in the column are co	(see instructi train I&Rs in a nd/or IRF unit(s ) igible for cost	ons) ın			107. 00		
instructions)  108.00 Is this a rural hospital qualifying for an exception to the CRN CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	•	See 42	N		108. 00		
		ıpati onal	Speech	Respi rator	У		
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	1.00	2. 00	3.00	4.00	109. 00		
				1.00			
110.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "Y" complete Worksheet E, Part A, lines 200 through 218, and Worksheapplicable.	for yes or "N" f	or no. It	f yes,	N	110. 00		
			1. 00	2. 00			
111.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cost "Y" for yes or "N" for no in column 1. If the response to column integration prong of the FCHIP demo in which this CAH is partic Enter all that apply: "A" for Ambulance services; "B" for addit for tele-health services.	reporting period n 1 is Y, enter ipating in colum	l? Enter the n 2.	N N	2.00	111.00		
112.00 Did this hospital participate in the Pennsylvania Rural Health (PARHM) demonstration for any portion of the current cost reporperiod? Enter "Y" for yes or "N" for no in column 1. If column "Y", enter in column 2, the date the hospital began participation.	Model ting n 1 is ng in the	1. 00 N	2.00	3.00	112. 00		
demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.							
Miscellaneous Cost Reporting Information							
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N in column 1. If column 1 is yes, enter the method used (A, B, o	r E only)	N			0 115. 00		

### HISPITAL AND HISPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA    Provider COL: 15-309	Health Financial Systems Rehabilitation Hospital				Lieu of Form CM	
118. Oil ist amounts of mal practice premiums and paid losses:  100 2.00 3.00 118. DI  100 2.00 3.00 118. DI  100 2.00 3.00 128. DI  101 2.00 With this full office premiums and paid losses reported in a cost center officer than the Modern stratus of Coveral? I figure, submit supporting schedule it sting cost centers and amounts contained therein.  119. DOID With USE THIS LIMI.  120. DOIS with a SOL for Excitation at call if less for the corporation in Idea in Interview of the Control of the Control of the Interview of the Control of the Interview of the Inter	HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CC		From 05/01/2	2023   Part I 2024   Date/Time	Prepared:
118. O'Dist amounts of mul practice premiums and paid i losses:  119. O'Dist practice premiums and paid i losses reported in a cost conter other than the content of the co			Premi ums	Losses	Insurance	9
118. O'Dist amounts of mul practice premiums and paid i losses:  119. O'Dist practice premiums and paid i losses reported in a cost conter other than the content of the co			1 00	2 00	3 00	
118.02 Add in istrative and depending and poses reported in a cost center other than the Add instrative and depending 1 if yes, submit is supporting schedule it isting cost centers and additional programs are contained therein.  119. In an amount's contained therein.  119. In a service, a contained therein amount in a contained there is a contained the contained there is a contained there is a contained there is a contained the contained the contained there is a contained therein the contained there is a contained therein the contained the contained the contained the contained there is a c	118.01 List amounts of malpractice premiums and paid losses:		11.00			0 118. 01
118.02 Add in istrative and depending and poses reported in a cost center other than the Add instrative and depending 1 if yes, submit is supporting schedule it isting cost centers and additional programs are contained therein.  119. In an amount's contained therein.  119. In a service, a contained therein amount in a contained there is a contained the contained there is a contained there is a contained there is a contained the contained the contained there is a contained therein the contained there is a contained therein the contained the contained the contained the contained there is a c				1 00	2.00	
120. 001s this a SOI or EACH that qualifies for the Outpatient Iold Harmless provision in ACA STATE and applicable immendments? See instructions Enter in column 1, "Ye for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient hold Harmless provision in ACA STATE and applicable immendments? (see instructions)  121. 0001d this Facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2. Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2. Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2. Services e.g. i. legal, accounting its propriate these taxes are included. Services e.g. i. legal, accounting its propriation hookseeping payroli, and/or management/consulting services. From an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% or total professional services expenses, for services purchased from unrelated organizations "N" for no.  Exterited Iransial and Center Information  25. 000 Bost bits Facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no.  Exterited Iransial and Center Information  26. 001 if this is a Medicare-certified lidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  27. 001 if this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  28. 001 if this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  29. 001 if this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  213. 001 if this is a Medicare-certifi	Administrative and General? If yes, submit supporting schedu and amounts contained therein.				2.00	
121.00 jud this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no. In column 1 is "Y", enter in column 2 in the Morksheet A line number where these taxes are included.  122.00 he Morksheet A line number where these taxes are included.  123.00 services e.g. legal, accounting tax preparation bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If yes companies of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no. If yes, enter certification date in column 1 and termination date, if applicable, in column 2.  125.00 pers this facility operate a Medicare-certified transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  127.00 if this is a Medicare-certified program, enter the certification date in column 1 and termination date, if applicable, in column 2.  128.00 if this is a Medicare-certified program, enter the certification date in column 1 and termination date, if applicable, in column 2.  129.00 if this is a Medicare-certified program, enter the certification date in column 1 and termination date, if applicable, in column 2.  129.00 if this is a Medicare-certified program, enter the certification date in column 1 and termination date, if applicable, in column 2.  129.00 if this is a Medicare-certified program, enter the certification date in column 1 and termination date, if applicable, in column 2.  129.00 if this is a Medicare-certified program, enter the certification date in column 1 and termination date, if applicable, in column 2.  130.00 if this is a Medicare-certified program, enter the certification date in column 1 and termination date, if applicable, in column 2.  130.00 if this is a Medicare-certified program, enter the certification date in column 1 and termination date, if applicable, in column 2.  131.00 if this is a Medicare-certified program enter the certification dat	120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qual Hold Harmless provision in ACA §3121 and applicable amendment	column 1, "Y" lifies for th	for yes or ne Outpatient		N	
122.00 bose the cost report contain heal thcare related taxes as defined in \$1903(w)(3) of the ActPenter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.  123.00 bid the Racil Ity and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or menagement/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no were the majority of the expenses. I. e., greater than 50% of total professional services expenses, for services proceeding in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.  255.00 bose this Facility operate a Medicare-certified transplant center? Enter "Y" for yes or "N" for no.  256.00 life this is a ledicare-certified ideare-certified mental through the column 2 in column 1 and termination date, if applicable, in column 2.  127.00 life this is a Medicare-certified they transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  128.00 life this is a bedicare-certified unp transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  129.00 life this is a bedicare-certified unp transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  130.00 life this is a bedicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  131.00 life this is a bedicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  132.00 life this is a bedicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  133.00 Removed and reserved  134.00 life this is a bedicare-certified intestinal transpla	121.00 Did this facility incur and report costs for high cost implan	table devices	charged to	N		121. 00
123. 00 lid the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no.  If column 1 is "Y", were the majority of the expenses, i. e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a GESA outside of the main hospital GESA? In column 2 enter "Y" for yes or "N" for no.  125. 00 loss, this facility operate a Medican-certified transplant center? Enter "Y" for yes or "N" for no.  126. 00 lif this is a Medican-certified kidney transplant program, enter the certification date in column 1 and termination date. If applicable, in column 2.  127. 00 lif this is a Medican-certified heart transplant program, enter the certification date in column 1 and termination date. If applicable, in column 2.  128. 00 lif this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date. If applicable, in column 2.  129. 00 lif this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  130. 00 lif this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  131. 00 lif this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  131. 00 lif this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  132. 00 Removed and reserved.  133. 00 life this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.  140. 00 life there any related organization or home office costs as de	122.00 Does the cost report contain healthcare related taxes as defi Act?Enter "Y" for yes or "N" for no in column 1. If column 1					122. 00
For yes or "N" for no.   If column 1 is "Y", were the majority of the expenses, i. e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.	123.00 Did the facility and/or its subproviders (if applicable) purc services, e.g., legal, accounting, tax preparation, bookkeepi	ng, payroll,	and/or	N		123. 00
125.00 Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.  126.00 If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  127.00 If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  128.00 If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  129.00 If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  130.00 If this is a Medicare-certified ling transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  131.00 If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  132.00 If this is a Medicare-certified illet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  133.00 Removed and reserved  134.00 If this is a hospital-based organ procurement organization (OPD), enter the OPO number in column 1 and termination date, if applicable, in column 2.  134.00 If this is a hospital-based organ procurement organization (OPD), enter the OPO number in column 1 and termination date, if applicable, in column 2.  134.00 If this is a hospital-based organization or home office costs as defined in CMS Pub. 15-1, Y HB1609  134.00 If this facility is part of a chain organization number. (See instructions)  135.00 Removed and reserved  136.00 If this facility is part of a chain organization number. (See instructions)  137.00 If this facility is part of a chain organization number. (See instructions)  138.00 If this facility is part of a chain or	for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., professional services expenses, for services purchased from u located in a CBSA outside of the main hospital CBSA? In colum "N" for no.	greater than nrelated orga	50% of total inizations			
and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.  126.00   f this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  127.00   f this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  128.00   f this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  129.00   f this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  130.00   f this is a Medicare-certified plancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  131.00   f this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  131.00   f this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  132.00   f this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  133.00   f this is a hosticare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  133.00   f this is a hostial-based organ procurement organization (0P0), enter the 0P0 number in column 1 and termination date, if applicable, in column 2.  134.00   f this is a hostial-based organ procurement organization (0P0), enter the 0P0 number in column 1 and termination date, if applicable, in column 2.  134.00   f this is a hostial-based organ procurement organization (0P0), enter the 0P0 number in column 1 and termination date, if applicable, in column 2.  134.00   f this is a hostial-based organ procurement organizatio		nter? Enter "	Y" for ves	N		125, 00
127.00   f this is a Medicare-certified heart transplant program, enter the certification date   127.00   128.00   f this is a Medicare-certified liver transplant program, enter the certification date   128.00   129.00   f this is a Medicare-certified place   129.00   120.00   f this is a Medicare-certified place   129.00   129.	and "N" for no. If yes, enter certification date(s) (mm/dd/yy 126.00 If this is a Medicare-certified kidney transplant program, en	yy) below.	,			
128.00   f this is a Medicare-certified liver triansplant program, enter the certification date   128.00   129.00   f this is a Medicare-certified ung transplant program, enter the certification date   129.00   130.00   f this is a Medicare-certified planceroes transplant program, enter the certification date   129.00   131.00   f this is a Medicare-certified planceroes transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 131.00   f this is a Medicare-certified planceroes transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 132.00   f this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 133.00   Removed and reserved   133.00   134.00   f this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.  140.00   All Providers   100   130.0	127.00 If this is a Medicare-certified heart transplant program, ent	er the certif	ication date			127. 00
in column 1 and termination date, if applicable, in column 2.  130.00   f this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  131.00   f this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  132.00   f this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  133.00   Removed and reserved   133.00   134.00   13	128.00 If this is a Medicare-certified liver transplant program, ent in column 1 and termination date, if applicable, in column 2.					
date in column 1 and termination date, if applicable, in column 2.  131.00 If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  132.00 If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  133.00 Removed and reserved  134.00 If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.  137.00 If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.  138.00 If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.  139.00 If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 2.  140.00 Are there any related organization or home office costs as defined in CMS Pub. 15-1, orapidate in CMS Pub. 15-1, orapida	in column 1 and termination date, if applicable, in column 2.					
132.00   f this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  133.00 Removed and reserved  133.00   f this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 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 Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)  1.00   2.00   3.00    If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.  141.00 Name: ERNEST HEALTH INC   Contractor's Name: NOVITAS SOLUTIONS   Contractor's Number: 04011   141.00    142.00   Street: 1024 N GALLOWAY AVE   PO Box:   TX   Zip Code:   75149   143.00    144.00   Are provider based physicians' costs included in Worksheet A?   N   144.00    145.00   If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, \$4020) If	date in column 1 and termination date, if applicable, in colu	mn 2.				
133.00 Removed and reserved  134.00 If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.  All Providers  140.00 Are there any related organization or home office costs are claimed, enter in column 2 the home office chain number. (see instructions)  1 1.00	132.00 If this is a Medicare-certified islet transplant program, ent	er the certif	ication date			132. 00
140. 00 Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)  1.00  2.00  3.00  If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.  141. 00 Name: ERNEST HEALTH INC  Contractor's Name: NOVITAS SOLUTIONS  Contractor's Number: 04011  141. 00  142. 00 Street: 1024 N GALLOWAY AVE  PO Box:  State: TX  Zip Code: 75149  143. 00  144. 00 Are provider based physicians' costs included in Worksheet A?  N 144. 00  145. 00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.  146. 00 Has the cost allocation methodology changed from the previously filed cost report?  N 146. 00 Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If	133.00 Removed and reserved 134.00 If this is a hospital-based organ procurement organization (0 in column 1 and termination date, if applicable, in column 2.		e OPO number			1
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: ERNEST HEALTH INC   Contractor's Name: NOVITAS SOLUTIONS   Contractor's Number: 04011   141.00   142.00   143.00   143.00   144.00   145.00   145.00   146	140.00 Are there any related organization or home office costs as de chapter 10? Enter "Y" for yes or "N" for no in column 1. If y are claimed, enter in column 2 the home office chain number.	es, and home	office costs			140. 00
142.00 Street: 1024 N GALLOWAY AVE	If this facility is part of a chain organization, enter on li home office and enter the home office contractor name and cor	itractor numbe	er.	name and addr	ess of the	
144.00 Are provider based physicians' costs included in Worksheet A?  1.00  1.00  2.00  145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.  146.00 Has the cost allocation methodology changed from the previously filed cost report?  N 146.00 Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If	142.00 Street: 1024 N GALLOWAY AVE PO Box:	IAS SOLUTIONS				142. 00
144.00 Are provider based physicians' costs included in Worksheet A?  1.00  1.00  2.00  145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.  146.00 Has the cost allocation methodology changed from the previously filed cost report?  N 146.00 Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If					1 00	
1.00 2.00  145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.  146.00 Has the cost allocation methodology changed from the previously filed cost report? N 146.00 Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If	144.00 Are provider based physicians' costs included in Worksheet A?					144. 00
145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.  146.00 Has the cost allocation methodology changed from the previously filed cost report?  Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If				1.00	2.00	
146.00 Has the cost allocation methodology changed from the previously filed cost report? N 146.00 Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If	inpatient services only? Enter "Y" for yes or "N" for no in c no, does the dialysis facility include Medicare utilization f	olumn 1. If c	olumn 1 is		2.00	145. 00
	146.00 Has the cost allocation methodology changed from the previous Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15					146. 00

Health Financial Systems	Rehabilitation H	Hospi tal	of Northern	Indi		In Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DAT	Ā	Provi der CC	N: 15-3047		ri od: om 05/01/2023 04/30/2024	Worksheet S- Part I Date/Time Pr 9/9/2024 1:5	epared:
							1. 00	
147.00 Was there a change in the statisti	cal hasis? Enter "Y"	for ve	s or "N" for	no			1.00 N	147. 00
148.00 Was there a change in the order of							N N	148. 00
149.00 Was there a change to the simplifi					for no	).	N	149. 00
	<u></u>		Part A	Part		Title V	Title XIX	
			1. 00	2. 00		3. 00	4. 00	
Does this facility contain a provi or charges? Enter "Y" for yes or '							3. 13)	
155. 00 Hospi tal			N	N		N	N	155. 00
156.00 Subprovi der - IPF			N	N		N	N	156. 00
157. 00 Subprovi der – IRF			N	N		N	N	157. 00
158. 00 SUBPROVI DER 159. 00 SNF			N	l N		N	N	158. 00 159. 00
160. 00 HOME HEALTH AGENCY			N N	l N	-	N N	N N	160.00
161. 00 CMHC			IN	I N		N N	N N	161. 00
TOT. OCIONITO				14		114	1. 00	101.00
Multicampus							1.00	
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	mpus hospital that h	nas one	or more campu	ises in di	fferer	nt CBSAs?	N	165. 00
	Name		County	State	Zip (	Code CBSA	FTE/Campus	
	0		1. 00	2. 00	3.0	00 4.00	5. 00	
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)							0. (	00 166. 00
							1.00	
Health Information Technology (HI	() incentive in the A	Ameri can	Recovery and	d Reinvest	ment	Act		
167.00 s this provider a meaningful user 168.00 f this provider is a CAH (line 10	05 is "Y") and is a m	neani ngf	ul user (line			enter the	N	167. 00 168. 00
reasonable cost incurred for the H 168.01 If this provider is a CAH and is r	not a meaningful user	, does	, this provider			hardshi p		168. 01
exception under §413.70(a)(6)(ii)?  169.00 If this provider is a meaningful under stransition factor. (see instruction	ıser (line 167 is "Y"					), enter the	0.0	00169.00
Transition ractor. (See Histractic						Begi nni ng	Endi ng	
						1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning period respectively (mm/dd/yyyy)	eginning date and er	nding da	te for the re	eporting				170. 00
						1. 00	2.00	
171.00 If line 167 is "Y", does this prov section 1876 Medicare cost plans r "Y" for yes and "N" for no in colu 1876 Medicare days in column 2. (s	reported on Wkst. S-3 umn 1. If column 1 is	3, Pt. I.	, line 2, col	. 6? Ente		N		0 171. 00

	Financial Systems Rehabilitation Hospit AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-3047 F	Peri od:	eu of Form CMS- Worksheet S-2		
			1 1	rom 05/01/2023		<u>′</u>	
				To 04/30/2024			
				Y/N	Date		
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSE	MENT QUESTIONN	IAI RE	1. 00	2. 00		
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	lfor all NO re	sponses. Enter	all dates in	the		
	Provider Organization and Operation						
1. 00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in c			N		1.00	
	preporting period: If yes, enter the date of the change in c	corumir 2. (see	Y/N	Date	V/I		
2.00	Hen the provider terminated participation in the Medicara D	ragram? I.f	1. 00 N	2. 00	3. 00	2, 00	
2. 00	Has the provider terminated participation in the Medicare P yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	nn 3, "V" for				3. 00	
3.00	ON Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)						
	(000 1100 100 100 100 100 100 100 100 10		Y/N	Туре	Date		
	Financial Data and Reports		1.00	2. 00	3. 00		
4.00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	for Compiled, milable in	Y	A		4.00	
5. 00	Are the cost report total expenses and total revenues differenthese on the filed financial statements? If yes, submit reconstructions are total revenues and total revenues differenthese differenthe		N			5. 00	
	Y/N	Legal Oper.					
	Approved Educational Activities			1. 00	2. 00		
6. 00	Column 1: Are costs claimed for a nursing program? Column the legal operator of the program?	2: If yes, is	the provider	N		6. 00	
7. 00 8. 00	O Are costs claimed for Allied Health Programs? If "Y" see instructions.						
9. 00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved		· ·	N		9. 00	
10. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated o		he current	N		10. 00	
11. 00	cost reporting period? If yes, see instructions.  Are GME cost directly assigned to cost centers other than I	& R in an App	proved	N		11. 00	
	Teaching Program on Worksheet A? If yes, see instructions.				Y/N		
					1. 00		
12. 00	Bad Debts Is the provider seeking reimbursement for bad debts? If yes	s. see instruct	i ons.		Y	12.00	
13. 00				st reporting	N N	13. 00	
14. 00		ance amounts wa	nived? If yes,	see	N	14. 00	
1E 00	Bed Complement Did total beds available change from the prior cost reporti	ng poriod2 lf	voc. soo instr	rueti enc	l N	15. 00	
13.00	but total beds available change from the pirol cost reporti		t A		rt B	15.00	
		Y/N	Date	Y/N	Date		
	PS&R Data	1.00	2.00	3. 00	4. 00		
16. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see	Y	08/19/2024	Y	08/19/2024	16. 00	
17. 00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17. 00	
18. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		18. 00	
19. 00	cost report? If yes, see instructions.  If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19. 00	

HOSPI T	Financial Systems Rehabilitation Hospit AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der CCI		Peri od:	u of Form CMS Worksheet S			
				From 05/01/2023 To 04/30/2024	Part II Date/Time P 9/9/2024 1:			
		Descri	pti on	Y/N	Y/N	JJ PIII		
		0		1. 00	3. 00			
20. 00				N	N	20.00		
	Report data for Other? Describe the other adjustments:	Y/N	Date	Y/N	Date			
		1.00	2. 00	3.00	4. 00			
21. 00	Was the cost report prepared only using the provider's	N	2.00	N	11 00	21. 00		
	records? If yes, see instructions.							
	COMPLETED BY COST DELMBURGED AND TEEDA HOSDITALS ONLY (EVGE	DT CHILL DDENC HO	CDL TALC)		1. 00			
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE Capital Related Cost	PI CHILDRENS HO	SPITALS)					
22. 00	Have assets been relifed for Medicare purposes? If yes, see	instructions				22. 0		
23. 00	Have changes occurred in the Medicare depreciation expense		als made dur	ing the cost		23. 0		
	reporting period? If yes, see instructions.			9				
24. 00	Were new leases and/or amendments to existing leases entere	ed into during t	:his cost re	porting period?		24. 0		
NE 00	If yes, see instructions	*L*				25.0		
25. 00	Have there been new capitalized leases entered into during instructions.	the cost report	.ing period?	ii yes, see		25. 0		
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during th	ne cost renortin	na period? I	f ves. see		26. 0		
	instructions.		.9	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
27. 00	Has the provider's capitalization policy changed during the	e cost reporting	յ period? If	ges, submit		27. 0		
	copy.							
28. 00	Interest Expense Were new Loans, mortgage agreements or Letters of credit en	torod into duri	ng the cost	roporting		28. 0		
20.00	period? If yes, see instructions.	iterea into auri	ing the cost	. reporting		20.0		
9. 00								
	treated as a funded depreciation account? If yes, see instr			, l				
30. 00								
21 00	instructions.	souches of now o	10h+2 1 f voc			21.0		
31. 00	Has debt been recalled before scheduled maturity without is instructions.	ssuance of new o	lebt? IT yes	,, see		31.0		
	Purchased Services							
32. 00	Have changes or new agreements occurred in patient care ser	rvi ces furni shed	through co	ontractual		32. 0		
	arrangements with suppliers of services? If yes, see instru							
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 app	olied pertaining	, to competi	tive bidding? If		33.0		
	no, see instructions.							
34. 00	Provider-Based Physicians Were services furnished at the provider facility under an a	rrangement with	nrovi der-t	pased physicians?		34.0		
31.00	If yes, see instructions.	ir angement with	i provider E	asca physicians.		01.0		
35. 00	If line 34 is yes, were there new agreements or amended exi		s with the	provi der-based		35. 0		
	physicians during the cost reporting period? If yes, see in	structions.			_			
				Y/N	Date			
	Home Office Costs			1. 00	2. 00			
	Were home office costs claimed on the cost report?					36.0		
37. 00	•	repared by the h	nome office?	,		37. 0		
	If yes, see instructions.	-p-:						
38. 00	If line 36 is yes , was the fiscal year end of the home off			2		38. 0		
20.00	the provider? If yes, enter in column 2 the fiscal year end			_		20.0		
39. 00	If line 36 is yes, did the provider render services to othe see instructions.	er chain compone	ents? If yes	<i>i</i> ,		39. 0		
40. 00	If line 36 is yes, did the provider render services to the	home office? I	f ves see			40. 0		
	instructions.							
		1.0	)0	2. (	00			
	Cost Report Preparer Contact Information	Moral		Di tanal:		44 ^		
	Enter the first name, last name and the title/position	Mary		Pi tcock		41.0		
	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	Mary		Pi tcock		41.0		
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	Mary Ernest Health I	nc	Pi tcock		41. 0		
41. 00 42. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		nc	Pi tcock				
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.  Enter the employer/company name of the cost report preparer.		nc	Pitcock marykay@ernesth	ealth.com			

Heal th	Financial Systems Re	habilitation Hospita	al of Northern I	ndi	In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMEN	T QUESTI ONNAI RE	Provider CCN		Peri od:	Worksheet S-2	
					From 05/01/2023 To 04/30/2024	Date/Time Pre	nared:
					10 04/30/2024	9/9/2024 1: 53	
			3.00	)			
	Cost Report Preparer Contact Information	<u> </u>					
	Enter the first name, last name and the		Reimbursement Ma	anager			41. 00
	held by the cost report preparer in colu	ımns 1, 2, and 3,					
	respecti vel y.						
42. 00	Enter the employer/company name of the c	cost report					42. 00
	preparer.						
43. 00	Enter the telephone number and email add						43. 00
	report preparer in columns 1 and 2, resp	ecti vel y.					

| Peri od: | Worksheet S-3 | From 05/01/2023 | Part | To 04/30/2024 | Date/Time Prepared: Health Financial Systems Rehabilitation Hospital of Northern Indi
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-3047

					0 04/30/2024	9/9/2024 1:53	
						I/P Days / 0/P	piii
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH/REH Hours	Title V	
		Li ne No.		Avai I abl e			
		1. 00	2. 00	3.00	4. 00	5. 00	
	PART I - STATISTICAL DATA			•			
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	40	14, 640	0.00	0	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		40	14, 640	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)		40	14, 640	0.00	l :	14. 00
15. 00	CAH visits				0.00	0	15. 00
15. 10	REH hours and visits				0.00	0	15. 10
16. 00	SUBPROVI DER - I PF						16.00
17. 00	SUBPROVIDER - I RF						17. 00
18. 00 19. 00	SUBPROVI DER	44. 00	0	(		ol	18. 00 19. 00
20. 00	SKILLED NURSING FACILITY NURSING FACILITY	44.00	U		,	١	20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY	101. 00				0	22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )	101.00				l	23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)	30. 00					24. 10
25. 00	CMHC - CMHC	30.00					25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				o	26. 25
27. 00	Total (sum of lines 14-26)	07.00	40			Ĭ	27. 00
28. 00	Observation Bed Days		10			0	28. 00
29. 00	Ambul ance Tri ps					, and the second	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
34.00	Temporary Expansion COVID-19 PHE Acute Care	30. 00	0	(	)	0	34.00

Health Financial Systems Rehabilitation Hospital of Northern Indi
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-3047

| Peri od: | Worksheet S-3 | From 05/01/2023 | Part I | Date/Time Prepared: |

				'	0 04/30/2024	9/9/2024 1:53	
		I/P Days	/ O/P Visits	/ Trips	Full Time E	Equi val ents	ļ
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7. 00	8. 00	9. 00	10.00	
	PART I - STATISTICAL DATA	0.00	7.00	0.00	7, 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	4, 232	246	11, 053			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)	1, 261	1, 153				2. 00
3.00	HMO IPF Subprovider	0	0				3. 00
4.00	HMO IRF Subprovider	0	0				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	C			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0	C			6. 00
7. 00	Total Adults and Peds. (exclude observation	4, 232	246	11, 053			7. 00
0.00	beds) (see instructions)						0.00
8.00	INTENSIVE CARE UNIT						8. 00
9. 00 10. 00	CORONARY CARE UNIT						9. 00 10. 00
11. 00	BURN INTENSIVE CARE UNIT						11.00
12. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY						13.00
14. 00	Total (see instructions)	4, 232	246	11, 053	0.00	110. 07	
15. 00	CAH visits	4, 232	0	11, 033		110.07	15. 00
15. 10	REH hours and visits	o o	0	Ö			15. 10
16. 00	SUBPROVI DER - I PF	Ĭ	Ĭ	· ·			16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18.00	SUBPROVI DER						18. 00
19.00	SKILLED NURSING FACILITY	o	o	C	0.00	0.00	19. 00
20.00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY	0	0	C	0.00	0.00	
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)			C			24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	C		1	1
27. 00	Total (sum of lines 14-26)				0.00	110. 07	
28. 00	Observation Bed Days	0	0	C			28. 00
29. 00	Ambul ance Tri ps	O O					29. 00
30. 00 31. 00	Employee discount days (see instruction) Employee discount days - IRF			C			30.00
32. 00	Labor & delivery days (see instructions)	0	0	0			32.00
32. 00	Total ancillary labor & delivery room		U U	0			32. 00
JZ. UI	outpatient days (see instructions)			C	]		32.01
33. 00	LTCH non-covered days	0					33.00
	LTCH site neutral days and discharges	o					33. 01
	Temporary Expansi on COVID-19 PHE Acute Care	o	o	C	)		34. 00
	1 3 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	-1	-1		1	'	

34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

34.00 Temporary Expansion COVID-19 PHE Acute Care

Provider CCN: 15-3047

Peri od: Worksheet S-3 From 05/01/2023 Part I To 04/30/2024 Date/Time Prepared:

9/9/2024 1:53 pm Full Time Di scharges Equi val ents Title XVIII Total All Component Nonpai d Title V Title XIX Workers Pati ents 14.00 15.00 12.00 13.00 11.00 PART I - STATISTICAL DATA Hospital Adults & Peds. (columns 5, 6, 7 and 1.00 305 14 764 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) 86 80 2.00 3.00 HMO IPF Subprovider 3.00 4.00 HMO IRF Subprovider ol 4.00 Hospital Adults & Peds. Swing Bed SNF 5.00 5.00 6.00 Hospital Adults & Peds. Swing Bed NF 6.00 Total Adults and Peds. (exclude observation 7.00 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 8.00 9.00 CORONARY CARE UNIT 9.00 10.00 BURN INTENSIVE CARE UNIT 10.00 SURGICAL INTENSIVE CARE UNIT 11.00 11.00 OTHER SPECIAL CARE (SPECIFY) 12.00 12.00 13.00 NURSERY 13.00 Total (see instructions) 0.00 305 14.00 14.00 14 764 CAH visits 15.00 15.00 15. 10 REH hours and visits 15. 10 16.00 SUBPROVIDER - IPF 16.00 SUBPROVIDER - IRF 17.00 17.00 18 00 SUBPROVI DER 18 00 SKILLED NURSING FACILITY 19.00 0.00 19.00 20.00 NURSING FACILITY 20.00 OTHER LONG TERM CARE 21.00 21.00 HOME HEALTH AGENCY 0 00 22 00 22 00 23.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 24.00 HOSPI CE 24.00 24. 10 HOSPICE (non-distinct part) 24. 10 CMHC - CMHC 25.00 25 00 26.00 RURAL HEALTH CLINIC 26.00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0.00 26.25 Total (sum of lines 14-26) 27.00 27.00 0.00 28 00 Observation Bed Days 28 00 29. 00 Ambul ance Trips 29.00 30.00 Employee discount days (see instruction) 30.00 Employee discount days - IRF 31.00 31.00 32.00 Labor & delivery days (see instructions) 32.00 Total ancillary labor & delivery room 32.01 32.01 outpatient days (see instructions) 33.00 LTCH non-covered days 33.00 0 33. 01 LTCH site neutral days and discharges 0 33.01

Health Financi	al Systems Rehabil	itation Hospital	of Northern	I ndi	In Lie	u of Form CMS-2	2552-10
	ION AND ADJUSTMENTS OF TRIAL BALANCE O		Provi der CO		Peri od:	Worksheet A	
					From 05/01/2023	5	
					To 04/30/2024	Date/Time Pre 9/9/2024 1:53	
Co	ost Center Description	Sal ari es	Other	Total (col	1 Reclassi fi cati	Reclassi fi ed	Pili
<u>.</u>	oot contor becompition	our ur roo	01.10.	+ col . 2)	ons (See A-6)	Trial Balance	
				,	, ,	(col. 3 +-	
						col . 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
	SERVICE COST CENTERS						
	AP REL COSTS-BLDG & FIXT		3, 057, 208			3, 379, 069	1. 00
	AP REL COSTS-MVBLE EQUIP		103, 318			129, 159	2. 00
	THER CAP REL COSTS		347, 702	347, 70		0	3. 00
	MPLOYEE BENEFITS DEPARTMENT	622, 591	1, 046, 357	1, 668, 94		1, 668, 948	4. 00
	DMINISTRATIVE & GENERAL	1, 671, 177	1, 293, 722	2, 964, 89		2, 964, 899	5. 00
	PERATION OF PLANT	37, 990	398, 425	436, 41		436, 415	7. 00
	AUNDRY & LINEN SERVICE	145 743	48, 215	48, 21		48, 215	8. 00
	OUSEKEEPI NG	145, 742	47, 415			193, 157	9.00
10. 00   01000 DI	URSING ADMINISTRATION	449, 767	265, 960 37, 678			715, 727 432, 400	10. 00 13. 00
	EDICAL RECORDS & LIBRARY	394, 722 93, 563	37, 678 18, 331	111, 89		111, 894	16.00
	NT ROUTINE SERVICE COST CENTERS	93, 303	10, 331	111, 05	74 0	111, 094	10.00
	DULTS & PEDIATRICS	3, 095, 872	426, 598	3, 522, 47	0 0	3, 522, 470	30.00
	KILLED NURSING FACILITY	3,073,072	420, 370	3, 322, 47	0 0	-,,	44. 00
	RY SERVICE COST CENTERS	٥			0 0	0	1 44. 00
	ADI OLOGY-DI AGNOSTI C	0	68, 561	68, 56	-6, 589	61, 972	54.00
57. 00 05700 C		o	0		0 5, 430	5, 430	57. 00
	AGNETIC RESONANCE IMAGING (MRI)	o	0		0 1, 159	1, 159	58. 00
	ABORATORY	o	40, 032	40, 03		40, 032	60.00
	ESPI RATORY THERAPY	93, 309	48, 637	141, 94	6 0	141, 946	65. 00
66. 00 06600 PI	HYSI CAL THERAPY	630, 779	80, 978	711, 75	-78, 235	633, 522	66. 00
67.00 06700 0	CCUPATIONAL THERAPY	542, 819	45, 123	587, 94	2 58, 215	646, 157	67. 00
68. 00 06800 SI	PEECH PATHOLOGY	249, 171	22, 681	271, 85	20, 020	291, 872	68. 00
71.00 07100 MI	EDICAL SUPPLIES CHARGED TO PATIENTS	46, 409	161, 730	208, 13	0	208, 139	71. 00
73. 00 07300 DI	RUGS CHARGED TO PATIENTS	382, 368	297, 550	679, 91	8 0	679, 918	73. 00
	ENAL DIALYSIS	0	232, 169			232, 169	74. 00
	THER ANCILLARY SERVICE COST CENTERS	0	-91, 984	-91, 98	34 0	-91, 984	76. 00
	ENT SERVICE COST CENTERS						
	MERGENCY	0	0		0	0	91. 00
	UTPATI ENT THERAPY	0	0		0	0	91. 01
	UTPATIENT WOUND CENTER	0	0		0 0	0	93. 00
	EI MBURSABLE COST CENTERS	_1				_	
	MBULANCE SERVICES	0	0		0		95. 00
	OME HEALTH AGENCY	0	0		0 0	0	101. 00
	PURPOSE COST CENTERS	ما		T		0	117 00
	THER SPECIAL PURPOSE COST CENTERS	0 8, 456, 279	7 004 404	16, 452, 68	0 0		117.00
	UBTOTALS (SUM OF LINES 1 through 117)	8, 456, 279	7, 996, 406	16, 452, 68	55  0	16, 452, 685	1118.00
	BURSABLE COST CENTERS HYSI CLANS' PRI VATE OFFI CES	0	^		0 0	^	192. 00
194. 00 07950 M		0	0		0 0		194. 00
	THER NONREIMBURSABLE COST CENTERS		0				194. 00
	OTAL (SUM OF LINES 118 through 199)	8, 456, 279	7, 996, 406	16, 452, 68	5 0		
	(35 3. 225 110 till bugil 177)	5, .55, 2, 7	., ., 0, 100	. 5, 152, 60	-,	.5, 152, 565	1-00.00

Health FinancialSystemsRehabilitation Hospitalof Northern IndiRECLASSIFICATIONAND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSESProvider CCN: 15-3047

Peri od: From 05/01/2023 To 04/30/2024 Date/Time Prepared:

			9/9/2024 1: 53	} pm
Cost Center Description	Adjustments	Net Expenses		
	(See A-8) F	or Allocation		
	6.00	7. 00		
GENERAL SERVICE COST CENTERS				
1.00 O0100 CAP REL COSTS-BLDG & FIXT	96, 984	3, 476, 053		1.00
2.00 O0200 CAP REL COSTS-MVBLE EQUIP	14, 838	143, 997		2. 00
3.00   00300 OTHER CAP REL COSTS	0	0		3. 00
4.00   00400   EMPLOYEE BENEFITS DEPARTMENT	-3, 901	1, 665, 047		4. 00
5.00   00500   ADMINISTRATIVE & GENERAL	1, 269, 814	4, 234, 713		5. 00
7.00   00700   OPERATION OF PLANT	-9, 690	426, 725		7. 00
8.00   00800   LAUNDRY & LINEN SERVICE	0	48, 215		8. 00
9. 00   00900   HOUSEKEEPI NG	0	193, 157		9. 00
10. 00   01000 DI ETARY	-5, 866	709, 861		10.00
13.00 O1300 NURSING ADMINISTRATION	0	432, 400		13. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	-18	111, 876		16. 00
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS	0	3, 522, 470		30.00
44.00 O4400 SKILLED NURSING FACILITY	0	0		44. 00
ANCILLARY SERVICE COST CENTERS				
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	61, 972		54.00
57.00  05700   CT   SCAN	0	5, 430		57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	1, 159		58. 00
60. 00   06000   LABORATORY	0	40, 032		60.00
65. 00 06500 RESPI RATORY THERAPY	-57	141, 889		65. 00
66. 00 06600 PHYSI CAL THERAPY	0	633, 522		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	646, 157		67. 00
68. 00   06800   SPEECH PATHOLOGY	0	291, 872		68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-1, 218	206, 921		71. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	679, 918		73. 00
74.00   07400   RENAL DIALYSIS	0	232, 169		74. 00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	102, 861	10, 877		76. 00
OUTPATIENT SERVICE COST CENTERS				
91. 00   09100   EMERGENCY	0	0		91.00
91. 01   04951   OUTPATI ENT THERAPY	0	0		91. 01
93.00 04950 OUTPATIENT WOUND CENTER	0	0		93. 00
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES	0	0		95. 00
101.00 10100 HOME HEALTH AGENCY	0	0		101. 00
SPECIAL PURPOSE COST CENTERS				
117.00 06950 OTHER SPECIAL PURPOSE COST CENTERS	0	0		117. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 463, 747	17, 916, 432		118. 00
NONREI MBURSABLE COST CENTERS				
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0		192. 00
194. 00 07950 MARKETI NG	0	0		194. 00
194.01 07951 OTHER NONREIMBURSABLE COST CENTERS	0	0		194. 01
200.00   TOTAL (SUM OF LINES 118 through 199)	1, 463, 747	17, 916, 432		200. 00

Heal th	Financial Systems	Rehabi	litation Hospi	tal of Northern	n Indi	In Lie	u of Form CMS-	-2552-10
RECLAS	SIFI CATIONS			Provi der C	CCN: 15-3047	Peri od:	Worksheet A-	6
						From 05/01/2023 To 04/30/2024		
		Increases						
	Cost Center	Li ne #	Sal ary	0ther				
	2. 00	3. 00	4. 00	5.00				
	A - RCLS PCT THERAPY							
1.00	OCCUPATI ONAL THERAPY	67.00	52, 970	5, 245				1.00
2.00	SPEECH PATHOLOGY	68.00	18, 216	1, 804				2. 00
	TOTALS		71, 186	7, 049				
	B - RCLS CT & MRI FROM RADIO	_OGY						
1.00	CT SCAN	57. 00	0	5, 430				1. 00
2.00	MAGNETIC RESONANCE IMAGING	58.00	0	1, 159				2. 00
	(MRI)							
	TOTALS		0	6, 589				
500.00	Grand Total: Increases		71, 186	13, 638				500.00

Heal th	Financial Systems	Rehabi	litation Hospi	tal of Norther	n Indi	In Lie	u of Form CMS	-2552-10
RECLAS	SIFICATIONS			Provi der (	CCN: 15-3047	Period: From 05/01/2023	Worksheet A-	6
						To 04/30/2024	Date/Time Pr 9/9/2024 1:5	epared: 3 pm
		Decreases						
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref			
	6. 00	7. 00	8. 00	9. 00	10.00			
	A - RCLS PCT THERAPY							
1.00	PHYSI CAL THERAPY	66. 00	71, 186	7, 049		0		1. 00
2.00		0.00	0	0		o		2. 00
	TOTALS	$  \overline{}$	71, 186	7, 049		7		
	B - RCLS CT & MRI FROM RADIOL	_OGY						
1.00	RADI OLOGY-DI AGNOSTI C	54.00	0	6, 589		0		1. 00
2.00		0.00	0	0		o		2. 00
	TOTALS		0	6, 589		7		
500.00	Grand Total: Decreases		71, 186	13, 638				500.00

7.00

8.00

9.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 15-3047 Peri od: Worksheet A-7 From 05/01/2023 Part I Date/Time Prepared: 04/30/2024 9/9/2024 1:53 pm 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 2.00 Land Improvements 0 0 2.00 0 3. 00 3.00 Buildings and Fixtures 19, 911, 038 1, 215 1, 215 0 Building Improvements 0 4.00 0 4.00 5.00 Fixed Equipment 95, 810 -286, 875 0 -286, 875 0 5.00 0 6.00 Movable Equipment 2, 791, 778 -1, 208, 424 -1, 208, 424 0 6.00 0 7.00 HIT designated Assets 0 7.00 8.00 Subtotal (sum of lines 1-7) 22, 798, 626 -1, 494, 084 -1, 494, 084 0 8.00 9.00 Reconciling Items 0 0 9.00 22, 7<u>98, 626</u> -1, 4<u>94, 084</u> Total (line 8 minus line 9) O 10.00 10.00 -1, 494, 084 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 1.00 2.00 Land Improvements 0 2.00 3.00 Buildings and Fixtures 19, 912, 253 0 3.00 0) 4.00 Building Improvements 4.00 5.00 Fi xed Equipment -191, 065 0 5.00 Movable Equipment 0 6.00 1,583,354 6.00

21, 304, 542

21, 304, 542

0

0

0

7.00

8.00

9.00

HIT designated Assets

10.00 Total (line 8 minus line 9)

Reconciling Items

Subtotal (sum of lines 1-7)

Health Financial Systems	Rehabilitation Hospita	l of Northern	Indi	In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der CO		Peri od: From 05/01/2023	Worksheet A-7 Part II	
				To 04/30/2024	Date/Time Prep 9/9/2024 1:53	
		SL	JMMARY OF CAPI	TAL		
Cost Center Description	Depreciation	Lease	Interest	Insurance (see		

						9/9/2024 1.33	PIII
			SL	JMMARY OF CAPIT	AL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see	
					instructions)	instructions)	
		9. 00	10.00	11. 00	12.00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	IN 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	447, 006	2, 584, 564	25, 638	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	72, 429	30, 889	0	0	0	2.00
3.00	Total (sum of lines 1-2)	519, 435	2, 615, 453	25, 638	0	0	3. 00
		SUMMARY 0	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	IN 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	3, 057, 208				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	103, 318				2. 00
3.00	Total (sum of lines 1-2)	0	3, 160, 526				3. 00

Heal th	n Financial Systems Rehabil	itation Hospit	al of Northern	Indi	In Lie	eu of Form CMS-:	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		Peri od:	Worksheet A-7	
					From 05/01/2023		
					To 04/30/2024	Date/Time Pre 9/9/2024 1:53	
		COME	PUTATION OF RAT	TLOS	ALLOCATION OF	OTHER CAPITAL	Pili
		COM			ALLOCATION OF	OTHER CALLTIAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio	instructions)		
				(col. 1 - col.			
				2)			
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE						
1.00	CAP REL COSTS-BLDG & FLXT	19, 721, 188	l e	19, 721, 18			
2.00	CAP REL COSTS-MVBLE EQUIP	1, 583, 354	l .	1, 583, 35			
3.00	Total (sum of lines 1-2)	21, 304, 542		21, 304, 54			3. 00
ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL							
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
	·		Capi tal -Relate	cols. 5			
			d Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	ENTERS					
1.00	CAP REL COSTS-BLDG & FLXT	283, 893	0	321, 86	1 543, 990	2, 584, 564	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	22, 793	0	25, 84°	1 87, 267	30, 889	2.00
3.00	Total (sum of lines 1-2)	306, 686	0	347, 70	2 631, 257	2, 615, 453	3.00
			Sl	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
	·		instructions)	instructions)	Capi tal -Relate	of cols. 9	
					d Costs (see	through 14)	
					instructions)		
		11. 00	12. 00	13. 00	14. 00	15. 00	
	DADT III DECONCILIATION OF CADITAL COSTS OF	MITEDO					

25, 638

0 25, 638

PART III - RECONCILIATION OF CAPITAL COSTS CENTERS
CAP REL COSTS-BLDG & FIXT

CAP REL COSTS-MVBLE EQUIP Total (sum of lines 1-2)

37, 968 3, 048 41, 016

283, 893

22, 793 306, 686

3, 476, 053 1. 00 143, 997 2. 00 3, 620, 050 3. 00

0 0 0

1.00

2.00

Peri od: Wo From 05/01/2023

					To 04/30/2024		
				Expense Classification o	n Worksheet A	9/9/2024 1: 53	pm
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4. 00	Wkst. A-7 Ref. 5.00	
1. 00	Investment income - CAP REL	1.00		CAP REL COSTS-BLDG & FIXT	1.00	0	1. 00
2. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0.00	0	3.00
	(chapter 2)		J				
4. 00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5. 00
6. 00	Rental of provider space by		0		0.00	0	6.00
7. 00	suppliers (chapter 8) Telephone services (pay	A	-1, 834	ADMINISTRATIVE & GENERAL	5. 00	0	7.00
	stations excluded) (chapter 21)		·				
8. 00	Television and radio service	А	-6, 846	OPERATION OF PLANT	7. 00	0	8. 00
9. 00	(chapter 21) Parking Lot (chapter 21)		0		0.00	0	9.00
10. 00	Provider-based physician adjustment	A-8-2	0			0	
11. 00	Sale of scrap, waste, etc.		0		0.00	0	11. 00
12. 00	(chapter 23) Related organization	A-8-1	1, 331, 253			0	12.00
	transactions (chapter 10)	-	0		0.00	0	
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests	В	-	DI ETARY	10.00	0	
15. 00	Rental of quarters to employee and others		0		0.00	0	15. 00
16. 00	Sale of medical and surgical		0		0.00	0	16. 00
	supplies to other than patients						
17. 00	Sale of drugs to other than patients		0		0.00	0	17.00
18. 00	Sale of medical records and	В	-18	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	abstracts Nursing and allied health		0		0.00	0	19. 00
	education (tuition, fees, books, etc.)						
20.00	Vending machines		0		0. 00 0. 00	0	
21. 00	Income from imposition of interest, finance or penalty		U		0.00	0	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	PHYSICAL THERAPY	66.00		24.00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization review - physicians' compensation		O	*** Cost Center Deleted ***	114. 00		25.00
24 00	(chapter 21) Depreciation - CAP REL		0	CAD DEL COSTS BLDC 0 ELVI	1 00	0	26. 00
26. 00	COSTS-BLDG & FLXT			CAP REL COSTS-BLDG & FIXT	1.00		
27. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
28. 00	Non-physician Anesthetist		0	*** Cost Center Deleted ***		0	28. 00 29. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	0. 00 67. 00	U	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) Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31.00
	pathology costs in excess of limitation (chapter 14)						
32. 00	CAH HIT Adjustment for		0		0.00	0	32.00
33. 00	Depreciation and Interest INTEREST INCOME	В	-1, 582	ADMINISTRATIVE & GENERAL	5. 00	0	33.00

76.00

34.63

50.00

ADJUSTMENTS TO EXPENSES Provider CCN: 15-3047 Peri od: Worksheet A-8 From 05/01/2023 04/30/2024 Date/Time Prepared: 9/9/2024 1:53 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Basis/Code (2) Cost Center Description Cost Center Line # Wkst. A-7 Ref. Amount 1.00 2.00 3.00 4.00 5.00 33. 02 MLSC I NCOME -8, 641 ADMINI STRATI VE & GENERAL 33. 02 В 5.00 PRE-OPENING AMORTIZATION - CAF 81, 895 CAP REL COSTS-BLDG & FIXT 33.04 Α 1.00 33.04 33.05 PRE-OPENING AMORTIZATION - A&G Α 260, 734 ADMI NI STRATI VE & GENERAL 5.00 33.05 33.08 OTHER -7, 007 ADMI NI STRATI VE & GENERAL 33.08 Α 5.00 EXPENSE-ADVERTI SI NG/MARKETI NG--9, 800 ADMINISTRATIVE & GENERAL 33.14 OTHER Α 5.00 33.14 EXPENSE-ADVERTI SI NG/MARKETI NG-33.22 BAD DEBT EXPENSE-BAD DEBT--Α -208, 756 ADMI NI STRATI VE & GENERAL 5.00 33. 22 OTHER EXPENSE-CONTRIBUTIONS / 33.35 -8, 322 ADMI NI STRATI VE & GENERAL 5.00 33.35 Α SP0NS0 OTHER EXPENSE-FLOWERS & -274 ADMINISTRATIVE & GENERAL 33.56 Α 5.00 33.56 GLFTS-33.57 OTHER EXPENSE-FLOWERS & -314 ADMINISTRATIVE & GENERAL 5.00 33.57 Α GLFTS-33.67 OTHER EXPENSE-PUBLIC Α -50 ADMINISTRATIVE & GENERAL 5.00 33.67 I NFORMATI ON - -33 91 OTHER EXPENSE-GLVEAWAYS---1, 930 ADMINISTRATIVE & GENERAL 33.91 5 00 Α 0 33.93 OTHER EXPENSE-GIVEAWAYS---7, 071 ADMI NI STRATI VE & GENERAL 5.00 0 33.93 Α OTHER FEES-LATE FEES---57 RESPIRATORY THERAPY 34.06 Α 65.00 34.06 34.10 OTHER FEES-LATE FEES---1, 218 MEDI CAL SUPPLI ES CHARGED TO 71.00 34. 10 Α PATI ENTS -2,844 OPERATION OF PLANT 34.13 OTHER FEES-LATE FEES--34. 13 Δ 7.00 34. 18 OTHER FEES-LATE FEES--Α -932 ADMINISTRATIVE & GENERAL 5.00 34.18 34. 21 OTHER FEES-LATE FEES--Α -130 ADMINISTRATIVE & GENERAL 5.00 34. 21 -15 ADMINISTRATIVE & GENERAL OTHER FEES-LATE FEES--5.00 34. 23 Α 34.23 -424 ADMINISTRATIVE & GENERAL 34.46 TAXES-SALES TAX--Α 5.00 34.46 34.54 MARKETING EXPENSE -9, 403 ADMINISTRATIVE & GENERAL 5.00 34. 54 34. 55 MARKETING BENEFITS -1, 014 EMPLOYEE BENEFITS DEPARTMENT 4.00 34.55 Α -23, 500 ADMI NI STRATI VE & GENERAL TELEPHONE OPERATOR EXPENSE 34.56 Α 5.00 34.56 34.57 TELEPHONE BENEFIT EXPENSE Α -2,887 EMPLOYEE BENEFITS DEPARTMENT 4.00 34.57 UNALLOWABLE LOBBYING % OF -2, 261 ADMINISTRATIVE & GENERAL 34.59 Α 5.00 34.59 ASSOC DUES

102, 861 OTHER ANCILLARY SERVICE COST

CENTERS

1, 463, 747

Α

TOTAL (sum of lines 1 thru 49)

PRIOR PD ACCR REVERSALS AND

(Transfer to Worksheet A, column 6, line 200.)

34.63

50.00

INVOLCES

<sup>(1)</sup> Description - all chapter references in this column pertain to CMS Pub. 15-1.

<sup>(2)</sup> Basis for adjustment (see instructions)

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

B. Amount Received - if cost cannot be determined.

<sup>(3)</sup> Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

				10 04/30/2024	9/9/2024 1:53	
	Li ne No.	Cost Center	Expense I tems	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 ADJUST!	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HO Alloc - Cap Rel Bldg	9, 331	0	1.00
2.00	2. 00	CAP REL COSTS-MVBLE EQUIP	HO Alloc - Cap Rel Equipment	14, 838	0	2.00
3.00	5. 00	ADMINISTRATIVE & GENERAL	HO Alloc - Cap Rel A&G	1, 559, 959	0	3.00
4.00	5. 00	ADMINISTRATIVE & GENERAL	Intercompany Management Fees	0	291, 644	4.00
4.04	5. 00	ADMINISTRATIVE & GENERAL	Pre-opening Amortization - H	33, 011	0	4.04
4.05	1.00	CAP REL COSTS-BLDG & FIXT	Pre-opening Amortization - H	5, 758	0	4.05
5. 00	0		0	1, 622, 897	291, 644	5. 00

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

			Related Organization(s) and/	or Home Office	
Symbol (1)	Name	Percentage of	Name	Percentage of	
•		Ownershi p		Ownershi p	
1. 00	2. 00	3. 00	4. 00	5. 00	
B. INTERRELATIONSHIP TO RELAT	ED ORGANIZATION(S) AND/OR HO	ME 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	В		O. OO ERNEST HEALTH	100.00	6. 00
7.00			0.00	0. 00	7. 00
8.00			0.00	0. 00	8. 00
9. 00			0.00	0. 00	9. 00
10.00			0.00	0. 00	10.00
100.00	G. Other (financial or	FINANCIAL			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 organi zati on.
- 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 provi der.

Heal th	Financial Syste	ems		Rehabilitation Hospital	of Northern Indi	In Lie	u of Form CMS-	2552-10
		SERVICES FROM	RELATED	ORGANIZATIONS AND HOME	Provider CCN: 15-3047	Peri od:	Worksheet A-8	3-1
OFFICE	COSTS					From 05/01/2023 To 04/30/2024	Date/Time Pre	
	Net	Wkst. A-7 Ref.						
	Adjustments							
	(col. 4 minus							
	col. 5)*							
	6. 00	7. 00						
	A. COSTS INCUR	RED AND ADJUSTM	MENTS REC	QUIRED AS A RESULT OF TR	ANSACTIONS WITH RELATED	ORGANIZATIONS OR	CLAI MED	
	HOME OFFICE CO	STS:						
1.00	9, 331	9						1. 00
2.00	14, 838	9						2. 00
3.00	1, 559, 959	0						3. 00
4.00	-291, 644	0						4. 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.

4.04

4 05

5.00

	Related Organization(s) and/or Home Office		
	Type of Business		
	6. 00		
B.	INTERRELATIONSHIP TO RELAT	ED 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.

	HOME OFFICE	6.00
7. 00 8. 00		7.00
8.00		8.00
9.00		9.00
10. 00 100. 00		10.00
100.00		100.00

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

4.04

4 05

5.00

33, 011

1, 331, 253

5.758

0

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-3047 Peri od: Worksheet B From 05/01/2023 Part I Date/Time Prepared: 04/30/2024 9/9/2024 1:53 pm 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 3, 476, 053 3, 476, 053 2.00 00200 CAP REL COSTS-MVBLE EQUIP 143, 997 143, 997 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 1, 665, 047 12, 502 518 1, 678, 067 4.00 00500 ADMINISTRATIVE & GENERAL 228, 794 9. 478 357, 986 4, 830, 971 5.00 5 00 4, 234, 713 00700 OPERATION OF PLANT 7.00 426, 725 1,033,242 42,802 8, 138 1, 510, 907 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 48, 215 48, 215 8.00 9.00 00900 HOUSEKEEPI NG 193, 157 76, 350 3, 163 31, 220 303, 890 9.00 01000 DI ETARY 10.00 709, 861 1, 054, 907 10 00 238, 808 9.893 96.345 13.00 01300 NURSING ADMINISTRATION 432, 400 119, 659 4, 957 84, 554 641, 570 13.00 01600 MEDICAL RECORDS & LIBRARY 20, 042 16.00 111,876 13, 522 560 146,000 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 3, 522, 470 1, 226, 508 50,808 663, 170 5, 462, 956 30.00 44.00 04400 SKILLED NURSING FACILITY 44.00 0 ANCILLARY SERVICE COST CENTERS 05400 RADI OLOGY-DI AGNOSTI C 61, 972 61, 972 54.00 0 54.00 05700 CT SCAN 57.00 5.430 Ω 0 0 5, 430 57 00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 1, 159 0 0 1, 159 58.00 60.00 06000 LABORATORY 40,032 12, 374 513 0 52, 919 60.00 06500 RESPIRATORY THERAPY 65.00 141.889 19.988 161, 877 65.00 0 06600 PHYSI CAL THERAPY 300, 360 66.00 633, 522 12.443 119, 872 1, 066, 197 66.00 06700 OCCUPATIONAL THERAPY 646, 157 52, 176 127, 625 828, 119 67.00 2, 161 67.00 68.00 06800 SPEECH PATHOLOGY 291, 872 21, 368 885 57, 278 371, 403 68.00 3, 089 9, 941 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 206, 921 74, 564 294, 515 71.00 73.00 07300 DRUGS CHARGED TO PATIENTS 679, 918 65, 698 2,722 81, 908 830, 246 73.00 07400 RENAL DIALYSIS 232, 169 74.00 232, 169 74.00 76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS 10,877 0 0 0 10,877 76.00 OUTPATIENT SERVICE COST CENTERS 09100 EMERGENCY 91.00 91.00 0 0 0 0 o 91.01 04951 OUTPATIENT THERAPY 0 0 91.01 04950 OUTPATIENT WOUND CENTER 0 93.00 93.00 0 0 0 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 0 0 101.00 10100 HOME HEALTH AGENCY 0 0 101.00 0 0 0 SPECIAL PURPOSE COST CENTERS 117. 00 06950 OTHER SPECIAL PURPOSE COST CENTERS 0 0 117.00 SUBTOTALS (SUM OF LINES 1 through 117) 17, 916, 432 3, 475, 925 143, 992 1, 678, 067 17, 916, 299 118. 00 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 192. 00 0 194. 00 07950 MARKETI NG 0 128 5 0 133 194. 00 194. 01 07951 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 194. 01 C Cross Foot Adjustments 200 00 0|200 00 201.00 Negative Cost Centers 0 201.00 202.00 TOTAL (sum lines 118 through 201) 17, 916, 432 3, 476, 053 143, 997 1, 678, 067 17, 916, 432 202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

						9/9/2024 1:53	pm
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVICE			
		5. 00	7. 00	8. 00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	4, 830, 971					5. 00
7.00	00700 OPERATION OF PLANT	557, 806	2, 068, 713	В			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	17, 800	C	66, 015			8. 00
9.00	00900 HOUSEKEEPI NG	112, 192	71, 744	. 0	487, 826		9. 00
10.00	01000 DI ETARY	389, 457	224, 403	1	54, 818	1, 723, 585	10.00
13. 00	01300 NURSING ADMINISTRATION	236, 859	112, 441	1	27, 467	0	13. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	53, 901	12, 707		3, 104	0	
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	33,701	12, 707		0, 101		10.00
30. 00	03000 ADULTS & PEDIATRICS	2, 016, 847	1, 152, 520	66, 015	281, 542	1, 723, 585	30.00
44. 00	04400 SKILLED NURSING FACILITY	2,010,047	1, 132, 320	00,013	l	1, 723, 303	44. 00
44.00	ANCILLARY SERVICE COST CENTERS	l o		)  0	U U	U	44.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	22, 879			ام	0	54.00
	05700 CT SCAN			ή	0	0	
57. 00		2, 005	C	0	0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	428	44 (00		0 040	ŭ	58. 00
60.00	06000 LABORATORY	19, 537	11, 628	3	2, 840	0	60.00
65. 00	06500 RESPI RATORY THERAPY	59, 763		) 0	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	393, 625	282, 242		68, 947	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	305, 730	49, 028	1	11, 977	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	137, 117	20, 079	1	4, 905	0	68. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	108, 731	70, 066	0	17, 116	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	306, 515	61, 735	5 O	15, 081	0	73. 00
74.00	07400 RENAL DIALYSIS	85, 714	C	0	0	0	74. 00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	4, 016	C	0	0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS			•			]
91.00	09100 EMERGENCY	0	C	0	0	0	91.00
91. 01	04951 OUTPATIENT THERAPY	0	C	ol o	o	0	91. 01
93.00	04950 OUTPATIENT WOUND CENTER	o	C	ol o	ol	0	93.00
	OTHER REIMBURSABLE COST CENTERS				-1		
95. 00	09500 AMBULANCE SERVICES	0	C	0	0	0	95. 00
	10100 HOME HEALTH AGENCY	0	Ċ		· ·		101. 00
	SPECIAL PURPOSE COST CENTERS	, J		,	٦		
117 0	06950 OTHER SPECIAL PURPOSE COST CENTERS	0	C	0	O	0	117. 00
118. 00		4, 830, 922	2, 068, 593	1	·	1, 723, 585	
110.00	NONREI MBURSABLE COST CENTERS	4, 030, 722	2,000,090	00,013	407, 797	1, 723, 303	1110.00
100 0	19200 PHYSI CLANS' PRI VATE OFFI CES	l			O		192. 00
			_	1	ا		
	07950 MARKETI NG	49	120	0	29		194. 00
	07951 OTHER NONREIMBURSABLE COST CENTERS	0	C	ט	O O	0	194. 01
200.00							200.00
201.00		0	C	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	4, 830, 971	2, 068, 713	66, 015	487, 826	1, 723, 585	202. 00

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-3047 Peri od: Worksheet B From 05/01/2023 Part I 04/30/2024 Date/Time Prepared: 9/9/2024 1:53 pm Cost Center Description NURSI NG MEDI CAL Subtotal Intern & Total RECORDS & ADMI NI STRATI ON Residents Cost LI BRARY & Post Stepdown Adj ustments 13.00 16.00 24.00 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 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 10.00 01300 NURSING ADMINISTRATION 13.00 13 00 1,018,337 01600 MEDICAL RECORDS & LIBRARY 16.00 215, 712 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 1, 018, 337 101, 357 11, 823, 159 11, 823, 159 30.00 0 04400 SKILLED NURSING FACILITY 44 00 44.00 0 0 ANCILLARY SERVICE COST CENTERS 05400 RADI OLOGY-DI AGNOSTI C 54.00 0 1, 408 86, 259 86, 259 54.00 0 0 05700 CT SCAN 7.558 7.558 57.00 57 00 123 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 26 1, 613 1, 613 58.00 60.00 06000 LABORATORY 10, 733 97, 657 0 97, 657 60.00 0000000 06500 RESPIRATORY THERAPY 229, 254 65.00 7, 614 0 0 0 229, 254 65.00 06600 PHYSI CAL THERAPY 1, 835, 495 1, 835, 495 66.00 24, 484 66 00 06700 OCCUPATIONAL THERAPY 67.00 25, 401 1, 220, 255 1, 220, 255 67.00 06800 SPEECH PATHOLOGY 8, 735 542, 239 542, 239 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 8, 932 499, 360 0 499, 360 71.00 07300 DRUGS CHARGED TO PATIENTS 26, 117 1, 239, 694 1, 239, 694 73 00 73 00 07400 RENAL DIALYSIS 74.00 703 318, 586 318, 586 74.00 14, 972 03950 OTHER ANCILLARY SERVICE COST CENTERS 79 14, 972 76.00 76.00 OUTPATIENT SERVICE COST CENTERS 91.00 91 00 09100 EMERGENCY 0 Ω 0 0 0 91.01 04951 OUTPATIENT THERAPY 0 0 0 0 0 91.01 04950 OUTPATIENT WOUND CENTER 0 93.00 93.00 0 0 0 0 OTHER REIMBURSABLE COST CENTERS 95.00 95 00 09500 AMBULANCE SERVICES 0 0 0 0 0 101.00 10100 HOME HEALTH AGENCY 0 0 101.00 SPECIAL PURPOSE COST CENTERS 117. 00 06950 OTHER SPECIAL PURPOSE COST CENTERS 0 117, 00 1, 0<u>18, 33</u>7 SUBTOTALS (SUM OF LINES 1 through 117) 215, 712 17, 916, 101 17, 916, 101 118. 00 118.00 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 192. 00 0 331 194. 00 194. 00 07950 MARKETI NG 0 Λ 331 194. 01 07951 OTHER NONREIMBURSABLE COST CENTERS 0 0 C 0 0 194. 01 200.00 Cross Foot Adjustments 0 0 200. 00 0 201.00 201.00 Negative Cost Centers 0 202.00 TOTAL (sum lines 118 through 201) 1, 018, 337 215, 712 17, 916, 432 17, 916, 432 202. 00

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 05/01/2023 Part II Rehabilitation Hospital of Northern Indi
Provider CCN: 15-3047

				To	04/30/2024	Date/Time Pre 9/9/2024 1:53	pared:
			CAPI TAL REL	ATED COSTS		77 97 2024 1. 53	Pili
	Cost Center Description	Directly Assigned New Capital	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		Related Costs 0	1. 00	2.00	2A	4. 00	
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	ZA	4.00	
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		12, 502	518	13, 020	13, 020	4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL		228, 794		238, 272	2, 777	5. 00
7. 00	00700 OPERATION OF PLANT		1, 033, 242		1, 076, 044	63	7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE		1, 000, 212	0	1, 0, 0, 0 1 1	0	8. 00
9. 00	00900 HOUSEKEEPI NG		76, 350	3, 163	79, 513	242	9. 00
10. 00	01000 DI ETARY	0	238, 808	·	248, 701	748	
13. 00	01300 NURSING ADMINISTRATION		119, 659		124, 616	656	13. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY		13, 522		14, 082	156	
	INPATIENT ROUTINE SERVICE COST CENTERS	-			,		
30.00	03000 ADULTS & PEDIATRICS	l	1, 226, 508	50, 808	1, 277, 316	5, 147	30.00
	04400 SKILLED NURSING FACILITY	l ol	0	·	0	0	44. 00
	ANCILLARY SERVICE COST CENTERS	'		- "	-1		
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	54.00
57.00	05700 CT SCAN	o	0	0	o	0	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	o	0	0	o	0	58. 00
60.00	06000 LABORATORY	o	12, 374	513	12, 887	0	60.00
65.00	06500 RESPI RATORY THERAPY	o	0	0	O	155	65. 00
66.00	06600 PHYSI CAL THERAPY	o	300, 360	12, 443	312, 803	930	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	52, 176	2, 161	54, 337	990	67. 00
68.00	06800 SPEECH PATHOLOGY	0	21, 368	885	22, 253	444	68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	74, 564	3, 089	77, 653	77	71. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	65, 698	2, 722	68, 420	635	73. 00
74.00	07400 RENAL DI ALYSI S	0	0	0	0	0	74. 00
76. 00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS						
91. 00	09100 EMERGENCY	0	0		0	0	91.00
91. 01	04951 OUTPATI ENT THERAPY	0	0		0	0	91. 01
93. 00	04950 OUTPATIENT WOUND CENTER	0	0	0	0	0	93. 00
	OTHER REIMBURSABLE COST CENTERS				-		
	09500 AMBULANCE SERVICES	0	0		0	0	
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
117 00	SPECIAL PURPOSE COST CENTERS		0	0	ام	0	117 00
	06950 OTHER SPECIAL PURPOSE COST CENTERS	0	0		0 (10 017		117. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)   NONREIMBURSABLE COST CENTERS	l U	3, 475, 925	143, 992	3, 619, 917	13, 020	]118.00
102 00	19200 PHYSI CLANS' PRI VATE OFFI CES		0	0	ol	0	192. 00
	07950 MARKETI NG		128	5	133		194. 00
	07951 OTHER NONREIMBURSABLE COST CENTERS		0	0	0		194. 00
200.00			J		0	O	200.00
201.00	, , , , , , , , , , , , , , , , , , , ,		O	n	0	n	201. 00
202.00		o	3, 476, 053	143, 997	3, 620, 050	13, 020	
	1 (22 22 23 24 27)	-1	-,,			-,	

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 05/01/2023 Part II
To 04/30/2024 Date/Time Prepared: 9/9/2024 1:53 pm

Cost Center Description							9/9/2024 1: 53	pm
		Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG		
CENERAL SERVICE COST CENTERS			& GENERAL	PLANT	LINEN SERVICE			
1.00			5.00	7. 00	8. 00	9. 00	10.00	
2.00								
4.00	1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
5.00	2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
7. 00	4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
B. 00   ORBOOL   LAUNDRY & LINEN SERVICE	5.00	00500 ADMINISTRATIVE & GENERAL	241, 049					5. 00
9.00   00900  HOUSEKEEPING	7.00	00700 OPERATION OF PLANT	27, 832	1, 103, 939				7. 00
10.00   01000   0150	8.00	00800 LAUNDRY & LINEN SERVICE	888	0	888	3		8. 00
13.00   01300   NURSI NG ADMINI STRATI ON   11, 818   60, 003   0   6, 962   0   13. 00	9.00	00900 HOUSEKEEPI NG	5, 598	38, 285	c	123, 638		9. 00
16.00     16.00     16.00     16.00   16.00   1787   0   16.00   18.	10.00	01000 DI ETARY	19, 432	119, 749	·l c	13, 893	402, 523	10.00
INPATIENT ROUTINE SERVICE COST CENTERS   100,637   615,026   888   71,357   402,523   30.00   40.00   30.00	13.00	01300 NURSING ADMINISTRATION	11, 818	60, 003	c	6, 962	0	13. 00
30.00	16.00	01600 MEDICAL RECORDS & LIBRARY	2, 689	6, 781	c	787	0	16. 00
44.00		INPATIENT ROUTINE SERVICE COST CENTERS						1
ANCILLARY SERVICE COST CENTERS	30.00	03000 ADULTS & PEDIATRICS	100, 637	615, 026	888	71, 357	402, 523	30.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C   1,142   0   0   0   0   0   54. 00   57. 00   05700   CT SCAN   100   0   0   0   0   0   57. 00   58. 00   05800   MAGNETI C RESONANCE I MAGI NG (MRI )   21   0   0   0   0   0   58. 00   60. 00   06600   LABORATORY   975   6, 205   0   720   0   60. 00   65. 00   06500   RESPI RATORY THERAPY   2, 982   0   0   0   0   0   65. 00   66. 00   06600   PHYSI CAL THERAPY   19, 640   150, 614   0   17, 474   0   66. 00   67. 00   06600   PHYSI CAL THERAPY   19, 640   150, 614   0   17, 474   0   66. 00   68. 00   06600   PHYSI CAL THERAPY   15, 255   26, 163   0   3, 035   0   67. 00   69. 00   06600   SPEECH PATHOLOGY   6, 842   10, 715   0   1, 243   0   08. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   15, 294   32, 944   0   3, 822   0   73. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   15, 294   32, 944   0   3, 822   0   73. 00   74. 00   07400   RENALD I ALLYSIS   4, 277   0   0   0   0   0   0   0   76. 00   09100   EMERGENCY   0   0   0   0   0   0   0   77. 00   09100   EMERGENCY   0   0   0   0   0   0   0   791. 00   09100   EMERGENCY   0   0   0   0   0   0   0   791. 00   09500   AMBULANCE SERVI CES   0   0   0   0   0   0   70100   OUTPATI ENT THERAPY   0   0   0   0   0   0   70100   04950   OUTPATI ENT WOUND CENTER   0   0   0   0   0   70100   04950   OUTPATI ENT WOUND CENTER   0   0   0   0   0   70100   04950   OUTPATI ENT HERAPY   0   0   0   0   0   70100   04950   OUTPATI ENT HERAPY   0   0   0   0   0   70100   04950   OUTPATI ENT HERAPY   0   0   0   0   0   70100   04950   OUTPATI ENT HERAPY   0   0   0   0   0   70100   04950   OUTPATI ENT HERAPY   0   0   0   0   0   70100   04950   OUTPATI ENT HERAPY   0   0   0   0   0   70100   04950   OUTPATI ENT HERAPY   0   0   0   0   0   70100   04950   OUTPATI ENT HERAPY   0   0   0   0   0   70100   04950   OUTPATI ENT HERAPY   0   0   0   0   0   70100   04950   OUTPATI ENT HERAPY   0   0   0   0   0   70100   04950   OUTPATI ENT HERAPY   0   0   0   0   0   70100   04950   OUTPAT	44.00	04400 SKILLED NURSING FACILITY	0	0	l c	0	0	44. 00
57. 00   05700   CT SCAN   100   0   0   0   0   57. 00			<u>'</u>					1
57. 00   05700   CT SCAN   100   0   0   0   0   57. 00	54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 142	0	C	0	0	54.00
60.00   06000   LABORATORY   975   6,205   0   720   0   60.00   65.00   05500   RESPI RATORY THERAPY   2,982   0   0   0   0   0   66.00   06500   RESPI RATORY THERAPY   19,640   150,614   0   17,474   0   66.00   67.00   06700   OCCUPATI ONAL THERAPY   15,255   26,163   0   3,035   0   67.00   68.00   06800   SPEECH PATHOLOGY   6,842   10,715   0   1,243   0   68.00   69.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   5,425   37,390   0   4,338   0   71.00   71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   15,294   32,944   0   3,822   0   73.00   74.00   07400   RENAL DIALYSIS   4,277   0   0   0   0   0   0   76.00   03950   OTHER ANCILLARY SERVICE COST CENTERS   200   0   0   0   0   0   76.00   03950   OTHER REI MEDICASCHERS   0   0   0   0   0   0   79.00   04950   OUTPATIENT WOUND CENTER   0   0   0   0   0   0   79.00   04950   OUTPATIENT WOUND CENTER   0   0   0   0   0   0   79.00   05000   AMBURANCE SERVICES   0   0   0   0   0   0   70   05000   AMBURANCE SERVICES   0   0   0   0   0   0   70   05000   AMBURANCE SERVICES   0   0   0   0   0   70   05000   AMBURANCE SERVICES   0   0   0   0   0   70   00000   00000   0   0   0   70   00000   00000   00000   00000   70   00000   00000   00000   00000   70   00000   00000   000000   70   00000   00000000   0000000000	57.00	05700 CT SCAN		0		0	0	57.00
65. 00	58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	21	0		0	0	58. 00
65. 00	60.00			6, 205		720	0	60.00
66. 00   06600   PHYSI CAL THERAPY   19, 640   150, 614   0   17, 474   0   66. 00   67. 00   06700   OCCUPATI ONAL THERAPY   15, 255   26, 163   0   3, 035   0   67. 00   68. 00   06800   SPECEH PATHOLOGY   6, 842   10, 715   0   1, 243   0   68. 00   06800   SPECEH PATHOLOGY   6, 842   10, 715   0   1, 243   0   68. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   5, 425   37, 390   0   4, 338   0   71. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   15, 294   32, 944   0   3, 822   0   73. 00   074. 00   0   0   0   0   0   0   0   0   0	65. 00	06500 RESPIRATORY THERAPY	2, 982	0		0	0	65.00
67. 00   06700   OCCUPATI ONAL THERAPY   15, 255   26, 163   0   3, 035   0   67. 00   68. 00   06800   SPEECH PATHOLOGY   6, 842   10, 715   0   1, 243   0   68. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   5, 425   37, 390   0   4, 338   0   71. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   15, 294   32, 944   0   3, 822   0   73. 00   74. 00   07400   RENAL DI ALYSI S   4, 277   0   0   0   0   0   0   76. 00   0950   OTHER ANCI LLARY SERVICE COST CENTERS   200   0   0   0   0   0   0   76. 00   0000   0000   0000   0000   0000   0000   76. 00   0000   0000   0000   0000   0000   0000   77. 00   09100   EMERGENCY   0   0   0   0   0   0   78. 00   094950   OUTPATI ENT THERAPY   0   0   0   0   0   0   791. 01   04951   OUTPATI ENT THERAPY   0   0   0   0   0   0   793. 00   094950   OUTPATI ENT WOUND CENTER   0   0   0   0   0   795. 00   09500   AMBULANCE SERVI CES   0   0   0   0   0   0   796. 00   09500   AMBULANCE SERVI CES   0   0   0   0   0   796. 00   09500   AMBULANCE SERVI CES   0   0   0   0   0   797. 00   09500   AMBULANCE SERVI CES   0   0   0   0   0   798. 00   09500   OTHER SPECIAL PURPOSE COST CENTERS   0   0   0   0   798. 00   09500   OTHER SPECIAL PURPOSE COST CENTERS   0   0   0   0   799. 00   09500   OTHER SPECIAL PURPOSE COST CENTERS   0   0   0   0   799. 00   09500   OTHER SPECIAL PURPOSE COST CENTERS   0   0   0   0   799. 00   09500   OTHER SPECIAL PURPOSE COST CENTERS   0   0   0   0   799. 00   09500   OTHER SPECIAL PURPOSE COST CENTERS   0   0   0   0   799. 00   09500   OTHER SPECIAL PURPOSE COST CENTERS   0   0   0   0   799. 00   09500   OTHER SPECIAL PURPOSE COST CENTERS   0   0   0   0   799. 00   09500   OTHER SPECIAL PURPOSE COST CENTERS   0   0   0   0   799. 00   09500   OTHER SPECIAL PURPOSE COST CENTERS   0   0   0   0   799. 00   09500   OTHER SPECIAL PURPOSE COST CENTERS   0   0   0   0   799. 00   09500   OTHER SPECIAL PURPOSE COST CENTERS   0   0   0   0   799. 0000   0000   0000   0000   0000   0000   0000   799. 0000   0000   0000   0000	66. 00	06600 PHYSI CAL THERAPY		150, 614		17, 474	0	66.00
68. 00 06800 SPEECH PATHOLOGY 6, 842 10, 715 0 1, 243 0 68. 00 71. 00 7100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 5, 425 37, 390 0 4, 338 0 71. 00 7300 DRUGS CHARGED TO PATIENTS 15, 294 32, 944 0 3, 822 0 73. 00 74. 00 7400 RENAL DIALYSIS 4, 277 0 0 0 0 0 74. 00 74. 00 7400 RENAL DIALYSIS 4, 277 0 0 0 0 0 74. 00 74.							0	
71. 00					l .	1	0	
73. 00	71. 00	1			1		0	
74. 00   07400   RENAL DI ALYSI S   4, 277   0   0   0   0   0   74. 00   76. 00   03950   OTHER ANCI LLARY SERVI CE COST CENTERS   200   0   0   0   0   0    91. 00   09100   EMERGENCY   0   0   0   0   0   0   91. 00    91. 01   04951   OUTPATI ENT THERAPY   0   0   0   0   0   0   91. 01    93. 00   04950   OUTPATI ENT WOUND CENTER   0   0   0   0   0   0   93. 00    OTHER REI MBURSABLE COST CENTERS   0   0   0   0   0   0    101. 00   10100   HOME HEALTH AGENCY   0   0   0   0   0   0    102. 00   05950   OTHER SPECI AL PURPOSE COST CENTERS   0   0   0   0   0    103. 00   05950   OTHER SPECI AL PURPOSE COST CENTERS   0   0   0   0   0    104. 00   05950   OTHER SPECI AL PURPOSE COST CENTERS   0   0   0   0    105. 00   05950   OTHER SPECI AL PURPOSE COST CENTERS   0   0   0   0    106. 00   05950   OTHER SPECI AL PURPOSE COST CENTERS   0   0   0   0    107. 00   05950   OTHER SPECI AL PURPOSE COST CENTERS   0   0   0   0    108. 00   05950   OTHER SPECI AL PURPOSE COST CENTERS   0   0   0   0    109. 00   09. 00   09. 00   09. 00    109. 00   09. 00   09. 00    109. 00   09. 00   09. 00    109. 00   09. 00    109. 00   09. 00    109. 00   09. 00    109. 00   09. 00    109. 00   09. 00    109. 00	73. 00				l .		0	73. 00
76. 00 03950 OTHER ANCILLARY SERVICE COST CENTERS 200 0 0 0 0 0 0 76. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0		0	0	
OUTPATI ENT SERVI CE COST CENTERS   O   O   O   O   O   O   O   O   O	76. 00	03950 OTHER ANCILLARY SERVICE COST CENTERS		0		0	0	76.00
91. 00				_				
91. 01	91. 00		0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS   O			1	0		0	0	
OTHER REIMBURSABLE COST CENTERS   O	93. 00	04950 OUTPATIENT WOUND CENTER	0	0		0	0	93. 00
95. 00								
101.00   10100   HOME   HEALTH   AGENCY   0   0   0   0   0   101.00	95.00		0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS   117. 00   06950   OTHER SPECIAL PURPOSE COST CENTERS   0   0   0   0   0   117. 00	101. 0			0		0	0	
117. 00 06950 OTHER SPECIAL PURPOSE COST CENTERS 0 0 0 0 0 0 117. 00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 241,047 1,103,875 888 123,631 402,523 118. 00 NONREI MBURSABLE COST CENTERS 0 0 0 0 0 192. 00 192. 00 194. 00 07950 MARKETING 2 64 0 7 0 194. 00 194. 01 194. 01 07951 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 194. 01 200. 00 Cross Foot Adjustments 0 Negative Cost Centers 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
118.00   SUBTOTALS (SUM OF LINES 1 through 117)   241,047   1,103,875   888   123,631   402,523   118.00	117. 0		0	0	0	0	0	117. 00
NONREI MBURSABLE COST CENTERS   192.00   19200   PHYSI CI ANS' PRI VATE OFFI CES   0   0   0   0   192.00     194.00   07950   MARKETI NG   2   64   0   7   0     194.01   07951   OTHER NONREI MBURSABLE COST CENTERS   0   0   0   0     200.00   Cross Foot Adjustments   200.00     201.00   Negati ve Cost Centers   0   0   0   0     201.00   0   0   0   0     201.00   0   0   0   0     201.00   0   0   0   0     201.00   0   0   0   0     201.00   0   0   0   0     201.00   0   0   0   0     201.00   0   0   0   0     201.00   0   0   0   0     201.00   0   0   0   0     201.00   0   0   0   0     201.00   0   0   0     201.00   0   0   0     201.00   0   0   0     201.00   0   0   0     201.00   0   0   0     201.00   0   0   0     201.00   0   0   0     201.00   0   0     201.00   0   0     201.00   0   0     201.00   0   0     201.00   0   0     201.00   0   0     201.00   0   0     201.00   0   0     201.00   0   0     201.00   0   0     201.00   0   0     201.00   0   0     201.00   0   0     201.00   0   0     201.00   0   0     201.0		1	241.047	1, 103, 875	888	123, 631	402, 523	118.00
192. 00				.,,			,	1
194. 00     07950     MARKETING     2     64     0     7     0     194. 00       194. 01     07951     OTHER NONREIMBURSABLE COST CENTERS     0     0     0     0     0     194. 01       200. 00     Cross Foot Adjustments     200. 00     0     0     0     0     0     0     0     201. 00	192.0		0	0	0	0	0	192. 00
194. 01     07951     OTHER NONREIMBURSABLE COST CENTERS     0     0     0     0     194. 01       200. 00     Cross Foot Adjustments     200. 00     0     0     0     0     0     0     0       201. 00     Negative Cost Centers     0     0     0     0     0     0     0     0			2	64		7		
200.00     Cross Foot Adjustments     200.00       201.00     Negative Cost Centers     0     0     0     0     0     0			0	0	d	0		
201.00   Negative Cost Centers   0   0   0   0   201.00		1			1			
		1 1	0	n		o o	n	
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			241, 049	1, 103, 939	888	123, 638		
		1 (30 23)		,,	,	-,	, ,	

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-3047 Peri od: Worksheet B From 05/01/2023 Part II 04/30/2024 Date/Time Prepared: 9/9/2024 1:53 pm Cost Center Description NURSI NG MEDI CAL Subtotal Intern & Total RECORDS & ADMI NI STRATI ON Residents Cost LI BRARY & Post Stepdown Adjustments 13.00 16.00 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 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 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 10.00 01300 NURSING ADMINISTRATION 13.00 13 00 204,055 01600 MEDICAL RECORDS & LIBRARY 16.00 24, 495 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 204, 055 11, 510 2, 688, 459 2, 688, 459 30.00 0 04400 SKILLED NURSING FACILITY 44.00 44.00 0 0 ANCILLARY SERVICE COST CENTERS 05400 RADI OLOGY-DI AGNOSTI C 54.00 0 1, 302 1, 302 54.00 160 0 0 05700 CT SCAN 57.00 57 00 14 114 114 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 24 24 58.00 60.00 06000 LABORATORY 1, 219 22,006 0 22,006 60.00 0000000 06500 RESPIRATORY THERAPY 65.00 865 4,002 0 0 0 4,002 65.00 06600 PHYSI CAL THERAPY 504, 241 504, 241 66.00 2 780 66 00 06700 OCCUPATIONAL THERAPY 67.00 2,884 102,664 102, 664 67.00 06800 SPEECH PATHOLOGY 992 42, 489 42, 489 68.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 1,014 125, 897 125, 897 71.00 07300 DRUGS CHARGED TO PATIENTS 124,080 124,080 73 00 73 00 2, 965 07400 RENAL DIALYSIS 0 74.00 80 4, 357 4, 357 74.00 03950 OTHER ANCILLARY SERVICE COST CENTERS 209 209 76.00 76.00 OUTPATIENT SERVICE COST CENTERS 91.00 91 00 09100 EMERGENCY 0 0 0 0 0 91.01 04951 OUTPATIENT THERAPY 0 0 0 0 0 91.01 04950 OUTPATIENT WOUND CENTER 93.00 93.00 0 0 0 0 0 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95 00 0 0 0 0 0 101.00 10100 HOME HEALTH AGENCY 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 117. 00 06950 OTHER SPECIAL PURPOSE COST CENTERS 0 117, 00 SUBTOTALS (SUM OF LINES 1 through 117) 204, 055 3, 619, 844 3, 619, 844 118. 00 24, 495 118.00 NONREIMBURSABLE COST CENTERS 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 192. 00 0 206 194. 00 194. 00 07950 MARKETI NG 0 206 C 194. 01 07951 OTHER NONREIMBURSABLE COST CENTERS 0 0 C 0 0 0 0 194. 01 200.00 Cross Foot Adjustments 0 0 200. 00 0 201.00 201.00 Negative Cost Centers 0 202.00 TOTAL (sum lines 118 through 201) 204, 055 24, 495 3, 620, 050 3, 620, 050 202. 00

Peri od: Wo From 05/01/2023

					o 04/30/2024		pared:
		CAPITAL REI	ATED COSTS			9/9/2024 1: 53	pm
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS	Reconci I i ati on	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
				SALARI ES)			
	CENEDAL CEDALCE COCT CENTERS	1.00	2. 00	4. 00	5A	5. 00	
	GENERAL SERVICE COST CENTERS DO100 CAP REL COSTS-BLDG & FIXT	54, 497					1.00
	00200 CAP REL COSTS-MVBLE EQUIP	34,477	54, 497				2.00
1	00400 EMPLOYEE BENEFITS DEPARTMENT	196	196	7, 833, 688	3		4.00
	00500 ADMINISTRATIVE & GENERAL	3, 587	3, 587	1, 671, 177		13, 085, 461	5. 00
7.00	00700 OPERATION OF PLANT	16, 199	16, 199			1, 510, 907	7. 00
	00800 LAUNDRY & LINEN SERVICE	0	0	C	0	48, 215	8. 00
1	00900 HOUSEKEEPI NG	1, 197	1, 197	145, 742		303, 890	1
1	D1000 DI ETARY	3, 744	3, 744	449, 767		1, 054, 907	1
1	D1300 NURSI NG ADMI NI STRATI ON	1, 876	1, 876			641, 570	1
	01600 MEDICAL RECORDS & LIBRARY NPATIENT ROUTINE SERVICE COST CENTERS	212	212	93, 563	8 0	146, 000	16. 00
	03000 ADULTS & PEDIATRICS	19, 229	19, 229	3, 095, 872	2 0	5, 462, 956	30.00
	04400 SKILLED NURSING FACILITY	0					1
	ANCILLARY SERVICE COST CENTERS				,		11.00
-	D5400 RADI OLOGY-DI AGNOSTI C	0	0	C	0	61, 972	54.00
57.00	D5700 CT SCAN	0	0	C	0	5, 430	57. 00
	D5800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	C	0	1, 159	58. 00
1	06000 LABORATORY	194	194	C	0	52, 919	1
1	06500 RESPI RATORY THERAPY	0	0	93, 309		161, 877	•
1	06600 PHYSI CAL THERAPY	4, 709	4, 709			1, 066, 197	•
- 1	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	818 335	818 335			828, 119 371, 403	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 169	1, 169	267, 387 46, 409		294, 515	
	07300 DRUGS CHARGED TO PATIENTS	1, 030	1, 103			830, 246	
- 1	07400 RENAL DIALYSIS	0	0	002,000		232, 169	1
- 1	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	d			
C	OUTPATIENT SERVICE COST CENTERS						
	09100 EMERGENCY	0	0	C	0		
1	04951 OUTPATI ENT THERAPY	0	0				
	04950 OUTPATIENT WOUND CENTER	0	0	C	0	0	93. 00
	OTHER REIMBURSABLE COST CENTERS						05.00
	09500 AMBULANCE SERVICES 10100 HOME HEALTH AGENCY	0	0				95. 00 101. 00
-	SPECIAL PURPOSE COST CENTERS	] 0	U		)	0	1101.00
	06950 OTHER SPECIAL PURPOSE COST CENTERS	0	0		0	0	117. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	54, 495	54, 495		-	13, 085, 328	
N	NONREI MBURSABLE COST CENTERS						
192. 00 1	19200 PHYSICIANS' PRIVATE OFFICES	0	0	C	0	0	192. 00
1	07950 MARKETI NG	2	2	C	0		194. 00
	07951 OTHER NONREIMBURSABLE COST CENTERS	0	0	C	0	0	194. 01
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	2 47/ 052	142 007	1 (70 0/7	,	4 000 071	201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	3, 476, 053	143, 997	1, 678, 067		4, 830, 971	202.00
203. 00	Unit cost multiplier (Wkst. B, Part I)	63. 784300	2. 642292	0. 214212		0. 369186	203. 00
204. 00	Cost to be allocated (per Wkst. B,			13, 020		241, 049	
205. 00	Part II) Unit cost multiplier (Wkst. B, Part			0. 001662	2	0. 018421	205. 00
206. 00	II)   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)						207.00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

10.00   01000   0150					Т	o 04/30/2024		
PLANT   COURT FETT)   LIRES SERVICE   CQUARE FEET)   TOTAL PATIENT AMM IN STRATION		Cost Center Description	OPERATION OF	I AUNDRY &	HOUSEKEEPING	DIFTARY		PIII
SOUARE FEED   TOTAL PATTENT   DAYS   CAURS INC SALARIES		occi contor boson per on						
SALARIES    SALA			(SQUARE FEET)	(TOTAL PATIENT		DAYS)		
CENERAL SERVICE COST CENTERS				DAYS)				
CEMBERAL SERVICE COST CENTERS   1.00   0.010   CAP REL COSTSBLOG & FIXT   2.00   0.0200   CAP REL COSTSBLOG & FIXT   2.00   0.0200   CAP REL COSTSMUSILE EQUIP   2.00   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.00000000			7.00	0.00		10.00		
1.00		CENEDAL CEDVICE COCT CENTEDO	7.00	8.00	9.00	10.00	13. 00	
2.00	1 00		I	I	T			1 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 7.00 00700 OPERATION OF PLANT								
5.00				•				1
7.00 00700   OPERATION OF PLANT   34,515   8.00   0								1
8. 00 00800 (ANINDRY & LINEN SERVICE 0 1,1097 0 33,318 1,000 10000 (INJEKEREPING 1,1997 0 0 33,318 1,000 10000 (INJEKENCA DIMINISTRATION 1,876 0 1,876 0 3,744 11,053 0 10,000 10,000 (INJEKINO ADMINISTRATION 1,876 0 1,876 0 3,095,872 13,000 (INJEKINO ADMINISTRATION 1,876 0 1,876 0 3,095,872 13,000 (INJEKINO ADMINISTRATION 1,876 0 0 2,212 0 0 10,000 (INJEKINO ADMINISTRATION 1,876 0 0 2,212 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			34 515					1
9.00   000900   0005KEFEPI NG			1	l .				
10.00   01000   015ARY   3.744   0   3.744   11.053   10.00   13.00			1, 197					9. 00
13.00   01300   MURSING ADMINISTRATION   1.876   0   1.876   0   3.095, 872   13.00			1	0		I I		10.00
IMPATI ENT ROUTINE SERVICE COST CENTERS   19,29   11,053   19,29   11,053   3,095,872   30.00   30.0	13.00	01300 NURSING ADMINISTRATION	1	l .			3, 095, 872	13.00
30.00   03000   ADULTS & PEDIATRICS   19,229   11,053   19,229   11,053   3,095,872   30.00   ARCILLARY SERVICE COST CENTERS	16.00	01600 MEDICAL RECORDS & LIBRARY	212	0	212	e o	0	16. 00
44.00   04400   SAILLED NURSING FACILITY		INPATIENT ROUTINE SERVICE COST CENTERS						
ANCILLARY SERVICE COST CENTERS	30.00	03000 ADULTS & PEDI ATRI CS	19, 229	11, 053	19, 229	11, 053	3, 095, 872	30. 00
S4.00	44.00	04400 SKILLED NURSING FACILITY	0	0	C	0	0	44. 00
57.00   05700   CT SCAN   0   0   0   0   0   0   57.00								
58.00   05800   MASNATTIC RESONANCE I MAGI NG (MRI)   0   0   0   0   0   0   0   0   0	54.00		0	0	C	0		54.00
60.00   06000   CABORATORY   194   0   194   0   0   60.00   65.00   06500   RESPIRATORY THERAPY   0   0   0   0   0   0   0   66.00   06600   PHYSI CAL THERAPY   4,709   0   4,709   0   0   0   67.00   06700   0CUPATI ONAL THERAPY   818   0   818   0   0   67.00   67.00   0700   0CUPATI ONAL THERAPY   818   0   818   0   0   67.00   67.00   0700   0CUPATI ONAL THERAPY   818   0   818   0   0   67.00   68.00   06800   SPECEH PATHOLOGY   335   0   335   0   335   0   0   68.00   68.00   06800   SPECEL PARTHOLOGY   335   0   335   0   0   0   0   0   71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   1,169   0   1,169   0   0   0   0   72.00   07300   DRUGS CHARGED TO PATIENTS   1,030   0   0   0   0   0   0   0   0   74.00   07400   RENAL DIALYSIS   0   0   0   0   0   0   0   0   0   75.00   07300   DRUGS CHARGED TO PATIENTS   1,030   0   0   0   0   0   0   0   0   76.00   03950   OTHER RANCILLARY SERVICE COST CENTERS   0   0   0   0   0   0   0   0   0   76.00   03950   OTHER ANGULLARY SERVICE COST CENTERS   0   0   0   0   0   0   0   0   0   79.10   04950   OUTPATI ENT THERAPY   0   0   0   0   0   0   0   0   0   79.10   04950   OUTPATI ENT WOUND CENTER   0   0   0   0   0   0   0   0   0   79.10   04950   OUTPATI ENT WOUND CENTER   0   0   0   0   0   0   0   0   79.10   04950   OUTPATI ENT WOUND CENTERS   0   0   0   0   0   0   0   0   79.10   04950   OUTPATI ENT WOUND CENTERS   0   0   0   0   0   0   0   0   79.10   04950   OUTPATI ENT WOUND CENTERS   0   0   0   0   0   0   0   0   79.10   04950   OUTPATI ENT WOUND CENTERS   0   0   0   0   0   0   0   0   79.10   04950   OUTPATI ENT WOUND CENTERS   0   0   0   0   0   0   0   0   0   79.10   04950   OUTPATI ENT WOUND CENTERS   0   0   0   0   0   0   0   0   0			0	0	C	0		57. 00
65.00   06500   RESPIRATORY THERAPY   0   0   0   0   0   0   65.00   66.00   06600   PHYSICAL THERAPY   4,709   0   4,709   0   0,65.00   67.00   06700   0CCUPATI ONAL THERAPY   818   0   818   0   0   67.00   68.00   06600   PHYSICAL THERAPY   335   0   335   0   0   68.00   68.00   06600   PHYSICAL SUPPLIES CHARGED TO PATIENTS   1,169   0   1,169   0   0   71.00   71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   1,030   0   1,030   0   0   0   0   0   73.00   07300   PRUSC CHARGED TO PATIENTS   1,030   0   0   0   0   0   0   0   0   74.00   07400   RENAL DIALYSIS   0   0   0   0   0   0   0   0   0   76.00   03950   OTHER ANCILLARY SERVICE COST CENTERS   0   0   0   0   0   0   0   0   79.00   07100   EMERGENCY   0   0   0   0   0   0   0   0   79.10   04951   OUTPATIENT THERAPY   0   0   0   0   0   0   0   0   0   79.00   04950   OUTPATIENT WOUND CENTER   0   0   0   0   0   0   0   79.00   07050   AMBULANCE SERVICES   0   0   0   0   0   0   0   79.00   07050   AMBULANCE SERVICES   0   0   0   0   0   0   0   79.00   07050   AMBULANCE SERVICES   0   0   0   0   0   0   79.00   07050   AMBULANCE SERVICES   0   0   0   0   0   0   79.00   07050   AMBULANCE SERVICES   0   0   0   0   0   0   79.00   07050   AMBULANCE SERVICES   0   0   0   0   0   0   79.00   07050   AMBULANCE SERVICES   0   0   0   0   0   0   79.00   07050   AMBULANCE SERVICES   0   0   0   0   0   0   79.00   07050   AMBULANCE SERVICES   0   0   0   0   0   0   79.00   07050   AMBULANCE SERVICE   0   0   0   0   0   79.00   07050   07050   07050   07050   07050   07050   07050   79.00   07050				0	1	- 1		58. 00
66.00   06600   PKYSI CAL THERAPY   4,709   0   4,709   0   6.60   67.00   06700   OCCUPATI ONAL THERAPY   818   0   818   0   0   67.00   68.00   06800   SPECEH PATHOLOGY   335   0   335   0   0   68.00   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   1,169   0   1,169   0   0   0   0   73.00   07300   ORUGS CHARGED TO PATIENTS   1,100   0   0   0   0   0   0   74.00   07400   RENAL DIALYSIS   0   0   0   0   0   0   0   0   75.00   07300   OTHER ANCILLARY SERVICE COST CENTERS   0   0   0   0   0   0   0   0   76.00   03950   OTHER ANCILLARY SERVICE COST CENTERS   0   0   0   0   0   0   0   791.00   09100   EMERGENCY   0   0   0   0   0   0   0   0   791.01   04951   OUTPATIENT HERAPY   0   0   0   0   0   0   0   791.01   04950   OUTPATIENT WOUND CENTER   0   0   0   0   0   0   0   792.00   09500   AMBULANCE SERVICES   0   0   0   0   0   0   0   795.00   09500   AMBULANCE SERVICES   0   0   0   0   0   0   0   795.00   09500   OTHER SHELD COST CENTERS   0   0   0   0   0   0   0   795.00   09500   OTHER ALL HIALTH AGENCY   0   0   0   0   0   0   0   795.00   09500   OTHER SHELD COST CENTERS   0   0   0   0   0   0   0   795.00   09500   OTHER SHELD COST CENTERS   0   0   0   0   0   0   0   795.00   09500   OTHER SHELD COST CENTERS   0   0   0   0   0   0   0   795.00   09500   OTHER SHELD COST CENTERS   0   0   0   0   0   0   0   795.00   OTHER SHELD COST CENTERS   0   0   0   0   0   0   0   795.00   OTHER SHELD COST CENTERS   0   0   0   0   0   0   0   795.00   OTHER SHELD COST CENTERS   0   0   0   0   0   0   0   795.00   OTHER SHELD COST CENTERS   0   0   0   0   0   0   0   795.00   OTHER SHELD COST CENTERS   0   0   0   0   0   0   795.00   OTHER SHELD COST CENTERS   0   0   0   0   0   0   795.00   OTHER SHELD COST CENTERS   0   0   0   0   0   0   795.00   OTHER SHELD COST CENTERS   0   0   0   0   0   0   795.00   OTHER SHELD COST CENTERS   0   0   0   0   0   0   795.00   OTHER SHELD COST CENTERS   0   0   0   0   0   0   795.00   OTHER SHELD COST CENTERS   0   0   0   0   0   0   0			1	0			-	60.00
67.00   06700   OCCUPATIONAL THERAPY   818   0   818   0   0   67.00   8.00   06800   SPEECH PATHOLOGY   335   0   335   0   0   68.00   971.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   1, 169   0   1, 169   0   0   0   973.00   07300   DRUGS CHARGED TO PATIENTS   1, 030   0   1, 030   0   0   0   0   974.00   07400   RENAL JULIARY SERVICE COST CENTERS   0   0   0   0   0   0   0   975.00   03950   OTHER ANCILLARY SERVICE COST CENTERS   0   0   0   0   0   0   0   971.01   04951   OUTPATIENT SERVICE COST CENTERS   0   0   0   0   0   0   0   971.01   04951   OUTPATIENT WOUND CENTER   0   0   0   0   0   0   91.01   972.00   OFFICE				0	1	- 1		•
68.00 06800 SPEECH PATHOLOGY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1, 169 0 1, 169 0 0 71.00 771.00 07300 DRUGS CHARGED TO PATIENTS 1, 169 0 1, 169 0 0 73.00 773.00 07300 DRUGS CHARGED TO PATIENTS 1, 1030 0 1, 030 0 0 73.00 774.00 07400 RENAL DIALYSIS 0 0 0 0 0 0 0 0 73.00 784.00 07400 RENAL DIALYSIS 0 0 0 0 0 0 0 0 73.00 785.00 07500 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 73.00 785.00 07500 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0 73.00 785.00 07500 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1			I .		•
71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   1, 169   0   1, 169   0   0   73. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   1, 030   0   0   0   0   0   0   0   0   0			1		•	· •		•
73.00   07300   DRUGS CHARGED TO PATIENTS   1,030   0   1,030   0   0   73.00   74.00   07400   RENAL DIALYSIS   0   0   0   0   0   0   74.00   75.00   03950   OTHER ANCILLARY SERVICE COST CENTERS   0   0   0   0   0   0   76.00   00100   EMERGENCY   0   0   0   0   0   0   0   79.00   09100   EMERGENCY   0   0   0   0   0   0   0   79.10   04951   OUTPATIENT THERAPY   0   0   0   0   0   0   0   79.01   04951   OUTPATIENT WOUND CENTER   0   0   0   0   0   0   79.01   04950   OUTPATIENT WOUND CENTER   0   0   0   0   0   0   79.02   04950   OUTPATIENT WOUND CENTERS   0   0   0   0   0   0   79.00   0500   AMBULANCE SERVICES   0   0   0   0   0   0   79.00   0500   OBBULANCE SERVICES   0   0   0   0   0   79.00   0500   OBBULANCE SERVICES   0   0   0   0   0   79.00   0500   OBBULANCE SERVICES   0   0   0   0   0   79.00   0500   OBBULANCE SERVICES   0   0   0   0   0   79.00   0500   OBBULANCE SERVICES   0   0   0   0   0   79.00   0500   OBBULANCE SERVICES   0   0   0   0   0   79.00   0500   OBBULANCE SERVICES   0   0   0   79.00   0500   OBBULANCE SERVICES   0   0   0   79.00   0500   OBBULANCE SERVICES   0   0   0   0   79.00   0500   OBBULANCE SERVICES   0   0   0   0   79.00   0500   OBBULANCE SERVICES   0   0   0   0   0   79.00   0500   OBBULANCE SERVICES   0   0   0   0   79.00   0500   OBBULANCE SERVICES   0   0   0   79.00   0500   OBBULANCE SERVICES   0   0   0   79.00   0500   OBBULAN			1		•	1		1
74. 00   07400   RENAL DI ALYSIS   0   0   0   0   0   0   74. 00   076. 00   0   0   0   0   0   0   0   0   0			1			I I		1
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS			1	l .	1	I I		1
OUTPATI ENT SERVICE COST CENTERS   O			1		1	- 1		
91. 00   09100   EMERGENCY   0   0   0   0   0   0   0   91. 00   91. 00   91. 00   91. 00   91. 00   91. 00   91. 00   91. 00   93. 00   93. 00   95. 00	76.00		0	ıj U		ıl U	0	76.00
91. 01 04951 OUTPATIENT THERAPY 0 0 0 0 0 0 0 0 0 91. 01 93. 00 04950 OUTPATIENT WOUND CENTER 0 0 0 0 0 0 0 0 0 93. 00  OTHER REI MBURSABLE COST CENTERS  95. 00 09500 AMBULANCE SERVICES 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	01 00					ا ا	0	01 00
93. 00 04950   OUTPATIENT WOUND CENTER   O   O   O   O   O   O   O   O   O						- 1		1
OTHER REIMBURSABLE COST CENTERS   O			1			- 1		1
95. 00	73.00		0	<u> </u>		η <u>σ</u>	0	73.00
101.00   10100   HOME HEALTH AGENCY   0   0   0   0   0   0   0   0   0	95 00					ا	0	95 00
SPECIAL PURPOSE COST CENTERS   117.00   06950   OTHER SPECIAL PURPOSE COST CENTERS   0   0   0   0   0   0   117.00			1					
117. 00			-	-	-	-1		
118.00   SUBTOTALS (SUM OF LINES 1 through 117)   34,513   11,053   33,316   11,053   3,095,872   118.00	117.00		0	0	C	0	0	117. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 0 192.00 194.00 195.00 194.00 194.00 195.00 194.00 195.00 194.00 195.00 194.00 195.00			34, 513	11, 053	33, 316	11, 053	3, 095, 872	118. 00
194. 00   07950   MARKETING   2   0   2   0   0   194. 0								
194. 01 07951 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 0 194. 01 200. 00 201. 00 Cross Foot Adjustments Negative Cost Centers 202. 00 Cost to be allocated (per Wkst. B, Part I) 203. 00 Unit cost multiplier (Wkst. B, Part II) 59. 936636 5. 972587 14. 641515 155. 938207 0. 328934 203. 00 204. 00 Cost to be allocated (per Wkst. B, Part II) 205. 00 Unit cost multiplier (Wkst. B, Part II) 31. 984326 0. 080340 3. 710847 36. 417534 0. 065912 205. 00 0. 080340 NAHE adjustment amount to be allocated (per Wkst. B, Part II) NAHE unit cost multiplier (Wkst. D, 207. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	C	0	0	192. 00
200.00 201.00 Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part II) Cost to be allocated (per Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) Cost to be allocated (per Wkst. B, Part II) Cost to be allocated (per Wkst. B, Part II) Cost to be allocated (per Wkst. B, Part II) Cost to be allocated (per Wkst. B, Part II) Cost unit cost multiplier (Wkst. B, Part III) Cost unit cost unitiplier (Wkst. B, Part III) Cost unit cost unitiplier (Wkst. B, Part III) Cost unitiplier (Wkst. B, Part IIII) Cost unitiplier (Wkst. B, Part IIII) Cost unitiplier (Wkst. B, Part IIII) Cost	194.00	07950 MARKETI NG	2	0	2	0	0	194. 00
201.00	194.01	07951 OTHER NONREIMBURSABLE COST CENTERS	0	0	C	0	0	194. 01
202.00 Cost to be allocated (per Wkst. B, Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 204.00 Cost to be allocated (per Wkst. B, Part I) 205.00 Unit cost multiplier (Wkst. B, Part II) 206.00 WAHE adjustment amount to be allocated (per Wkst. D,  207.00 NAHE unit cost multiplier (Wkst. D,  208.713 66,015 487,826 1,723,585 1,018,337 202.00  59.936636 5.972587 14.641515 155.938207 0.328934 203.00  10.328934 203.00  10.328934 203.00  10.080340 3.710847 36.417534 0.065912 205.00  206.00 NAHE unit cost multiplier (Wkst. D, 207.00	200.00	Cross Foot Adjustments						200. 00
Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II)  205.00 Unit cost multiplier (Wkst. B, Part III)  206.00 NAHE adjustment amount to be allocated (per Wkst. D,  Part II) S9. 936636 5. 972587 14. 641515 155. 938207 0. 328934 203. 00 0. 080340 3. 710847 36. 417534 0. 065912 205. 00 206. 00 NAHE unit cost multiplier (Wkst. D, 207. 00	201.00							201. 00
203.00 Unit cost multiplier (Wkst. B, Part I) 59.936636 5.972587 14.641515 155.938207 0.328934 203.00 204.00 Cost to be allocated (per Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part III) 31.984326 0.080340 3.710847 36.417534 0.065912 205.00 NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207.00 NAHE unit cost multipli	202.00		2, 068, 713	66, 015	487, 826	1, 723, 585	1, 018, 337	202. 00
204.00   Cost to be allocated (per Wkst. B, Part II)   1,103,939   888   123,638   402,523   204,055   204.00   205.00   Unit cost multiplier (Wkst. B, Part II)   31.984326   0.080340   3.710847   36.417534   0.065912   205.00   10   10   10   10   10   10   10		Part I)						
Part II) Unit cost multiplier (Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207.00						I I		
205.00 Unit cost multiplier (Wkst. B, Part II) 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 20	204.00		1, 103, 939	888	123, 638	402, 523	204, 055	204. 00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00			04 004004			0, 447504	0.045040	
206. 00 NAHE adjustment amount to be allocated (per Wkst. B-2) 207. 00 NAHE unit cost multiplier (Wkst. D,	205. 00		31. 984326	0. 080340	3. 710847	36. 417534	0. 065912	205. 00
207.00 NÄHE unit cost multiplier (Wkst. D, 207.00	206. 00	NAHE adjustment amount to be allocated						206. 00
	007 5							007.00
rai t5	207.00							207.00
		rants iii and iv)	I	I	I			I

COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 15-3047 Peri od: Worksheet B-1 From 05/01/2023 To 04/30/2024 Date/Time Prepared: 9/9/2024 1:53 pm Cost Center Description MEDI CAL RECORDS & LI BRARY (GROSS CHARGES) 16.00 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 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 10.00 01300 NURSING ADMINISTRATION 13 00 13 00 01600 MEDICAL RECORDS & LIBRARY 16.00 23, 528, 340 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 11, 055, 000 30.00 04400 SKILLED NURSING FACILITY 44.00 44.00 ANCILLARY SERVICE COST CENTERS 05400 RADI OLOGY-DI AGNOSTI C 54.00 153, 580 54.00 05700 CT SCAN 57.00 57 00 13 450 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 2, 867 58.00 60.00 06000 LABORATORY 1, 170, 660 60.00 65. 00 06500 RESPIRATORY THERAPY 830, 512 65.00 66. 00 06600 PHYSI CAL THERAPY 2 670 560 66 00 06700 OCCUPATIONAL THERAPY 67.00 2,770,657 67.00 68.00 06800 SPEECH PATHOLOGY 952, 815 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 974, 272 71.00 07300 DRUGS CHARGED TO PATIENTS 2, 848, 700 73 00 73 00 74.00 07400 RENAL DIALYSIS 76,650 74.00 03950 OTHER ANCILLARY SERVICE COST CENTERS 76.00 76.00 8, 617 OUTPATIENT SERVICE COST CENTERS 91 00 09100 EMERGENCY 91.00 0 91.01 04951 OUTPATIENT THERAPY 0 91.01 04950 OUTPATIENT WOUND CENTER 93.00 93.00 0 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95 00 0 101.00 10100 HOME HEALTH AGENCY 0 101.00 SPECIAL PURPOSE COST CENTERS 117. 00 06950 OTHER SPECIAL PURPOSE COST CENTERS 117.00 23, 528, 340 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 118. 00 NONREIMBURSABLE COST CENTERS 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 192.00 194. 00 194. 00 07950 MARKETI NG 0 194. 01 07951 OTHER NONREIMBURSABLE COST CENTERS 0 194. 01 200.00 Cross Foot Adjustments 200.00 Negative Cost Centers 201.00 201.00 202.00 Cost to be allocated (per Wkst. B, 215, 712 202. 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 0.009168 203. 00 204.00 Cost to be allocated (per Wkst. B, 24.495 204.00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.001041 205. 00 H) 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)

Heal th	Financial Systems Rehabi	litation Hospita	I of Northern	Indi	In Lie	eu of Form CMS-2	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provi der Co		Peri od:	Worksheet C	
					From 05/01/2023		
					To 04/30/2024		
				\0.41.1.1		9/9/2024 1: 53	pm
				XVIII	Hospi tal	PPS	
			Charges	I =			
	Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
						Ratio	
		6.00	7. 00	8. 00	9. 00	10. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	11, 055, 000		11, 055, 00			30. 00
44.00	04400 SKILLED NURSING FACILITY	0			0		44. 00
	ANCILLARY SERVICE COST CENTERS				_		1
	05400  RADI OLOGY-DI AGNOSTI C	153, 580	0	153, 58		l e	
	05700 CT SCAN	13, 450	0	13, 45		0. 000000	
58. 00	05800   MAGNETIC RESONANCE I MAGING (MRI)	2, 867	0	2, 86	7 0. 562609	0.000000	58. 00
60.00	06000 LABORATORY	1, 170, 660	0	1, 170, 66	0. 083420	0.000000	60.00
65.00	06500 RESPI RATORY THERAPY	830, 512	0	830, 51	2 0. 276039	0.000000	65.00
66.00	06600 PHYSI CAL THERAPY	2, 670, 560	0	2, 670, 56	0. 687307	0.000000	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	2, 770, 657	0	2, 770, 65	7 0. 440421	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	952, 815	0	952, 81	5 0. 569092	0.000000	68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	974, 272	0	974, 27	2 0. 512547	0.000000	71. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 848, 700	0	2, 848, 70	0. 435179	0.000000	73. 00
74.00	07400 RENAL DIALYSIS	76, 650	0	76, 65	0 4. 156373	0. 000000	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	8, 617	0	8, 61	7 1. 737496	0. 000000	76. 00
	OUTPATIENT SERVICE COST CENTERS	· · ·					1
91.00	09100 EMERGENCY	0	0		0. 000000	0.000000	91.00
91. 01	04951 OUTPATIENT THERAPY	0	0		0. 000000	0. 000000	91. 01
	04950 OUTPATIENT WOUND CENTER	o	0		0. 000000	0. 000000	93. 00
	OTHER REIMBURSABLE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					
95.00	09500 AMBULANCE SERVI CES	0	0		0. 000000	0.000000	95. 00
101.00	10100 HOME HEALTH AGENCY	o	0		0		101.00
	SPECIAL PURPOSE COST CENTERS	· · · · · ·			-		
117. 00	06950 OTHER SPECIAL PURPOSE COST CENTERS	0	0		o		117. 00
200.00		23, 528, 340	0		o		200.00
201.00		,,,	· ·			l	201. 00
202.00		23, 528, 340	0	23, 528, 34	0	l	202. 00
202.00	1.000 1130 400 013)	20, 020, 040	O	20, 020, 04	~ <sub> </sub>	1	1202.00

			To 04/30/2024	Date/Time Prep 9/9/2024 1:53	
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11. 00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00   03000   ADULTS & PEDI ATRI CS					30.00
44.00 04400 SKILLED NURSING FACILITY					44.00
ANCILLARY SERVICE COST CENTERS					
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 561655				54.00
57. 00   05700   CT   SCAN	0. 561933				57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 562609				58. 00
60. 00   06000   LABORATORY	0. 083420				60.00
65. 00 06500 RESPI RATORY THERAPY	0. 276039				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 687307				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 440421				67. 00
68.00 06800 SPEECH PATHOLOGY	0. 569092				68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 512547				71. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 435179				73. 00
74. 00   07400   RENAL DI ALYSI S	4. 156373				74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	1. 737496				76.00
OUTPATIENT SERVICE COST CENTERS					
91. 00   09100   EMERGENCY	0. 000000				91.00
91. 01  04951 0UTPATI ENT THERAPY	0. 000000				91. 01
93. 00 O4950 OUTPATIENT WOUND CENTER	0. 000000				93.00
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVICES	0. 000000				95.00
101.00 10100 HOME HEALTH AGENCY					101. 00
SPECIAL PURPOSE COST CENTERS					
117. 00 06950 OTHER SPECIAL PURPOSE COST CENTERS					117. 00
200.00 Subtotal (see instructions)				[2	200. 00
201.00 Less Observation Beds				2	201. 00
202.00 Total (see instructions)				2	202. 00

Health Fina	ancial Systems Rehabi	litation Hospit	al of Northern	Indi	In Lie	eu of Form CMS-:	2552-10
COMPUTATI O	N OF RATIO OF COSTS TO CHARGES		Provi der Co		Peri od:	Worksheet C	
					From 05/01/2023		
					To 04/30/2024		
			T1.11			9/9/2024 1: 53	pm
			1111	e XIX	Hospi tal	PPS	
					Costs	<del></del>	
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		1
		Part I, col.					
		26)					
		1. 00	2.00	3. 00	4. 00	5. 00	
	ATIENT ROUTINE SERVICE COST CENTERS		1		_1		4
	OO ADULTS & PEDIATRICS	11, 823, 159	l e	11, 823, 15	9 0	1 , ===,	
	00 SKILLED NURSING FACILITY	0			0 0	0	44. 00
	LLARY SERVICE COST CENTERS		,				4
	OO RADI OLOGY-DI AGNOSTI C	86, 259	l .	86, 25		86, 259	
	OO CT SCAN	7, 558		7, 55		7, 558	
	MAGNETIC RESONANCE IMAGING (MRI)	1, 613		1, 61		1, 613	
	00 LABORATORY	97, 657		97, 65	7 0	97, 657	
65. 00 0650	00 RESPI RATORY THERAPY	229, 254	0	229, 25	4 0	229, 254	65.00
66.00 0660	00 PHYSI CAL THERAPY	1, 835, 495	0	1, 835, 49	5 0	1, 835, 495	66. 00
67. 00 0670	OCCUPATIONAL THERAPY	1, 220, 255	0	1, 220, 25	5 0	1, 220, 255	67.00
68.00 0680	OO SPEECH PATHOLOGY	542, 239	0	542, 23	9 0	542, 239	68. 00
71. 00 0710	MEDICAL SUPPLIES CHARGED TO PATIENTS	499, 360		499, 36	0	499, 360	71. 00
73.00 0730	DO DRUGS CHARGED TO PATIENTS	1, 239, 694		1, 239, 69	4 0	1, 239, 694	73.00
74. 00 0740	OO RENAL DIALYSIS	318, 586		318, 58	6 0	318, 586	74. 00
76. 00 0395	OTHER ANCILLARY SERVICE COST CENTERS	14, 972		14, 97	2 0	14, 972	76.00
	PATIENT SERVICE COST CENTERS						1
91. 00 0910	OO EMERGENCY	0			0 0	0	91. 00
91. 01 0495	51 OUTPATI ENT THERAPY	0			0 0	0	91. 01
	OUTPATIENT WOUND CENTER	0			0	0	93. 00
	R REIMBURSABLE COST CENTERS				-		
	00 AMBULANCE SERVICES	0			0 0	0	95. 00
	DO HOME HEALTH AGENCY	0		•	0	0	101. 00
	CIAL PURPOSE COST CENTERS				<u> </u>		1.000
	50 OTHER SPECIAL PURPOSE COST CENTERS	0			0	0	117. 00
200. 00	Subtotal (see instructions)	17, 916, 101			٥	17, 916, 101	
201. 00	Less Observation Beds	17, 710, 101	Ĭ	1,,,,,,,,,,,	ol		201.00
202. 00	Total (see instructions)	17, 916, 101	l o	17, 916, 10	1 0	1	
_000	1	1, ,, 101		1	٠, ۷		1-32.00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provi der CCN: 15-3047 Peri od: Worksheet C From 05/01/2023 Part I 04/30/2024 Date/Time Prepared: 9/9/2024 1:53 pm Title XIX Hospi tal PPS Charges TEFRA Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other I npati ent + col . 7) Ratio Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 11, 055, 000 11, 055, 000 30.00 04400 SKILLED NURSING FACILITY 44.00 44.00 ANCILLARY SERVICE COST CENTERS 54.00 05400 RADI OLOGY-DI AGNOSTI C 153, 580 153, 580 0. 561655 0.000000 54.00 57.00 05700 CT SCAN 0 13, 450 0.561933 0.000000 57.00 13, 450 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 2,867 2,867 0.562609 0.000000 58.00 60.00 06000 LABORATORY 1, 170, 660 1, 170, 660 0.083420 0.000000 60.00 06500 RESPIRATORY THERAPY 65.00 830.512 0 830, 512 0.276039 0.000000 65.00 0. 687307 06600 PHYSI CAL THERAPY 0 2, 670, 560 0.000000 66.00 2, 670, 560 66.00 67.00 06700 OCCUPATIONAL THERAPY 2, 770, 657 0 2, 770, 657 0.440421 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 952, 815 0 952, 815 0. 569092 0.000000 68.00 OI 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.512547 0.000000 71.00 974, 272 974, 272 71.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 2, 848, 700 2, 848, 700 0.435179 0.000000 73.00 74.00 07400 RENAL DIALYSIS 76,650 0 76, 650 4. 156373 0.000000 74.00 76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS 8, 617 8, 617 1.737496 0.000000 76.00 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 0 0 0 0.000000 0.000000 91.00 04951 OUTPATIENT THERAPY 0 0 0 0.000000 0.000000 91.01 91.01 04950 OUTPATIENT WOUND CENTER 0 0 0.000000 0.000000 93.00 93.00 0 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 0 0 0.000000 0.000000 95.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 117. 00 06950 OTHER SPECIAL PURPOSE COST CENTERS 0 117.00 200.00 Subtotal (see instructions) 23, 528, 340 0 23, 528, 340 200. 00 201.00 Less Observation Beds 201.00 0 202.00 Total (see instructions) 23, 528, 340 23, 528, 340 202.00

			To 04/30/2024	Date/Time Pre 9/9/2024 1:53	
		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
44.00 04400 SKILLED NURSING FACILITY					44. 00
ANCILLARY SERVICE COST CENTERS					
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 561655				54. 00
57. 00  05700   CT   SCAN	0. 561933				57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 562609				58. 00
60. 00   06000   LABORATORY	0. 083420				60.00
65. 00 06500 RESPIRATORY THERAPY	0. 276039				65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 687307				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 440421				67. 00
68.00 06800 SPEECH PATHOLOGY	0. 569092				68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 512547				71. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 435179				73. 00
74.00   07400   RENAL DI ALYSI S	4. 156373				74. 00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	1. 737496				76. 00
OUTPATIENT SERVICE COST CENTERS					
91. 00   09100   EMERGENCY	0. 000000				91.00
91. 01  04951 0UTPATI ENT THERAPY	0. 000000				91. 01
93. 00 O4950 OUTPATIENT WOUND CENTER	0. 000000				93. 00
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVICES	0. 000000				95. 00
101.00 10100 HOME HEALTH AGENCY					101. 00
SPECIAL PURPOSE COST CENTERS					
117.00 06950 OTHER SPECIAL PURPOSE COST CENTERS					117. 00
200.00 Subtotal (see instructions)					200. 00
201.00 Less Observation Beds					201. 00
202.00   Total (see instructions)					202. 00

Health Financial Systems	Rehabilitation Hospital	of Northern Indi	In Lie	u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE (	COST TO CHARGE RATIOS NET OF	Provider CCN: 15-3047		Worksheet C
			From OF /01 /2022	Dost II

From 05/01/2023 To 04/30/2024 Part II Date/Time Prepared: REDUCTIONS FOR MEDICALD ONLY 9/9/2024 1:53 pm Title XIX Hospi tal PPS Total Cost Capital Cost Operating Cost Operating Cost Cost Center Description Capi tal Reducti on (Wkst. B, Part (Wkst. B, Part Net of Capital Reducti on Cost (col. 1 I, col. 26) II col. 26) Amount col. 2) 1. 00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 54.00 05400 RADI OLOGY-DI AGNOSTI C 86, 259 1, 302 84, 957 54.00 0 0 0 0 0 0 0 0 0 0 0 57.00 05700 CT SCAN 7, 444 57.00 7, 558 114 0 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 1,613 24 1, 589 58.00 06000 LABORATORY 97, 657 22, 006 75, 651 60.00 0 60.00 06500 RESPIRATORY THERAPY 229, 254 225, 252 65.00 4,002 0 65.00 06600 PHYSI CAL THERAPY 504, 241 66.00 1, 835, 495 1, 331, 254 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 1, 220, 255 102, 664 1, 117, 591 0 67.00 68.00 06800 SPEECH PATHOLOGY 542, 239 42, 489 499, 750 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 125, 897 71.00 71 00 499, 360 373, 463 0 73.00 07300 DRUGS CHARGED TO PATIENTS 1, 239, 694 124,080 1, 115, 614 0 73.00 4, 357 74.00 07400 RENAL DIALYSIS 318, 586 314, 229 0 74.00 o 76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS 14, 972 209 14, 763 0 76.00 OUTPATIENT SERVICE COST CENTERS 91.00 91.00 09100 EMERGENCY 0 0 0 0 04951 OUTPATIENT THERAPY 0 0 0 0 0 91.01 91.01 04950 OUTPATIENT WOUND CENTER 0 0 0 93.00 93.00 0 Ω OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 0 0 0 0 0 95.00 101.00 10100 HOME HEALTH AGENCY 0 101.00 0 0 0 0 SPECIAL PURPOSE COST CENTERS 117. 00 06950 OTHER SPECIAL PURPOSE COST CENTERS 0 0 117.00 0 Subtotal (sum of lines 50 thru 199) 0 200.00 200.00 6, 092, 942 931, 385 5, 161, 557 0 201.00 201.00 Less Observation Beds 0 202.00 Total (line 200 minus line 201) 6, 092, 942 931, 385 5, 161, 557 0 202. 00 Peri od: Worksheet C From 05/01/2023 Part II To 04/30/2024 Date/Ti me Prepared: 9/9/2024 1:53 pm

						9/9/2024 I:53 pm
				e XIX	Hospi tal	PPS
	Cost Center Description	Cost Net of	Total Charges			
		Capital and	(Worksheet C,			
		Operating Cost			6	
		Reduction	8)	/ col. 7)		
		6. 00	7. 00	8. 00		
	NCILLARY SERVICE COST CENTERS					
	05400 RADI OLOGY-DI AGNOSTI C	86, 259		1		54.00
57.00	05700 CT SCAN	7, 558			33	57. 00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 613	2, 867	0. 56260	)9	58. 00
60.00	06000 LABORATORY	97, 657	1, 170, 660	0. 08342	20	60.00
65.00	06500 RESPI RATORY THERAPY	229, 254	830, 512	0. 27603	39	65. 00
66.00	06600 PHYSI CAL THERAPY	1, 835, 495	2, 670, 560	0. 68730	)7	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	1, 220, 255	2, 770, 657	0. 44042	21	67. 00
68.00	06800 SPEECH PATHOLOGY	542, 239	952, 815	0. 56909	92	68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	499, 360	974, 272	0. 51254	17	71. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 239, 694	2, 848, 700	0. 43517	79	73. 00
74.00	07400 RENAL DIALYSIS	318, 586	76, 650	4. 15637	73	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	14, 972	8, 617	1. 73749	96	76. 00
C	OUTPATIENT SERVICE COST CENTERS					
91.00	9100 EMERGENCY	0	0	0.00000	00	91.00
91. 01	04951 OUTPATI ENT THERAPY	0	0	0. 00000	00	91. 01
93.00	04950 OUTPATIENT WOUND CENTER	0	0	0. 00000	00	93.00
C	THER REIMBURSABLE COST CENTERS					
95. 00	09500 AMBULANCE SERVICES	0	0	0.00000	00	95. 00
101.00 1	0100 HOME HEALTH AGENCY	0	0	0. 00000	00	101. 00
S	PECIAL PURPOSE COST CENTERS					
117.00	06950 OTHER SPECIAL PURPOSE COST CENTERS	0	0	0.00000	00	117. 00
200.00	Subtotal (sum of lines 50 thru 199)	6, 092, 942	12, 473, 340	)		200. 00
201.00	Less Observation Beds	0	l 0	)		201.00
202.00	Total (line 200 minus line 201)	6, 092, 942	12, 473, 340	)		202. 00
- 1				•		1

Health Financial Systems Rehab	ilitation Hospit	al of Northern	Indi	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	_ COSTS	Provi der Co	F	Period: From 05/01/2023 To 04/30/2024		
		Title	xVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost	Swing Bed Adjustment	Reduced Capi tal	Days	Per Diem (col. 3 / col. 4)	
	(from Wkst. B, Part II, col. 26)		Related Cost (col. 1 - col.			
	1.00	2, 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	2, 688, 459	0	2, 688, 459	11, 053	243. 23	30.00
44.00 SKILLED NURSING FACILITY	0			0	0.00	44. 00
200.00 Total (lines 30 through 199)	2, 688, 459		2, 688, 459	11, 053		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	4, 232	1, 029, 349				30. 00
44.00 SKILLED NURSING FACILITY	0	0				44. 00
200.00 Total (Lines 30 through 199)	4, 232	1, 029, 349				200.00

Health Financial Systems Rehabi	litation Hospit	al of Northern	I ndi	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der Co	CN: 15-3047	Peri od:	Worksheet D	
				From 05/01/2023		
				To 04/30/2024		
		Ti +l o	: XVIII	Hospi tal	9/9/2024 1: 53 PPS	pm
Cost Center Description	Capi tal	Total Charges			Capital Costs	
cost center bescription		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,				column 4)	
	Part II, col.	8)	2)	. Charges	Corumir 4)	
	26)		2)			
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	1.00	2.00	0.00	1. 00	0.00	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 302	153, 580	0. 00847	8 61, 026	517	54.00
57. 00   05700 CT SCAN	114		•		<b>l</b>	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	24	2, 867	0.00837		0	58.00
60. 00   06000   LABORATORY	22, 006			8 432, 440	8, 129	60.00
65. 00 06500 RESPIRATORY THERAPY	4,002	830, 512	0. 00481	9 307, 650	1, 483	65. 00
66. 00 06600 PHYSI CAL THERAPY	504, 241	2, 670, 560	0. 18881	5 1, 048, 300	197, 935	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	102, 664	2, 770, 657	0. 03705	4 1, 087, 100	40, 281	67. 00
68. 00 06800 SPEECH PATHOLOGY	42, 489	952, 815	0. 04459	327, 585	14, 608	68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	125, 897	974, 272	0. 12922	2 421, 745	54, 499	71. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	124, 080	2, 848, 700	0. 04355	7 1, 002, 717	43, 675	73. 00
74. 00   07400   RENAL DI ALYSI S	4, 357	76, 650	0. 05684	3 25, 650	1, 458	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	209	8, 617	0. 02425	4, 308	104	76. 00
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	0	0	0.00000	0 0	0	91.00
91. 01   04951 OUTPATI ENT THERAPY	0	0	0.00000	0 0	0	91. 01
93.00 04950 OUTPATIENT WOUND CENTER	0	0	0.00000	0 0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00   Total (lines 50 through 199)	931, 385	12, 473, 340		4, 724, 344	362, 738	200. 00

Health Financial Systems	Rehabilitation Hospita	al of Northern	Indi	In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE	CE OTHER PASS THROUGH COST		F	Period: From 05/01/2023 To 04/30/2024	Date/Time Pre 9/9/2024 1:53	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
·	Program	Program	Post-Stepdown	Cost	Medi cal	
	Post-Stepdown	ŭ	Adjustments		Education Cost	
	Adjustments		,			
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CEN	TERS					
30. 00 03000 ADULTS & PEDIATRICS	0	0	(	0	0	30.00
44.00 04400 SKILLED NURSING FACILITY	l ol	0	(	0		44.00
200.00 Total (lines 30 through 199)	l ol	0	(	0	0	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	Inpatient	
·	Adjustment	(sum of cols.	Days	5 ÷ col . 6)	Program Days	
	Amount (see	1 through 3,	, and the second	,		
	instructions)	minus col. 4)				
	4.00	5. 00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CEN	TERS					
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	11, 053	0.00	4, 232	30.00
44.00 04400 SKILLED NURSING FACILITY		0	. (		0	44.00
200.00 Total (lines 30 through 199)		0	11, 053			200.00
Cost Center Description	Inpatient			<u>'</u>	•	
·	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CEN	TERS					
30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
44.00 04400 SKILLED NURSING FACILITY	O					44.00
200.00 Total (lines 30 through 199)	o					200. 00
	1 31					1

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SETTHROUGH COSTS	RVICE OTHER PAS	S Provider C	CN: 15-3047	Period: From 05/01/2023 To 04/30/2024	Date/Time Pre 9/9/2024 1:53	
			XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician Anesthetist Cost	Nursi ng Program Post-Stepdown Adj ustments	Nursi ng Program	Allied Health Post-Stepdown Adjustments	Allied Health	
	1.00	2A	2. 00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS		1	1			4
54. 00   05400   RADI OLOGY - DI AGNOSTI C	0	0	1	0	0	0 00
57. 00   05700   CT   SCAN	0	0	1	0	0	07.00
58. 00   05800   MAGNETIC RESONANCE I MAGING (MRI)	0	0		0	0	58. 00
60. 00   06000   LABORATORY	0	0		0	0	00.00
65. 00   06500   RESPI RATORY THERAPY	0	0		0	0	00.00
66. 00   06600   PHYSI CAL THERAPY	0		1	0		66. 00
67. 00   06700   OCCUPATI ONAL THERAPY	0		1	0	0	07.00
68. 00   06800   SPEECH PATHOLOGY	0				0	00.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0				0	1 , 00
73. 00   07300   DRUGS CHARGED TO PATLENTS 74. 00   07400   RENAL DLALYSLS	0				0	
74.00 07400 RENAL DIALYSIS 76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0					
OUTPATIENT SERVICE COST CENTERS			1	U C	)	76.00
91. 00   09100   EMERGENCY	1		1		) 0	91.00
91. 01   04951   OUTPATI ENT THERAPY						
93. 00   04950   OUTPATIENT WOUND CENTER						
OTHER REIMBURSABLE COST CENTERS			1	<u> </u>	,	75.00
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50 through 199)			J		م ا	200.00

		litation Hospit				u of Form CMS-	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS	VICE OTHER PASS	Provider CO		Peri od: From 05/01/2023 To 04/30/2024		epared:
			Title	XVIII	Hospi tal	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)		(see	
						instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 153, 580		
57. 00	05700 CT SCAN	0	0		0 13, 450		1
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 2, 867	0. 000000	
	06000 LABORATORY	0	0		0 1, 170, 660		
65.00	06500 RESPI RATORY THERAPY	0	0		0 830, 512	0.000000	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0		0 2, 670, 560	0. 000000	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 2, 770, 657	0. 000000	67. 00
68.00	06800 SPEECH PATHOLOGY	0	0		0 952, 815	0.000000	68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 974, 272	0.000000	71. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 2, 848, 700	0. 000000	73. 00
74.00	07400 RENAL DIALYSIS	0	0		0 76, 650	0. 000000	74. 00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0 8, 617	0. 000000	76. 00
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	0	0		0 0	0. 000000	91.00
91.01	04951 OUTPATI ENT THERAPY	0	0		0 0	0.000000	91. 01
93.00	04950 OUTPATIENT WOUND CENTER	0	0		0	0. 000000	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)	o	0		0 12, 473, 340		200.00

Health Financial Systems Rehabilitation Hospital of Northern Indi In Lieu of Form CMS-2552-10							
	APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVER THROUGH COSTS		Provider Co	Provider CCN: 15-3047		Worksheet D Part IV Date/Time Pre 9/9/2024 1:53	
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷ col.		Costs (col. 8	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	,				,	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	61, 026		0	0	54.00
57. 00	05700  CT SCAN	0. 000000	5, 823		0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0	0	58. 00
60.00	06000 LABORATORY	0. 000000	432, 440		0	0	60.00
65. 00	06500 RESPI RATORY THERAPY	0. 000000	307, 650		0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000	1, 048, 300		0 0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	1, 087, 100		0 0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0. 000000	327, 585		0 0	0	68. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	421, 745		0 0	0	71. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 002, 717		0 0	0	73. 00
74.00	07400 RENAL DIALYSIS	0. 000000	25, 650		0 0	0	74. 00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	4, 308		0 0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	0. 000000	0		0 0	0	91.00
91. 01	04951 OUTPATIENT THERAPY	0. 000000	0		0 0	0	91. 01
93.00	04950 OUTPATIENT WOUND CENTER	0. 000000	0		0 0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)		4, 724, 344		0 0	0	200. 00

0 202.00

0

202.00

Net Charges (line 200 - line 201)

				To 04/30/2024	Date/Time Prep 9/9/2024 1:53	
		Title	XVIII	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Reimbursed				
	Servi ces	Servi ces Not				
	Subject To	Subject To				
	Ded. & Coi ns.	Ded. & Coins.				
	(see inst.)	(see inst.)				
ANOTHER OF THE CONTROL OF THE CONTRO	6. 00	7. 00				
ANCI LLARY SERVI CE COST CENTERS	1	1	1			
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0	1			54.00
57. 00   05700   CT SCAN	0	0	1			57. 00
58. 00   05800   MAGNETIC RESONANCE   MAGING (MRI)	0	0	1			58. 00
60. 00   06000   LABORATORY	0	0	1			60.00
65. 00 06500 RESPI RATORY THERAPY	0	0	1			65. 00
66. 00   06600   PHYSI CAL THERAPY	0	0	1			66. 00
67. 00   06700   OCCUPATI ONAL THERAPY	0	0	1			67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	1			68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1			71. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	1			73. 00
74. 00   07400   RENAL DI ALYSI S	0	0				74. 00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0				76. 00
OUTPATIENT SERVICE COST CENTERS	1	1	1			
91. 00   09100   EMERGENCY	0	0	1			91. 00
91. 01   04951   OUTPATI ENT THERAPY	0	0	1			91. 01
93. 00 O4950 OUTPATIENT WOUND CENTER	0	0				93. 00
OTHER REIMBURSABLE COST CENTERS	_	T	1			
95. 00 09500 AMBULANCE SERVICES	0	_				95. 00
200.00 Subtotal (see instructions)	0	0	1			200. 00
201.00 Less PBP Clinic Lab. Services-Program	0					201. 00
Only Charges						000 00
202.00   Net Charges (line 200 - line 201)	1 0	0	1		ļ	202. 00

Health Financial Systems Rehabi	litation Hospit	al of Northern	Indi	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C		Period: From 05/01/2023 To 04/30/2024		
		Ti tl	e XIX	Hospi tal	PPS	<del></del>
Cost Center Description	Capi tal	Swi ng 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	2, 688, 459	0	2, 688, 45	9 11, 053	243. 23	30. 00
44.00 SKILLED NURSING FACILITY	0			0	0.00	44. 00
200.00 Total (lines 30 through 199)	2, 688, 459		2, 688, 45	9 11, 053		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 & PEDI ATRI CS	246	59, 835				30. 00
44.00 SKILLED NURSING FACILITY	0	0	)			44. 00
200.00 Total (lines 30 through 199)	246	59, 835	i			200.00

Health Financial Systems Rehabil	litation Hospit	al of Northern	Indi	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der Co		Peri od: From 05/01/2023	Worksheet D Part II	
				To 04/30/2024		
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.		. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
54. 00   05400   RADI OLOGY-DI AGNOSTI C	1, 302					
57. 00  05700   CT   SCAN	114				0	07.00
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)	24	,			0	58. 00
60. 00   06000   LABORATORY	22, 006		1			
65. 00 06500 RESPI RATORY THERAPY	4, 002	· ·	1			
66. 00 06600 PHYSI CAL THERAPY	504, 241	2, 670, 560	1			
67. 00 06700 OCCUPATI ONAL THERAPY	102, 664		1			
68.00 06800 SPEECH PATHOLOGY	42, 489		1			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	125, 897		1			
73.00 07300 DRUGS CHARGED TO PATIENTS	124, 080		l .			
74. 00   07400   RENAL DI ALYSI S	4, 357		1		1	
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	209	8, 617	0. 02425	4, 308	104	76. 00
OUTPATIENT SERVICE COST CENTERS						
91. 00  09100 EMERGENCY	0	0	0.00000	0 0	0	91. 00
91. 01  04951 0UTPATI ENT THERAPY	0	0	0.00000		0	, , , , , ,
93. 00 O4950 OUTPATIENT WOUND CENTER	0	0	0.00000	0 0	0	93. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00   Total (lines 50 through 199)	931, 385	12, 473, 340	)	444, 433	29, 220	200. 00

Health Financial Systems Rehabil	itation Hospit	al of Northern	I ndi	In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COST		!	Period: From 05/01/2023 Fo 04/30/2024	Date/Time Pre 9/9/2024 1:53	pared:
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursi ng Program Post-Stepdown	Nursi ng Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
	Adjustments					
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS 44. 00   04400   SKI LLED   NURSI NG   FACI LI TY	0	0	(	0 0	0	44. 00
200.00 Total (lines 30 through 199)	0	0	(	0		200. 00
Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	4.00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	11, 05	0.00	246	30. 00
44.00 04400 SKILLED NURSING FACILITY		0		0.00	0	44.00
200.00 Total (lines 30 through 199)		0	11, 05	3	246	200. 00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00   03000   ADULTS & PEDIATRICS 44.00   04400   SKILLED NURSING FACILITY 200.00   Total (lines 30 through 199)	0 0 0					30. 00 44. 00 200. 00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SETTHROUGH COSTS	RVICE OTHER PAS			То	05/01/2023 04/30/2024	9/9/2024 1:53	
			e XIX		Hospi tal	PPS	
Cost Center Description	Non Physician Anesthetist Cost	Nursi ng Program Post-Stepdown Adj ustments	Nursi ng Program	Po	lied Health st-Stepdown djustments	Allied Health	
	1.00	2A	2.00		3A	3. 00	
ANCILLARY SERVICE COST CENTERS		1					
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0		0	0	0	0 00
57. 00   05700   CT   SCAN	0	0	)	0	0	0	07.00
58. 00   05800   MAGNETIC RESONANCE I MAGING (MRI)	0	0	)	0	0	0	58. 00
60. 00   06000   LABORATORY	0	0	)	0	0	0	00.00
65. 00 06500 RESPI RATORY THERAPY	0	0	)	0	0	0	00.00
66. 00   06600   PHYSI CAL THERAPY	0	0	)	0	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	)	0	0	0	07.00
68. 00   06800   SPEECH PATHOLOGY	0	0	)	0	0	0	00.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		2	0	0	0	,
73. 00 07300 DRUGS CHARGED TO PATIENTS	0		2	0	0	0	
74. 00 07400 RENAL DIALYSIS	0		2	0	0	0	,
76. 00 03950 OTHER ANCILLARY SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS	0		ή	U	U	0	76. 00
91. 00 09100 EMERGENCY			\		٥	0	91.00
91. 01   04951   OUTPATI ENT THERAPY	0			0	0	0	
93. 00   04950   OUTPATIENT WOUND CENTER				0	0	0	
OTHER REIMBURSABLE COST CENTERS			<u>'I</u>	U <sub>I</sub>	<u> </u>	0	73.00
95. 00 09500 AMBULANCE SERVICES							95. 00
200.00 Total (lines 50 through 199)				0	0	0	200. 00

		itation Hospit				u of Form CMS-	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS	VICE OTHER PASS	S Provider CO		Period: From 05/01/2023 To 04/30/2024		
			Ti tl	e XIX	Hospi tal	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)		(see	
						instructions)	
		4. 00	5. 00	6.00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
54.00	05400  RADI OLOGY-DI AGNOSTI C	0	0		0 153, 580		
57.00	05700  CT SCAN	0	0		0 13, 450	0.000000	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 2, 867	0.000000	58. 00
60.00	06000 LABORATORY	0	0		0 1, 170, 660	0.000000	60.00
65.00	06500 RESPI RATORY THERAPY	0	0		0 830, 512	0.000000	65.00
66.00	06600 PHYSI CAL THERAPY	0	0		0 2, 670, 560	0.000000	66.00
67.00	06700 OCCUPATI ONAL THERAPY	o	0		0 2, 770, 657	0.000000	67. 00
68.00	06800 SPEECH PATHOLOGY	O	0		0 952, 815	0. 000000	68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	0		0 974, 272	0. 000000	71. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	o	0		0 2, 848, 700	0. 000000	73. 00
74.00	07400 RENAL DI ALYSI S	o	0		0 76, 650	0. 000000	74. 00
76. 00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0 8, 617	0. 000000	76. 00
	OUTPATIENT SERVICE COST CENTERS	- 1					
91.00	09100 EMERGENCY	0	0		0 0	0. 000000	91. 00
	04951 OUTPATIENT THERAPY	1 0	0		ol o	0. 000000	
	04950 OUTPATIENT WOUND CENTER	o	0		0	0. 000000	
	OTHER REIMBURSABLE COST CENTERS	-1			-		1
95.00	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)	0	0		0 12, 473, 340		200.00

Heal th	Financial Systems Rehabi	litation Hospita	al of Northern	Indi	In Lie	eu of Form CMS-2	2552-10
APPORT	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS		Provi der CC	CN: 15-3047	Period: From 05/01/2023 To 04/30/2024	Worksheet D Part IV Date/Time Pre 9/9/2024 1:53	pared:
				e XIX	Hospi tal	PPS	
	Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col.	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8		Outpatient Program Pass-Through Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9. 00	10.00	11. 00	12.00	13.00	
	ANCILLARY SERVICE COST CENTERS						
54.00	05400   RADI OLOGY-DI AGNOSTI C	0. 000000	2, 624		0	0	54. 00
57. 00	05700  CT SCAN	0. 000000	0		0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0	0	
60.00	06000 LABORATORY	0. 000000	32, 356		0	0	60.00
65. 00	06500 RESPI RATORY THERAPY	0. 000000	27, 141		0	0	65.00
66. 00	06600 PHYSI CAL THERAPY	0. 000000	59, 780		0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	62, 885		0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	16, 495		0	0	68. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	42, 016		0	0	71. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	196, 828		0	0	
74. 00	07400 RENAL DI ALYSI S	0. 000000	0		0	0	
76. 00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	4, 308		0 0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS						
91. 00	09100 EMERGENCY	0. 000000	0		0	0	
91. 01	04951 OUTPATI ENT THERAPY	0. 000000	0		0	0	91. 01
93. 00	04950 OUTPATIENT WOUND CENTER	0. 000000	0		0 0	0	93. 00
	OTHER REIMBURSABLE COST CENTERS						
95. 00	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)		444, 433		0 0	0	200. 00

Heal th	Financial Systems Rehabi	litation Hospit	al of Northern	Indi	In Lie	u of Form CMS-:	2552-10
APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der C		Peri od: From 05/01/2023	Worksheet D Part V	
						Date/Time Pre	narod.
					10 04/30/2024	9/9/2024 1: 53	
			Ti tl	e XIX	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge			Cost	PPS Services	
			Services (see		Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Servi ces Not		
		Part I, col. 9		Subject To	Subj ect To		
				Ded. & Coins			
				(see inst.)	(see inst.)		
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
	05400 RADI OLOGY-DI AGNOSTI C	0. 561655	l .		0	0	
	05700 CT SCAN	0. 561933	l .	)	0	0	07.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 562609		)	0	0	58. 00
	06000 LABORATORY	0. 083420		)	0	0	60.00
65.00	06500 RESPI RATORY THERAPY	0. 276039	0	)	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 687307	0	)	0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 440421	0		0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0. 569092	0	)	0	0	68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 512547	0	)	0	0	71. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 435179	0		0	0	73. 00
74.00	07400 RENAL DIALYSIS	4. 156373	0		0	0	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	1. 737496	0		0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	0. 000000	0		0 0	0	91. 00
91. 01	04951 OUTPATIENT THERAPY	0. 000000	0		0	0	91. 01
93.00	04950 OUTPATIENT WOUND CENTER	0. 000000	0		0	0	93. 00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0. 000000	0		0		95. 00
200.00	Subtotal (see instructions)		0		0	0	200. 00
201.00	Less PBP Clinic Lab. Services-Program				0 0	I	201. 00
	Only Charges					I	
202.00	Net Charges (line 200 - line 201)		[ o	)	0	0	202. 00

				To 04/30/2024	Date/Time Pre 9/9/2024 1:53	
		Ti tl	e XIX	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Reimbursed				
	Servi ces	Servi ces Not				
	Subject To	Subject To				
	Ded. & Coi ns.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCI LLARY SERVI CE COST CENTERS		1	T			
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0				54.00
57. 00   05700   CT SCAN	0	0				57. 00
58. 00   05800   MAGNETIC RESONANCE   MAGING (MRI)	0	0				58. 00
60. 00   06000   LABORATORY	0	0				60.00
65. 00 06500 RESPI RATORY THERAPY	0	0				65. 00
66. 00   06600   PHYSI CAL THERAPY	0	0				66. 00
67. 00   06700   OCCUPATI ONAL THERAPY	0	0				67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0				68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0				73. 00
74. 00   07400   RENAL DI ALYSI S	0	0				74. 00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0				76. 00
OUTPATIENT SERVICE COST CENTERS	1	1	ı			
91. 00   09100   EMERGENCY	0	0				91.00
91. 01   04951   OUTPATI ENT THERAPY	0	0				91. 01
93. 00 O4950 OUTPATIENT WOUND CENTER	0	0				93. 00
OTHER REIMBURSABLE COST CENTERS	_	T	ı			
95. 00 09500 AMBULANCE SERVICES	0	_				95. 00
200.00 Subtotal (see instructions)	0	0				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201. 00
Only Charges						000 00
202.00   Net Charges (line 200 - line 201)	1 0	0	1			202. 00

Health Financial Systems	Rehabilitation Hospital	of Northern Indi	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-3047	Peri od: From 05/01/2023 To 04/30/2024	Worksheet D-1 Date/Time Pre 9/9/2024 1:53	pared:
		Title XVIII	Hospi tal	PPS	
Cost Center Description					
				1. 00	
PART I - ALL PROVIDER COMPONENTS					

	Title XVIII Hospital	PPS	
	Cost Center Description	1 00	
	PART I - ALL PROVIDER COMPONENTS	1. 00	
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	11, 053	1. 00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	11, 053	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3. 00
	do not complete this line.		
4.00	Semi-private room days (excluding swing-bed and observation bed days)	11, 053	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	٥	0.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
	reporting period		
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)		
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	4, 232	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	o	10. 00
10.00	through December 31 of the cost reporting period (see instructions)	٥	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	o	11. 00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
	through December 31 of the cost reporting period	_	
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14. 00
15. 00	Total nursery days (title V or XIX only)	0	
16. 00	Nursery days (title V or XIX only)	ő	
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17.00
	reporting period		
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0. 00	18. 00
10.00	reporting period	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20. 00
	reporting period		
21. 00	Total general inpatient routine service cost (see instructions)	11, 823, 159	21.00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22.00
22.00	5 x line 17)		22.00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
21.00	7 x 1 ine 19)	ĭ	21.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25.00
	x line 20)		
26. 00	Total swing-bed cost (see instructions)	0	
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	11, 823, 159	27. 00
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29. 00	Pri vate room charges (excluding swing-bed charges)	0	
30.00	Semi -private room charges (excluding swing-bed charges)	ő	30. 00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)	0. 00	32.00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00	
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x line 31)	0.00	
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line	0 11, 823, 159	36. 00 37. 00
37.00	27 minus line 36)	11,023,139	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM I NPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 069. 68	
39. 00	Program general inpatient routine service cost (line 9 x line 38)	4, 526, 886	
40. 00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	4, 526, 886	41.00

	Financial Systems Rehabil	itation Hospit	al of Northern	Indi	In Lie	eu of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST		Provi der Co		Peri od:	Worksheet D-1	
					From 05/01/2023 To 04/30/2024	Doto/Time Dros	narad.
					10 04/30/2024	Date/Time Prep 9/9/2024 1:53	pareu: pm
			Title	xVIII	Hospi tal	PPS	
	Cost Center Description	Total	Total	Average Per		Program Cost	
		Inpatient Cost	Inpatient Days		÷	(col. 3 x col.	
		1.00	2. 00	col . 2) 3.00	4. 00	4) 5. 00	
42 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42. 00
42.00	Intensive Care Type Inpatient Hospital Units						42.00
43. 00	INTENSIVE CARE UNIT						43.00
44. 00	CORONARY CARE UNIT						44. 00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description						
10.00	10					1.00	10.00
48. 00 48. 01	Program inpatient ancillary service cost (Wk: Program inpatient cellular therapy acquisition			III line 10	column 1)	2, 310, 878 0	1
	Total Program inpatient costs (sum of lines				COLUMN 1)	6, 837, 764	
49.00	PASS THROUGH COST ADJUSTMENTS	+1 thi bugii 46. C	ri) (see Tiisti uc	ti ons)		0, 837, 704	49.00
50. 00	Pass through costs applicable to Program inpo	1, 029, 349	50.00				
		', '=', '					
51. 00	Pass through costs applicable to Program inp	sum of Parts II	362, 738	51.00			
	and IV)						
52.00	Total Program excludable cost (sum of lines					1, 392, 087	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line !		erated, non-pny	sıcıan anestr	netist, and	5, 445, 677	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION	02)					
54. 00	Program discharges					0	54.00
55. 00	Target amount per discharge					0.00	
55. 01	Permanent adjustment amount per discharge					0.00	
	Adjustment amount per discharge (contractor	use only)				0.00	55. 02
56. 00	Target amount (line 54 x sum of lines 55, 55					0	56. 00
57. 00	Difference between adjusted inpatient operat	ing cost and ta	rget amount (I	ine 56 minus	line 53)	0	
58. 00	Bonus payment (see instructions)					0	
59. 00	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	the cost repo	orting period	endi ng 1996,	0.00	59. 00
	updated and compounded by the market basket)	== 0					
60. 00	Expected costs (lesser of line 53 ÷ line 54,	or line 55 fro	m prior year c	ost report, ι	ipdated by the	0.00	60.00
61. 00	market basket) Continuous improvement bonus payment (if line	52 · lino 54	ic loce than t	ho lowest of	lince 55 plue	0	61.00
01.00	55.01, or line 59, or line 60, enter the less					ا	01.00
	53) are less than expected costs (lines 54 x						
	enter zero. (see instructions)	,,	g	(	.,,		
						ol	62.00
62. 00	Relief payment (see instructions)						
	Allowable Inpatient cost plus incentive payme	ent (see instru	ctions)			0	63. 00
53. 00	Allowable Inpatient cost plus incentive paymer PROGRAM INPATIENT ROUTINE SWING BED COST	•	,				
63. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	•	,	cost reporti	ng period (See	0	
62. 00 63. 00 64. 00 65. 00	Allowable Inpatient cost plus incentive paymer PROGRAM INPATIENT ROUTINE SWING BED COST	ts through Dece	mber 31 of the				64. 00

			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Total Inpati ent Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only)						42. 00
40.00	Intensive Care Type Inpatient Hospital Units		I	1		Г	40.00
43. 00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
	SURGICAL INTENSIVE CARE UNIT						46. 00
	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description			'	11		
						1. 00	
48. 00	Program inpatient ancillary service cost (Wk			40	. 4	2, 310, 878	
48. 01 49. 00	Program inpatient cellular therapy acquisiti Total Program inpatient costs (sum of lines				column I)	0 6, 837, 764	48. 01 49. 00
49.00	PASS THROUGH COST ADJUSTMENTS	41 till ough 46. c	) (see This truc	ti ons)		0, 037, 704	49.00
50. 00	Pass through costs applicable to Program inp	atient routine	services (from	n Wkst. D, sum	of Parts I and	1, 029, 349	50.00
			·				
51. 00	Pass through costs applicable to Program inp	atient ancillar	ry services (fr	om Wkst. D, su	m of Parts II	362, 738	51. 00
E2 00	and IV)	EO and E1)				1 202 007	E2 00
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		alated non-nhy	veician aneethe	tist and	1, 392, 087 5, 445, 677	1
33. 00	medical education costs (line 49 minus line		ratea, non prij	isi ci dii dilestile	tist, and	3, 443, 077	33.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
	Program di scharges					0	54. 00
	Target amount per discharge					0.00	•
	Permanent adjustment amount per discharge					0.00	1
	Adjustment amount per discharge (contractor Target amount (line 54 x sum of lines 55, 55	J .				0.00	55. 02 56. 00
56.00	Difference between adjusted inpatient operat			ine 56 minus I	ine 53)	0	57.00
58. 00	Bonus payment (see instructions)	ing cost and ta	inger amount (i	THE 30 IIITHUS I	THE 33)	0	58.00
59. 00	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	n the cost repo	orting period e	ndi ng 1996,	0.00	•
	updated and compounded by the market basket)		•	3 1	3 .		
60.00	Expected costs (lesser of line 53 ÷ line 54,	or line 55 fro	om prior year o	cost report, up	dated by the	0.00	60.00
(1.00	market basket)	- 50   1: 54	:- ! 46 4		: FF		/1 00
61. 00	Continuous improvement bonus payment (if lin 55.01, or line 59, or line 60, enter the les					0	61. 00
	53) are less than expected costs (lines 54 x		,				
	enter zero. (see instructions)	00), 01 1 % 01	the target an	iodire (11116 00)	, other wise		
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive paym	ent (see instru	uctions)			0	63. 00
(4.00	PROGRAM I NPATIENT ROUTINE SWING BED COST	4- 4bb D	21 -6 +1-				/ / 00
64. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Dece	ember 31 or the	e cost reportin	g period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	oer 31 of the o	cost reporting	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	55)(title XVIII	only); for	0	66. 00
67. 00	CAH, see instructions Title V or XIX swing-bed NF inpatient routin	o costs through	Docombor 21 o	of the cost ron	orting ported	0	67. 00
07.00	(line 12 x line 19)	e costs till ougi	i becember 51 c	i the cost rep	or tring period	٥	07.00
68. 00	Title V or XIX swing-bed NF inpatient routin	e costs after D	December 31 of	the cost repor	ting period	0	68. 00
	(line 13 x line 20)						
69. 00	Total title V or XIX swing-bed NF inpatient		•			0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil						70. 00
70.00	Adjusted general inpatient routine service c						70.00
72. 00	Program routine service cost (line 9 x line			,			72.00
73. 00	Medically necessary private room cost applic	•	n (line 14 x li	ne 35)			73. 00
74.00	Total Program general inpatient routine serv	ice costs (line	e 72 + line 73)				74. 00
75. 00	Capital-related cost allocated to inpatient	routine service	e costs (from V	lorksheet B, Pa	rt II, column		75. 00
74 00	26, line 45)	no 2)					7/ 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minu						78. 00
79. 00	Aggregate charges to beneficiaries for exces		orovi der record	ls)			79. 00
80. 00	Total Program routine service costs for comp			•	s line 79)		80.00
81.00	Inpatient routine service cost per diem limi	tati on			•		81. 00
82. 00	Inpatient routine service cost limitation (I	ine 9 x line 81	1)				82. 00
83. 00	Reasonable inpatient routine service costs (		ns)				83. 00
84. 00	Program inpatient ancillary services (see in						84. 00
85.00	Utilization review - physician compensation	•					85. 00
86. 00	Total Program inpatient operating costs (sum		nrough 85)				86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PAST Total observation bed days (see instructions					0	87. 00
88. 00	Adjusted general inpatient routine cost per		- line 2)			0.00	ł
89. 00	Observation bed cost (line 87 x line 88) (se					0.00	1
	, , , , , , , , , , , , , , , , , , , ,						

Health Financial Systems Rehabi	litation Hospita	itation Hospital of Northern Indi						
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1			
				From 05/01/2023 To 04/30/2024				
		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	2, 688, 459	11, 823, 159	0. 22738	9 0	0	90. 00		
91.00 Nursing Program cost	0	11, 823, 159	0.00000	0 0	0	91.00		
92.00 Allied health cost	0	11, 823, 159	0.00000	0	0	92. 00		
93.00 All other Medical Education	0	11, 823, 159	0. 00000	0 0	0	93. 00		

Health Financial Systems	Rehabilitation Hospital	of Northern Indi	In Lie	u of Form CMS-	2552-10	
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-3047	Peri od: From 05/01/2023			
			To 04/30/2024	Date/Time Pre 9/9/2024 1:53	pared: pm	
	Title XIX Hospital					
Cost Center Description	<u> </u>					
				1. 00		
PART I - ALL PROVIDER COMPONENTS						
I NPATI ENT DAYS					1	

	Cost Center Description	113	
	DADT I ALL DROWDED COMPONENTS	1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	11, 053	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	11, 053	
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	11, 053	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
6.00	reporting period (if calendar year, enter 0 on this line)	١	0.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
8.00	reporting period (if calendar year, enter 0 on this line)	١	0.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	246	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
10.00	through December 31 of the cost reporting period (see instructions)	١	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, enter 0 on this line) Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12. 00
12.00	through December 31 of the cost reporting period	١	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14. 00
15. 00	Total nursery days (title V or XIX only)	0	•
16. 00	Nursery days (title V or XIX only)	0	
47.00	SWING BED ADJUSTMENT		47.00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0.00	18. 00
40.00	reporting period		40.00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19. 00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20. 00
04.00	reporting period	44 000 450	04 00
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	11, 823, 159 0	21. 00 22. 00
22.00	5 x line 17)	ı "	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
21.00	7 x line 19)		
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
26. 00	x line 20)   Total swing-bed cost (see instructions)	0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	11, 823, 159	
20.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		1 20 00
	General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges)	0	
30. 00	Semi -pri vate room charges (excluding swing-bed charges)	0	1
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)	0.00	1
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00 0. 00	1
35. 00	Average per diem private room cost differential (line 34 x line 31)	0.00	1
36. 00	Private room cost differential adjustment (line 3 x line 35)	0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	11, 823, 159	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 069. 68	1
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35)	263, 141 0	39. 00 40. 00
	Total Program general inpatient routine service cost (line 39 + line 40)	263, 141	1

32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	11, 823, 159	37. 00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 069. 68	38.00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	263, 141	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	263, 141	41.00

Heal th	Financial Systems Rehabi	litation Hospit	al of Northern	Indi	In Lie	eu of Form CMS-:	2552-10			
	ATION OF INPATIENT OPERATING COST		Provi der Co		Peri od:	Worksheet D-1				
					From 05/01/2023					
					To 04/30/2024	Date/Time Pre 9/9/2024 1:53	pared: pm			
			Ti tl	e XIX	Hospi tal	PPS				
	Cost Center Description Total Total Average Per Program Days Progr									
		Inpatient Cost	Inpatient Days		÷	(col. 3 x col.				
		1.00	2.00	col . 2)	4.00	4) 5. 00				
42.00	NURSERY (title V & XIX only)	1.00	2.00	3. 00	4. 00	5.00	42. 00			
42.00	Intensive Care Type Inpatient Hospital Units						42.00			
43. 00	INTENSIVE CARE UNIT						43. 00			
44. 00	CORONARY CARE UNIT						44. 00			
45. 00	BURN INTENSIVE CARE UNIT						45. 00			
	SURGICAL INTENSIVE CARE UNIT						46. 00			
	OTHER SPECIAL CARE (SPECIFY)						47. 00			
	Cost Center Description									
		-				1. 00				
48. 00	Program inpatient ancillary service cost (Wk					204, 510	1			
48. 01	Program inpatient cellular therapy acquisiti				column 1)	0				
49. 00	Total Program inpatient costs (sum of lines	41 through 48.0	01)(see instruc	ctions)		467, 651	49. 00			
	PASS THROUGH COST ADJUSTMENTS			1111						
50. 00	Pass through costs applicable to Program inp	atient routine	services (from	n Wkst. D, sum	of Parts I and	59, 835	50.00			
51. 00	  Pass through costs applicable to Program inp	ationt ancillar	sy corvicos (fr	com Wkst D s	rum of Darte II	29, 220	51.00			
31.00	and IV)	attent ancitrai	y services (ii	OIII WKSt. D, S	sum of rarts if	27, 220	31.00			
52. 00	Total Program excludable cost (sum of lines	50 and 51)				89, 055	52. 00			
53. 00	Total Program inpatient operating cost exclu		elated, non-phy	sician anesth	etist, and	378, 596	1			
	medical education costs (line 49 minus line		. , ,			· ·				
	TARGET AMOUNT AND LIMIT COMPUTATION									
	Program discharges					0				
55. 00	Target amount per discharge					0.00				
	Permanent adjustment amount per discharge					1	55. 01			
	Adjustment amount per discharge (contractor					0.00				
56. 00	Target amount (line 54 x sum of lines 55, 55			! F/!	L: F2)	0				
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	arget amount (i	The 56 minus	11 ne 53)	0 0				
59. 00	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	the cost rone	orting ported	anding 1006	0.00	1			
37.00	updated and compounded by the market basket)	of Title 55 from	i the cost repu	n tring period	ending 1990,	0.00	39.00			
60. 00	Expected costs (lesser of line 53 ÷ line 54,	or line 55 fro	om prior vear o	cost report. u	updated by the	0.00	60.00			
	market basket)									
61. 00	Continuous improvement bonus payment (if lin	e 53 ÷ line 54	is less than t	he lowest of	lines 55 plus	0	61.00			
	55.01, or line 59, or line 60, enter the les	ser of 50% of t	the amount by w	which operatir	ng costs (line					
	53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise									
	enter zero. (see instructions)									
	Relief payment (see instructions)					0	02.00			
63. 00	Allowable Inpatient cost plus incentive paym	enτ (see instru	uctions)			0	63. 00			
44.00	PROGRAM INPATIENT ROUTINE SWING BED COST	to through Door	mbor 21 of the	cost roperti	ng poriod (Cas	1 ^	44.00			
64. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	is in ough Dece	ember 31 OF The	e cost reporti	ng perrou (see	0	64. 00			
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	per 31 of the o	cost reporting	period (See	0	65. 00			
55.00	instructions)(title XVIII only)			opor critic	, _ 5 54 (555		55. 55			

Cost Center Description							9/9/2024 1:53	pm
1.00   2.00   3.00   4.00   5.00   3.00   4.00   5.00   3.00   4.00   5.00   3.00		Cost Center Description		Total	Average Per Diem (col. 1 :		(col. 3 x col.	
42 00			1 00	2.00		4.00		
	42. 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	3.00	42. 00
44.00   Coronwary Care unit								
45.00   SIRRIC LINE CARE UNIT   46.00   SIRRIC LINE STEEL CARE (SECLIF)   46.00   SIRRIC LINE STEEL CARE (SECLIF)   46.00   SIRRIC LINE STEEL CARE (SECLIF)   46.00   47.00   47.00   47.00   47.00   48.00   Program Inpatient of cull unit riboracy acquisition cost ((0x4s.beet 0-6, Part III., Iline 10, column 1)   0.41.01   48.00   49.00   10741   Program Inpatient costs (cum of Tines 41 through 46.01) (cee Instructions)   46.00   47.00   48.0								
46.00   Cost Center Description   1.00   1								
1.00   Programs inpatient micro cost (like t. P.3, col. 3, like 200)   204,510   48.01   709,700   709,7								
1.00   Program inputient ancillary service cost (Mest. 0-3; col. 3; line 200)   20,4510   48,00   20,4510   20,4	47. 00							47. 00
200, 510   48.00   Program inpatient ancillarly service cost (Mixt. D-3, col. 3, line 200)   48.01   100, 100   100, 100, 100, 100, 100,		Cost Center Description					1.00	
Program inpatient cell ular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	48 00	Program inpatient ancillary service cost (Wk	st D-3 col 3	3 Line 200)				48 00
PASS THROUGH COST ADJUSTMENTS		Program inpatient cellular therapy acquisition	on cost (Worksh	neet D-6, Part	III, line 10,	column 1)		
50.00   Pass through costs applicable to Program inpatient routine services (from Wist. D., sum of Parts I and 15.00   Pass through costs applicable to Program inpatient ancillary services (from Wist. D., sum of Parts II 29, 20   51.00   20.00	49. 00		41 through 48.0	01)(see instruc	tions)		467, 651	49. 00
1110   290   200   201   202   202   203   201   202   203   201   202   203   201   203   201   203   201   203	EO 00		ationt routing	convices (from	Wks+ D sum	of Dorte L and	E0 02E	E0 00
51.00   Pass through costs applicable to Program Inpatient and ITary services (from Wist. D. sum of Parts II 29, 220   51.00   and ITD)   29.005   52.00   378,596   53.00   Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 378,596   53.00   Total Program Inpatient operating cost excluding capital related, non-physician anesthetist, and 378,596   53.00   70.00   7	30.00		atrent routine	services (11011	I WKSt. D, Suiii	OI PALLS I ANU	39, 633	30.00
1.00   Total Program excludable cost (sum of lines 50 and 51)   38,0,655   52.00   378,596   53.00   Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 378,596   53.00   1	51.00		atient ancillar	y services (fr	om Wkst. D, su	m of Parts II	29, 220	51. 00
	F0 00		-0   -1				00.055	F0 00
medical education costs (line 49 minus line 52)		,	,	elated non-nhv	sician anesthe	otist and		
54.00   Program discharges   0.00   55.00   55.00   Total amount per discharge   0.00   55.00   55.00   Total amount per discharge   0.00   55.00	33.00			oratea, non phy	31 Clair ancstric	trot, and	370, 370	33.00
Permanent adjustment amount per discharge   0.00   55.02   Adjustment amount per discharge (contractor use only)   0.00   55.02   Adjustment amount (line 54 x sum of lines 55, 55.01, and 55.02)   0.00   55.02   0.00   0								
55.02   Adjustment amount per discharge (contractor use only)								
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 0 57.00 0 58.00 Box payment (see instructions) 0 58.00 box payment (see instructions) 0 58.00 costs (lesser of line 53 + line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket) 0 0 Expected costs (lesser of line 53 + line 54, or line 55 from prior year cost report, updated by the market basket) 1 0 0 Continuous improvement bonus payment (if line 53 + line 54 is less than the lowest of lines 55 plus 0 0 1.00 Continuous improvement bonus payment (if line 53 + line 54 is less than the lowest of lines 55 plus 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			use only)					
88 00 Bonus payment (see instructions) 99 00 Treaded costs (clesser of line 54 + line 54 or line 55 from the cost reporting period ending 1996, 0.00 59 00 updated and compounded by the market basket) 00 00 Expected costs (clesser of line 53 + line 54 t, or line 55 from prior year cost report, updated by the market basket) 10 00 close (clesser of line 53 + line 54 t, or line 55 from prior year cost report, updated by the market basket) 10 00 close (clesser of line 53 + line 54 t is less than the lowest of lines 55 plus of 1.00 close (clesser of line 53) are less than expected costs (line 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions) 10 00 Relider payment (see instructions) 10 00 All lowable lippatient cost plus incentive payment (see instructions) 10 00 All owable lippatient cost plus incentive payment (see instructions) 10 00 All owable lippatient cost plus incentive payment (see instructions) 10 00 All owable lippatient cost plus incentive payment (see instructions) 10 00 All owable are swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See Instructions) (tile XVIII only); for 0 All owable are swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only); for 0 All owable are swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only); for 0 All owable are swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See Intitle V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (See Intitle V or XIX swing-bed NF inpatient routine costs (line 64 plus line 65) (title XVIII only); for 0 All used general inpatient proutine service cost (line 67 + line 68) (1 All of Cost (line 13 x line 20) (1 All other x line 20) (2 All o		,					0	
59.00 Trended costs (lesser of line 53 + line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)  6.00 Expected costs (lesser of line 53 + line 54, or line 55 from prior year cost report, updated by the market basket)  6.100 Continuous improvement bonus payment (if line 53 + line 54 is less than the lowest of lines 55 plus 5, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)  6.200 Relief payment (see instructions)  8.200 Relief payment (see instructions)  9.0 63.00 Allowable Inpatient cost plus incentive payment (see instructions)  9.0 63.00 Allowable Inpatient cost plus incentive payment (see instructions)  9.0 63.00 Allowable Inpatient cost plus incentive payment (see instructions)  9.0 63.00 Allowable Inpatient cost plus line for plus line for the cost reporting period (see instructions) (title XVIII only)  9.0 65.00 Microre swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (see instructions) (title XVIII only)  9.0 60.00 Total Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  9.0 60.00 Total Medicare swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19)  9.0 7.0 00 Skilled Volume of the cost instructions (line 12 x line 19)  9.0 7.0 00 Skilled Volume of the cost instructions (line 3 x line 20)  9.0 7.0 00 Skilled Volume of the cost instructions (line 3 x line 20)  9.0 7.0 00 Skilled Volume of the cost instructions (line 3 x line 20)  9.0 7.0 00 Skilled Volume of the cost instructions (line 3 x line 20)  9.0 7.0 00 Skilled Order of the cost instructions (line 3 x line 20)  9.0 7.0 00 Skilled Order of the cost instructions (line 3 x line 3)  9.0 8.0 00 Hodically necessary private room cost applicable to Program (line 14 x line 35)  9.0 10 10 Inpatie		, , , , , , , , , , , , , , , , , , , ,	ing cost and ta	arget amount (I	ine 56 minus I	ine 53)	-	
updated and compounded by the market basket)  60.00			or line 55 from	n the cost reno	urting period e	endi na 1996		
market basket)  1.00 Continuous improvement bonus payment (if line 53 + line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero. (see instructions)  2.00 Relief payment (see instructions)  3.00 Allowable Inpatient cost plus incentive payment (see instructions)  4.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)  6.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)  6.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only): for CAH, see instructions)  6.00 Total Medicare swing-bed NNF inpatient routine costs through December 31 of the cost reporting period (See instructions)  6.00 Title V or XIX swing-bed NNF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  6.00 Title V or XIX swing-bed NNF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19)  6.00 Total title V or XIX swing-bed NNF inpatient routine costs (line 67 + line 68)  9.00 Total title V or XIX swing-bed NNF inpatient routine costs (line 67 + line 68)  9.00 Total title V or XIX swing-bed NNF inpatient routine service cost (line 37)  7.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  7.00 Program routine service cost (line 9 x line 71)  7.00 Program routine service cost (line 9 x line 71)  7.00 Program routine service cost (line 9 x line 71)  7.00 Program apital-related costs (line 9 x line 77)  7.00 Program capital-related costs (line 9 x line 77)  7.00 Program capital-related costs (line 9 x line 77)  8.00 Inpatient routine service cost for comparison to the cost limitation (line 78 minus line 79)  8.00 Inpatient routine se	07.00		51 11110 00 11 011	ii the cost repe	a tring period c	maring 1770,	0.00	07.00
61.00 Continuous improvement borrus payment (if line 53 * line 54 is less than the lowest of lines 55 plus 5.01, or line 95 or line 60. enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions) 0.0 c.2.00 Rel lef payment (see instructions) (lite Will in lite of the cost seporting period (see instructions) (it le Will in only) 1.0 c.2.00 led care swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (see instructions) (it le Will in only) 1.0 c.2.00 led care swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only): for 0.0 c.2.00 c.2.00 c.2.00 c.2.00 litle vor XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) c.2.00 c.2.00 c.2.00 litle V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) c.2.00 line 14 x line 35) c.2.00 line	60.00	,	or line 55 fro	om prior year c	ost report, up	dated by the	0.00	60. 00
55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero. (see instructions)  62.00 Relief payment (see instructions)  63.00 Allowable Inpatient cost plus incentive payment (see instructions)  64.00 Mallowable Inpatient cost plus incentive payment (see instructions)  64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)  65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only) for CAH, see instructions) (title XVIII only) for CAH, see instructions (title VXIII only) for CAH, see instructions  67.00 Title Vor XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  68.00 Title Vor XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  60.01 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  60.02 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  60.03 Total title V or XIX swing-bed NF inpatient routine costs (line 70 + line 2)  71.00 Adjusted general inpatient routine service cost (line 70 + line 2)  72.00 Medically necessary private room cost applicable to Program (line 14 x line 35)  73.00 Total Program general inpatient routine service costs (fine 72 + line 73)  74.00 Total Program general inpatient routine service costs (fine 72 + line 73)  75.00 Capital -related costs (line 75 + line 2)  76.00 Per diem capital-related costs (line 75 + line 2)  77.00 Program capital-related costs (line 75 + line 2)  78.00 Program routine service cost (line 74 minus line 77)  79.00 Aggregate charges to beneficiaries for excess costs (from provider records)  80.00 Tota	61 00	·	53 ± line 54	is loss than t	he lowest of L	ines 55 nlus	0	61 00
enter zero. (see instructions)   0 62.00   62.00   Allowable Inpatient cost plus incentive payment (see instructions)   0 63.00   ROGEMM INPATIENT ROUTINE SWING BED COST   64.00   ROGEMM INPATIENT ROUTINE SWING BED COST   64.00   Medicare swing-bed SNF Inpatient routine costs through December 31 of the cost reporting period (See Instructions) (title XVIII only)   65.00   Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See Instructions) (title XVIII only)   66.00   Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only);   67.00   Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only);   68.00   Total title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)   68.00   Total title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)   69.00   Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)   0 69.00   70.00   Skilled nursing facility/other nursing facility/OfF/IID routine service cost (line 37)   70.00   71.00   Adjusted general inpatient routine service cost per diem (line 70 + line 2)   71.00   72.00   Program routine service cost (line 9 x line 71)   72.00   73.00   74.00   75.00   7	01.00							01.00
62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See Instructions) (title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See Instructions) (title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only): for CAH, see instructions (title XVIII only) 67.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only): for CAH, see instructions 67.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  60.01 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  60.02 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  60.03 Algusted general inpatient routine service cost (line 67 + line 68)  60.04 Algusted general inpatient routine service costs (line 67 + line 20) 67.00 Porgram routine service cost (line 9 x line 71) 67.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 67.00 Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 67.00 Per diem capital -related costs (line 75 + line 2) 67.00 Porgram coutine service costs (line 75 + line 2) 67.00 Porgram routine service costs (from 90 x line 81) 68.00 Algorital -related costs (line 74 minus line 76) 68.00 Total Program routine service costs for comparison to the cost limitation (li			60), or 1 % of	f the target am	ount (line 56)	, otherwise		
63.00   Allowable   Inpatient cost plus incentive payment (see instructions)   0   63.00   PROGRAM INPATIENT ROUTINE SWING BED COST   64.00   Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)   64.00   65.00   Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)   66.00   Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only); for CAH, see instructions   66.00   Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only); for CAH, see instructions   67.00   Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)   68.00   Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)   69.00   Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)   69.00   PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY   70.00   Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)   70.00   70.00   Medically necessary private room cost perid dem (line 70 + line 2)   71.00   72.00   Program routine service cost (line 9 x line 71)   73.00   74.00   Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26. line 45)   75.00   76.00   Per diem capital-related costs (line 75 + line 2)   76.00   77.00   79.00   Aggregate charges to beneficial-ies for excess costs (from provider records)   79.00   79.00   Aggregate charges to beneficial-ies for excess costs (from provider records)   79.00   79.0	42.00							42.00
PROGRAM INPATIENT ROUTINE SWING BED COST			ent (see instru	uctions)				
Instructions) (title XVIII only)   Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See Instructions) (title XVIII only)   66.00   Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only): for CAH, see instructions   67.00   Total Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (I line 12 x line 19)   68.00   Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (I line 12 x line 20)   69.00   Total title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (I line 13 x line 20)   69.00   Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)			(000 1110 11				_	
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only); for CAH, see instructions 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine service cost (line 37) 70.00 Skilled nursing facility/other nursing facility/IcF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 75.00 Per diem capital-related costs (line 75 + line 2) 77.00 Program crutine service cost (line 9 x line 76) 78.00 Inpatient routine service costs (line 7 x minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service cost (see instructions) 81.00 Reasonable inpatient routine service costs (see instructions) 82.00 Unpatient routine service cost (see instructions) 83.00 Reasonable inpatient routine service cost (see instructions) 84.00 Program inpatient routine service cost (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient routine cost per diem (line 27 + line 2) 87.00 Total observation bed days (see instructions)	64. 00		ts through Dece	ember 31 of the	cost reportir	ng period (See	0	64. 00
instructions) (itile XVIII only)  Cath, see instructions  67.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only); for 0 66.00 CAH, see instructions  67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period 0 67.00 (line 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period 0 68.00 (line 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 0 69.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  70.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2)  71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2)  72.00 Program routine service cost (line 9 x line 71)  73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)  73.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  74.00 Program capital -related costs (line 75 + line 2)  75.00 Program capital -related costs (line 75 + line 2)  77.00 Program capital -related costs (line 74 minus line 77)  78.00 On Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)  80.00 Total Program routine service cost (see instructions)  80.00 Inpatient routine service cost (see instructions)  81.00 Inpatient routine service cost (see instructions)  82.00 Reasonable inpatient routine service costs (see instructions)  83.00 Utilization review - physician compensation (see instructions)  84.00 Program inpatient obed days (see instructions)  86.00 Total Program inpatient routine cost (see instructions)  87.00 Total Program inpatient routine service cost (see instructions)  88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)	65.00	, , , , , , , , , , , , , , , , , , , ,	ts after Decemb	ner 31 of the c	ost renorting	neriod (See	0	65.00
CAH, see instructions Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 + line 2) 77.00 Program capital-related costs (line 75 + line 2) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost for comparison to the cost limitation (line 78 minus line 79) 82.00 Inpatient routine service cost for comparison to the cost limitation (line 78 minus line 79) 83.00 Reasonable inpatient routine service cost (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 88.00 Adjusted general inpatient routine cost per die	03.00	instructions)(title XVIII only)						03.00
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68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2)  72.00 Program routine service cost (line 9 x line 71)  73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)  74.00 Total Program general inpatient routine service costs (line 72 + line 73)  75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  76.00 Per diem capital-related costs (line 75 + line 2)  77.00 Program capital-related costs (line 9 x line 76)  78.00 Inpatient routine service cost (line 74 minus line 77)  79.00 Aggregate charges to beneficiaries for excess costs (from provider records)  79.00 Aggregate charges to beneficiaries for excess costs (from provider records)  79.00 Reasonable inpatient routine service costs (see instructions)  80.00 Reasonable inpatient routine service costs (see instructions)  81.00 Reasonable inpatient routine service (see instructions)  82.00 Willization review - physician compensation (see instructions)  83.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)  84.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)  85.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)  86.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)  87.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)	07.00		e costs till ougi	i becember 51 c	i the cost rep	of tring period		07.00
Total title V or XÍX swing-bed NF inpatient routine costs (line 67 + line 68)   0   69.00	68. 00	Title V or XIX swing-bed NF inpatient routing	e costs after [	December 31 of	the cost repor	ting period	0	68. 00
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Program routine service cost (line 9 x line 71)  72.00  73.00  Medically necessary private room cost applicable to Program (line 14 x line 35)  74.00  75.00  Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  76.00  Per diem capital -related costs (line 75 ÷ line 2)  Program capital -related costs (line 9 x line 76)  18.00  19.00  Aggregate charges to beneficiaries for excess costs (from provider records)  79.00  10.	70.00	Skilled nursing facility/other nursing facili	ty/ICF/IID rou	utine service c	ost (line 37)			70. 00
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Total Program general inpatient routine service costs (line 72 + line 73)  75.00  75.00  76.00  76.00  76.00  77.00  78.00  79.00  79.00  79.00  70.00  80.00		,	•	n (line 14 v li	ne 35)			
26, line 45)  76.00 Per diem capital-related costs (line 75 ÷ line 2)  77.00 Program capital-related costs (line 9 x line 76)  78.00 Inpatient routine service cost (line 74 minus line 77)  78.00 Aggregate charges to beneficiaries for excess costs (from provider records)  80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)  81.00 Inpatient routine service cost per diem limitation  82.00 Inpatient routine service cost limitation (line 9 x line 81)  83.00 Reasonable inpatient routine service costs (see instructions)  84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  85.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00		, , , , , , , , , , , , , , , , , , , ,		•				
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87.00 Total observation bed days (see instructions)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  0.00 88.00	86.00			ıı ougn 85)				86.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 0.00 88.00	87. 00						0	87. 00
89.00   Ubservation bed cost (line 87 x line 88) (see instructions) 0   89.00		Adjusted general inpatient routine cost per	diem (line 27 ÷					
	89.00	Ubservation bed cost (line 87 x line 88) (se	e instructions)	)			0	89.00

Health Financial Systems Rehabi	litation Hospita	itation Hospital of Northern Indi						
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1			
				From 05/01/2023 To 04/30/2024				
		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	2, 688, 459	11, 823, 159	0. 22738	9 0	0	90.00		
91.00 Nursing Program cost	0	11, 823, 159	0.00000	0	0	91.00		
92.00 Allied health cost	0	11, 823, 159	0.00000	0	0	92. 00		
93.00 All other Medical Education	0	11, 823, 159	0. 00000	0 0	0	93. 00		

Heal th	Financial Systems Rehabilitation Hospital	of Northern	Indi	In Lie	eu of Form CMS-2	2552-10
INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-3047	Peri od:	Worksheet D-3	
				From 05/01/2023 To 04/30/2024		narod
				10 04/30/2024	9/9/2024 1:53	
		XVIII	Hospi tal	PPS		
	Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
	·		To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
	LUBATI ENT. DOUTLING OFFINAS OFFITEDO		1.00	2. 00	3. 00	
20.00	INPATIENT ROUTINE SERVICE COST CENTERS			4 000 000		00.00
30. 00	03000 ADULTS & PEDI ATRI CS			4, 232, 000		30. 00
E4 00	ANCI LLARY SERVI CE COST CENTERS  05400 RADI OLOGY-DI AGNOSTI C		0. 56165	61, 026	34, 276	54. 00
	05700 CT SCAN		0. 56193			
	05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 56260		3, 2/2	
	06000 LABORATORY		0. 08342		_	60.00
65. 00	06500 RESPI RATORY THERAPY		0. 27603			65.00
66. 00	06600 PHYSI CAL THERAPY		0. 68730			
67. 00	06700 OCCUPATI ONAL THERAPY		0. 44042			
	06800 SPEECH PATHOLOGY		0. 56909			
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 51254	•		1
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 43517	1, 002, 717	436, 361	73. 00
74.00	07400 RENAL DIALYSIS		4. 15637	25, 650	106, 611	74. 00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS		1. 73749	4, 308	7, 485	76. 00
	OUTPATIENT SERVICE COST CENTERS					
	09100 EMERGENCY		0.00000		0	
	04951 OUTPATI ENT THERAPY		0.00000		1	
	04950 OUTPATIENT WOUND CENTER		0.00000	00 0	0	93. 00
	OTHER REIMBURSABLE COST CENTERS					
	09500 AMBULANCE SERVICES					95. 00
200.00		(1)		4, 724, 344		
201.00		(line 61)		4 704 044	•	201. 00
202. 00	Net charges (line 200 minus line 201)		I	4, 724, 344	I	202. 00

Heal th	Financial Systems Rehabilitation Hospital	of Northern	Lndi	In lie	eu of Form CMS-2	2552-10
	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-3047	Peri od:	Worksheet D-3	
				From 05/01/2023 To 04/30/2024	Date/Time Pre 9/9/2024 1:53	pared:
		e XIX	Hospi tal	PPS		
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
	[		1.00	2. 00	3. 00	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1	1	1	
30.00	03000 ADULTS & PEDI ATRI CS			246, 000		30. 00
E 4 00	ANCILLARY SERVICE COST CENTERS		0.5/4/5			F 4 00
	05400 RADI OLOGY-DI AGNOSTI C		0. 56165			
	05700 CT SCAN		0. 56193		0	57. 00 58. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI) 06000 LABORATORY		0. 56260 0. 08342		0	60.00
60. 00 65. 00	06500 RESPI RATORY THERAPY		0. 08342		2, 699 7, 492	65.00
66.00	06600 PHYSI CAL THERAPY		0. 27603			66.00
67. 00	06700 OCCUPATI ONAL THERAPY		0. 68730			
68. 00	06800 SPEECH PATHOLOGY		0. 44042			68.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 51254			
	07300 DRUGS CHARGED TO PATIENTS		0. 31234			
74. 00	07400 RENAL DIALYSIS		4. 15637		05,055	74.00
	03950 OTHER ANCILLARY SERVICE COST CENTERS		1. 73749		1	
70.00	OUTPATIENT SERVICE COST CENTERS		1.73747	4, 300	7,403	70.00
91 00	09100 EMERGENCY		0.00000	00 0	0	91. 00
	04951 OUTPATIENT THERAPY		0.00000		Ö	91. 01
	04950 OUTPATIENT WOUND CENTER		0. 00000		0	93. 00
70.00	OTHER REI MBURSABLE COST CENTERS		0.0000	,0		70.00
95.00	09500 AMBULANCE SERVI CES					95. 00
200.00				444, 433	204, 510	
201.00		s (Line 61)		0		201. 00
202.00		_ ( 01)		444, 433	•	202. 00
			•		ļ	

th Financial Systems	Rehabilitation Hospital	of	fΝ	lort	hei	⁻n I	nd	li			In Li	eu d	of F	orm	CMS	-2552	-10	
									_	 								

Health Financial Systems	Rehabilitation Hospital	of Northern Indi	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 15-3047	Peri od: From 05/01/2023 To 04/30/2024	Worksheet E Part B Date/Time Prep 9/9/2024 1:53	
		Title XVIII	Hospi tal	PPS	
				1. 00	

		Title XVIII Hospital PPS		PPS	
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1. 00	Medical and other services (see instructions)			0	1. 00
2.00	Medical and other services reimbursed under OPPS (see instruction	ons)		0	2. 00
3.00	OPPS or REH payments			0	3. 00
4.00	Outlier payment (see instructions)			0	4. 00
4. 01 5. 00	Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instructi	ons)		0. 000	4. 01 5. 00
6. 00	Line 2 times line 5	0113)		0.000	6. 00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0. 00	7. 00
8.00	Transitional corridor payment (see instructions)			0	8. 00
9. 00	Ancillary service other pass through costs including REH direct	graduate medical educ	ation costs from	0	9. 00
10. 00	Wkst. D, Pt. IV, col. 13, line 200 Organ acquisitions			0	10. 00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			Ö	
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e charges			_	
12.00	Ancillary service charges	. (0)		0	
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line Total reasonable charges (sum of lines 12 and 13)	9 69)		0	
14.00	Customary charges			- O	14.00
15. 00	Aggregate amount actually collected from patients liable for pay	yment for services on	a charge basis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for patients liable for patients liable for patients liable for patients.	payment for services o	n a chargebasis	0	16. 00
17. 00	had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17. 00
	Total customary charges (see instructions)			0.000000	18. 00
19. 00	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds li	ne 11) (see	Ö	19. 00
	instructions)				
20. 00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds li	ne 18) (see	0	20. 00
21 00	instructions) Lesser of cost or charges (see instructions)			0	21. 00
	Interns and residents (see instructions)			0	
	Cost of physicians' services in a teaching hospital (see instruc	ctions)		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0	24. 00
25. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	25. 00
26. 00	Deductibles and coinsurance amounts (for CAH, see instructions) Deductibles and Coinsurance amounts relating to amount on line 2	24 (for CAH see instr	uctions)	0	26. 00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plu	•	'	0	27. 00
	instructions)		- `		
28. 00	Direct graduate medical education payments (from Wkst. E-4, line	e 50)		0	28. 00
28. 50 29. 00	REH facility payment amount (see instructions)			0	28. 50 29. 00
30. 00	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27, 28, 28.50 and 29)			0	30.00
31.00	Pri mary payer payments			0	31.00
32.00	Subtotal (line 30 minus line 31)			0	32. 00
22.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES	5)		0	22.00
34. 00	Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)			0	
35. 00	Adjusted reimbursable bad debts (see instructions)			0	35. 00
36.00	Allowable bad debts for dual eligible beneficiaries (see instruc	ctions)		0	
37. 00	Subtotal (see instructions)			0	37. 00
38. 00	MSP-LCC reconciliation amount from PS&R			0	38. 00
39. 00 39. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)			0	39. 00 39. 50
39. 75	N95 respirator payment adjustment amount (see instructions)			0	39. 75
39. 97	Demonstration payment adjustment amount before sequestration			0	39. 97
39. 98	Partial or full credits received from manufacturers for replaced	d devices (see instruc	tions)	0	39. 98
39. 99 40. 00	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			0	39. 99 40. 00
40. 00	Sequestration adjustment (see instructions)			0	40. 00
	Demonstration payment adjustment amount after sequestration			0	40. 02
40. 03	Sequestration adjustment-PARHM pass-throughs				40. 03
	Interim payments			0	41.00
	Interim payments-PARHM Tentative settlement (for contractors use only)			0	41. 01 42. 00
42. 00	Tentative settlement-PARHM (for contractor use only)			U <sub>I</sub>	42. 00
43. 00	Balance due provider/program (see instructions)			0	43. 00
43. 01	Balance due provider/program-PARHM (see instructions)				43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2,	chapter 1,	0	44. 00
	§115. 2 TO BE COMPLETED BY CONTRACTOR				
90. 00	Original outlier amount (see instructions)			0	90. 00
	Outlier reconciliation adjustment amount (see instructions)			0	
92. 00	The rate used to calculate the Time Value of Money			0. 00	
93. 00	Time Value of Money (see instructions)			0	93. 00

Health Financial Systems	Rehabilitation Hospital	of Northern Indi	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-3047	Peri od:	Worksheet E	
			From 05/01/2023		
			To 04/30/2024	Date/Time Prepared:	
				9/9/2024 1:53	pm
		Title XVIII	Hospi tal	PPS	
				1. 00	
94.00 Total (sum of lines 91 and 93)				0	94.00
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				0	200. 00

Part I

From 05/01/2023 04/30/2024 Date/Time Prepared: 9/9/2024 1:53 pm 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 8, 192, 697 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 0 0 3.01 0 0 3.02 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 3.51 0 3.51 0 0 3.52 3.52 0 3.53 3.53 0 0 3.54 0 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 0 0 3.99 3.50-3.98) 8, 192, 697 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 5. 99 0 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 72, 496 0 6.01 6 02 SETTLEMENT TO PROGRAM 0 6.02 7.00 Total Medicare program liability (see instructions) 8, 265, 193 7.00 Contractor NPR Date (Mo/Day/Yr) Number 0 1 00 2 00 8.00 Name of Contractor 8.00

Health Financial Systems	Rehabilitation Hospital	of Northern Indi	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	·	Provider CCN: 15-3047	From 05/01/2023	Worksheet E-3 Part III Date/Time Prepared:

9/9/2024 1:53 pm Title XVIII Hospi tal PPS 1.00 PART III - MEDICARE PART A SERVICES - IRF PPS Net Federal PPS Payment (see instructions) 8, 013, 760 1.00 Medicare SSI ratio (IRF PPS only) (see instructions) 0.0213 2.00 2.00 Inpatient Rehabilitation LIP Payments (see instructions) 359, 016 3.00 3.00 4.00 Outlier Payments 195, 091 4.00 5.00 Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior 0.00 5.00 to November 15, 2004 (see instructions) Cap increases for the unweighted intern and resident FTE count for residents that were displaced by 5.01 0.00 5. 01 program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR  $\S412.424(d)(1)(iii)(F)(1)$  or (2) (see instructions) 6.00 New Teaching program adjustment. (see instructions) 0.00 6.00 7.00 Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new 0.00 7.00 teaching program" (see instructions) 0 00 8 00 Current year's unweighted I&R FTE count for residents within the new program growth period of a "new 8 00 teaching program" (see instructions) 9.00 Intern and resident count for IRF PPS medical education adjustment (see instructions) 0.00 9 00 10.00 Average Daily Census (see instructions) 30. 199454 10.00 Teaching Adjustment Factor (see instructions) 0.000000 11.00 11.00 12.00 Teaching Adjustment (see instructions) 12.00 13.00 Total PPS Payment (see instructions) 8, 567, 867 13.00 14.00 Nursing and Allied Health Managed Care payments (see instruction) 14.00 15.00 Organ acquisition (DO NOT USE THIS LINE) 15.00 16.00 Cost of physicians' services in a teaching hospital (see instructions) 16.00 17.00 Subtotal (see instructions) 8, 567, 867 17.00 18.00 Primary payer payments 18.00 19.00 Subtotal (line 17 less line 18). 8, 567, 867 19 00 20.00 Deducti bl es 75, 744 20.00 21.00 Subtotal (line 19 minus line 20) 8, 492, 123 21.00 22.00 Coi nsurance 63.424 22.00 23.00 Subtotal (line 21 minus line 22) 8, 428, 699 23.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 7, 956 24.00 24.00 25.00 Adjusted reimbursable bad debts (see instructions) 5, 171 25.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 26 00 4 800 26 00 27.00 Subtotal (sum of lines 23 and 25) 8, 433, 870 27.00 Direct graduate medical education payments (from Wkst. E-4, line 49) 28.00 28.00 29.00 Other pass through costs (see instructions) 29.00 0 30 00 Outlier payments reconciliation 30.00 0 31.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 31.00 31.50 Pioneer ACO demonstration payment adjustment (see instructions) 31.50 Recovery of accelerated depreciation. 31.98 31.98 Λ  ${\tt Demonstration}\ \ {\tt payment}\ \ {\tt adjustment}\ \ {\tt amount}\ \ {\tt before}\ \ {\tt sequestration}$ 31 99 0 31 99 Total amount payable to the provider (see instructions) 32.00 8, 433, 870 32.00 32.01 Sequestration adjustment (see instructions) 168, 677 32.01 32.02 32.02 Demonstration payment adjustment amount after sequestration 8, 192, 697 33.00 Interim payments 33 00 34.00 Tentative settlement (for contractor use only) 34.00 Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34) 35.00 72.496 35.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 36.00 0 36.00 TO BE COMPLETED BY CONTRACTOR 50.00 Original outlier amount from Wkst. E-3, Pt. III, line 4 195, 091 50.00 Outlier reconciliation adjustment amount (see instructions) 51.00 0 51.00 52.00 The rate used to calculate the Time Value of Money 0.00 52.00 Time Value of Money (see instructions) 53.00 53.00 0 FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE) 99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 0 000000 99 00 99.01 Calculated Teaching Adjustment Factor for the current year. (see instructions) 0.000000 99.01

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

Provider CCN: 15-3047

Peri od: Worksheet G From 05/01/2023 To 04/30/2024 Date/Time Prepared:

9/9/2024 1:53 pm General Fund Speci fi c Endowment Fund Plant Fund Purpose Fund 1.00 3.00 4.00 2.00 CURRENT ASSETS 1.00 1.00 Cash on hand in banks 6,031,170 0 0 0 Temporary investments 0 0 2.00 0 2.00 3.00 Notes receivable 0 0 0 0 0 3.00 4, 087, 747 0 4 00 4 00 Accounts receivable 0 5.00 Other receivable 24, 624 0 0 5.00 6.00 Allowances for uncollectible notes and accounts receivable 130, 684 6.00 0 7.00 Inventory 126, 268 0 0 7.00 0 8.00 Prepaid expenses 386, 636 0 8.00 0 9.00 Other current assets 0 9.00 10 00 Due from other funds 0 0 0 10 00 10, 787, 129 Total current assets (sum of lines 1-10) 0 0 11.00 0 11 00 FIXED ASSETS 12.00 Land 0 0 0 12.00 Land improvements 0 13.00 0 0 0 0 0 0 0 0 0 0 0 0 0 13.00 οl Accumulated depreciation 14.00 0 14.00 15.00 Bui I di ngs 19, 912, 253 0 0 15.00 Accumulated depreciation 16.00 -1, 141, 542 16.00 0 17.00 Leasehold improvements 17.00 0 C 0 18 00 Accumulated depreciation 0 18 00 Fi xed equipment -191, 065 19.00 19.00 0 20.00 Accumulated depreciation -24, 856 0 20.00 0 Automobiles and trucks 21.00 0 21.00 22.00 Accumulated depreciation 0 22.00 23.00 Major movable equipment 1, 583, 354 0 0 23.00 Accumulated depreciation -976, 338 24.00 24.00 0 25.00 Mi nor equi pment depreci able Λ 25, 00 26.00 Accumulated depreciation C 0 0 26.00 27.00 HIT designated Assets 0 0 0 0 27.00 0 28.00 28.00 Accumulated depreciation 0 0 0 29.00 Mi nor equi pment-nondepreci abl e 0 29.00 30.00 Total fixed assets (sum of lines 12-29) 19, 161, 806 0 30.00 OTHER ASSETS 31 00 Investments 0 n 31 00 0 0 32.00 Deposits on Leases C 0 32.00 Due from owners/officers 0 0 0 33.00 33.00 0 34.00 Other assets 141, 979, 066 0 0 34.00 0 Total other assets (sum of lines 31-34) 141, 979, 066 35.00 0 35, 00 36.00 Total assets (sum of lines 11, 30, and 35) 171, 928, 001 0 0 0 36.00 CURRENT LIABILITIES 37 00 410 588 O 0 n 37 00 Accounts payable 0 0 38.00 Salaries, wages, and fees payable 731, 556 0 38.00 0 Payroll taxes payable 872, 494 0 39.00 39.00 0 40.00 Notes and Loans payable (short term) C 0 40.00 0 0 Deferred income 41 00 41 00 Ω 0 42.00 Accelerated payments 0 42.00 43.00 Due to other funds 0 0 0 43.00 Other current liabilities 153, 491, 919 0 0 44.00 0 44.00 155, <u>506, 557</u> 0 Total current liabilities (sum of lines 37 thru 44) 0 45.00 0 45.00 ONG TERM LIABILITIES 46.00 Mortgage payable 0 46.00 0 0 47.00 Notes payable 0 0 47.00 48 00 Unsecured Loans 0 0 0 48 00 Other long term liabilities 19, 953, 393 0 0 49.00 49.00 0 50 00 Total long term liabilities (sum of lines 46 thru 49) 19, 953, 393 0 0 0 50.00 Total liabilities (sum of lines 45 and 50) 175, 459, 950 51.00 0 0 0 51.00 CAPITAL ACCOUNTS General fund balance 52.00 -3, 531, 949 52.00 53.00 Specific purpose fund 0 53.00 Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted 54.00 0 54.00 55.00 0 55.00 56.00 Governing body created - endowment fund balance 0 56.00 Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement, 57.00 0 57.00 58.00 0 58.00 replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) -3, 531, 949 0 59.00 60.00 Total liabilities and fund balances (sum of lines 51 and 171, 928, 001 0 0 0 60.00

Rehabilitation Hospital of Northern Indi In Lieu of Form CMS-2552-10 Health Financial Systems STATEMENT OF CHANGES IN FUND BALANCES Provi der CCN: 15-3047 Peri od: Worksheet G-1 From 05/01/2023 04/30/2024 Date/Time Prepared: 9/9/2024 1:53 pm General Fund Special Purpose Fund Endowment Fund 1.00 2.00 3.00 4. 00 5. 00 1.00 Fund balances at beginning of period -6, 393, 435 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 2, 861, 487 2.00 3.00 Total (sum of line 1 and line 2) -3, 531, 948 0 3.00 4.00 0 Additions (credit adjustments) (specify) 0 4.00 0 0 0 0 5.00 0 5.00 6.00 6.00 0 7.00 0 7.00 0 8.00 0 8.00 9.00 0 9.00 10.00 Total additions (sum of line 4-9) 10.00 Subtotal (line 3 plus line 10) -3, 531, 948 11.00 11.00 0 12.00 ROUNDI NG 0 12.00 13.00 0000 13.00 14.00 14.00 0 15.00 15.00 0 16.00 0 16.00 17.00 17.00 Total deductions (sum of lines 12-17) 18.00 18.00 Fund balance at end of period per balance -3, 531, 949 19.00 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 Total (sum of line 1 and line 2) 3.00 0 0 3.00 4.00 Additions (credit adjustments) (specify) 4.00 5.00 0 5.00 0 6.00 6.00 7.00 0 7 00 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 0 0 10.00 11.00 Subtotal (line 3 plus line 10) 0 0 11.00 12.00 ROUNDI NG 12.00 13.00 13.00 14.00 0 14.00

0

0

0

0

15.00

16.00

17.00

18.00

19.00

15. 00 16. 00

17.00

18.00

19.00

Total deductions (sum of lines 12-17)

sheet (line 11 minus line 18)

Fund balance at end of period per balance

16, 452, 685

43.00

Worksheet G-2 From 05/01/2023 Parts I & II Date/Time Prepared: 04/30/2024 9/9/2024 1:53 pm Cost Center Description Outpati ent Inpati ent Total 1.00 2. 00 3.00 PART I - PATIENT REVENUES General Inpatient Routine Services 1.00 Hospi tal 11, 055, 000 11, 055, 000 1.00 2.00 SUBPROVIDER - IPF 2.00 3.00 SUBPROVIDER - IRF 3.00 4.00 SUBPROVI DER 4.00 Swing bed - SNF Swing bed - NF 5.00 0 0 5.00 6.00 0 0 6.00 SKILLED NURSING FACILITY 0 7.00 Λ 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) 11, 055, 000 11, 055, 000 10 00 Intensive Care Type Inpatient Hospital Services 11.00 INTENSIVE CARE UNIT 11.00 12.00 CORONARY CARE UNIT 12.00 BURN INTENSIVE CARE UNIT 13 00 13 00 SURGICAL INTENSIVE CARE UNIT 14.00 14.00 15.00 OTHER SPECIAL CARE (SPECIFY) 15.00 Total intensive care type inpatient hospital services (sum of lines 16, 00 0 0 16, 00 11 - 15) 17.00 Total inpatient routine care services (sum of lines 10 and 16) 11, 055, 000 11, 055, 000 17.00 18.00 Ancillary services 12, 473, 341 12, 473, 341 18.00 Outpatient services 19.00 0 0 0 19.00 RURAL HEALTH CLINIC 20.00 0 0 20.00 21.00 FEDERALLY QUALIFIED HEALTH CENTER 0 0 21.00 22. 00 HOME HEALTH AGENCY 0 0 22.00 AMBULANCE SERVICES 23.00 0 23.00 CMHC 24.00 24.00 25.00 AMBULATORY SURGICAL CENTER (D. P.) 25.00 26.00 HOSPI CE 26.00 27.00 OTHER (SPECIFY) 27.00 0 Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. 23, 528, 341 23, 528, 341 28.00 28.00 G-3, line 1) PART II - OPERATING EXPENSES Operating expenses (per Wkst. A, column 3, line 200) 29.00 16, 452, 685 29.00 0 30.00 30.00 ADD (SPECIFY) 0 31.00 31.00 32.00 32.00 0 33.00 33.00 0 34.00 34.00 35.00 35.00 36.00 Total additions (sum of lines 30-35) 0 36.00 0 37.00 DEDUCT (SPECIFY) 37.00 0 38.00 38.00 39.00 0 39.00 40.00 0 40.00 0 41.00 41.00 Total deductions (sum of lines 37-41) 42.00 42.00

Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer

43.00

to Wkst. G-3, line 4)

Health Financial Systems Rehabilitation Hospital of Northern Indi In Lieu of Form CMS-2552-					
STATE	IENT OF REVENUES AND EXPENSES	Provider CCN: 15-3047	Peri od:	Worksheet G-3	
			From 05/01/2023 To 04/30/2024	Date/Time Pre	
				9/9/2024 1: 53	pm
				1 00	
1. 00	Total nations revenues (from What C.2 Dont L. column 2 Lin	20)		1. 00	1. 00
	Total patient revenues (from Wkst. G-2, Part I, column 3, lin			23, 528, 341	•
2.00	Less contractual allowances and discounts on patients' accoun	ıs		4, 230, 276	1
3.00	Net patient revenues (line 1 minus line 2)	42)		19, 298, 065	•
4. 00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		16, 452, 685 2, 845, 380	•
5.00	5.00 Net income from service to patients (line 3 minus line 4)				5. 00
6. 00	OTHER INCOME			0	/ 00
7. 00				1, 582	6. 00 7. 00
				1, 582	•
8.00				0	0.00
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase di scounts			0	1
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			5, 866	•
15.00	Revenue from rental of living quarters			0	
16.00				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			-	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	1 . ,
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
	Rental of vending machines			0	= 00
22. 00	Rental of hospital space			0	22. 00
22 00	Covernmental appropriations			Λ.	1 22 00

24.00

25.00

26.00 27. 00 0 0 28.00 2, 861, 487 29.00

0 23.00

0 24. 50

8, 641

16, 107

2, 861, 487

23.00 Governmental appropriations

24.00 MISC INC
24.50 COVID-19 PHE Funding
25.00 Total other income (sum of lines 6-24)
26.00 Total (line 5 plus line 25)
27.00 OTHER EXPENSES (SPECIFY)
28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)

24. 00 MISC INC