Health Financial SystemsBloomington RegioThis report is required by law (42 USC 1395g; 42 CFR 413.20(b)	). Failure	e to report can resul	t in all interim		
payments made since the beginning of the cost reporting period	being dee	emed overpayments (42	USC 1395g).	OMB NO. 0938-0 EXPIRES 09-30-	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFIC AND SETTLEMENT SUMMARY	CATION Pro	ovider CCN: 15-3049	Period: From 12/17/2021 To 12/31/2022	Worksheet S Parts I-III Date/Time Prep 5/17/2023 3:18	
PART I – COST REPORT STATUS					
Provider 1. [X] Electronically prepared cost report			Date: 5/17/20	23 Time: 3:	18 pm
use only 2. [ ] Manually prepared cost report					
3.[0]If this is an amended report enter the 4.[F]Medicare Utilization. Enter "F" for full	number of I, "L" fo	times the provider re r low, or "N" for no.	esubmitted this co	ost report	
Contractor use only5. [1] Cost Report Status6. Date Received: (1) As Submitted(1) As Submitted7. Contractor No. (2) Settled without Audit8. [N] Initial Report (3) Settled with Audit(3) Settled with Audit9. [N] Final Report (4) Reopened (5) Amended	port for t rt for thi	11.C his Provider CCN 12.[	PR Date: ontractor's Vendo O ]If line 5, co number of tim	or Code: Jumn 1 is 4: Er nes reopened = C	4 nter )-9.
PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINI	STRATOR O	R PROVIDER(S)			
MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINE ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTL ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.	LAW. FUR Y OF A KIO	THERMORE, IF SERVICES CKBACK OR WERE OTHERW	IDENTIFIED IN TH	IIS REPORT WERE	
CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTR/	ATOR OF PR	OVI DER(S)			
I HEREBY CERTIFY that I have read the above certificate electronically filed or manually submitted cost report Statement of Revenue and Expenses prepared by Blooming cost reporting period beginning 12/17/2021 and ending this report and statement are true, correct, complete accordance with applicable instructions, except as not regulations regarding the provision of health care ser report were provided in compliance with such laws and	t and subm gton Regio 12/31/202 and prepa ted. I fur rvices, and regulatio	itted cost report and hal Rehabilitation Ho 2 and to the best of red from the books an ther certify that La d that the services i	I the Balance Shee ospital (15-3049 my knowledge and nd records of the mm familiar with t dentified in this	et and ) for the belief, provider in the laws and	
SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX 2	SLGN	ELECTRONIC		
1	2	I have read and agre		corti fi cati on	1
Caleb Reed	Y	statement. I certify signature on this ce binding equivalent c	that I intend my rtification be th	y electronic ne legally	I
2 Signatory Printed Name Caleb Reed					2

			Title	XVIII			
		Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	175, 009	0	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
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	175, 009	0	0	0	200.00

3

4

CONTROLLER

(Dated when report is electronica

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, Maryl and 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.

3 Signatory Title

4 Date

	AL AND HOSPITAL HEALTH CARE COMPLEX I	DENIFFICATION DATA	Provi c	ier CCN		Period: From 12/17/ To 12/31/		Workshe Part I Date/Ti 5/17/20	me Pre	pare
	1.00	2.00		3.00			4.00			
	Hospital and Hospital Health Care Co	mplex Address:								
00	Street: 3050 N Lintel Drive	P0 Box:								] 1.
00	City: Bloomington	State: IN	Zip Cod	e: 4740	4 Count	y: MONROE				2.
		Component Name	CCN	CBSA	A Provider	Date	Payme	ent Syst	em (P,	
			Number	Numbe	er Type	Certified	T	, 0, or	N)	
							V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Componen	t Identification:							_	
0		Bloomington Regional	153049	1402	0 5	12/17/2021	N	P	P	3
		Rehabilitation Hospital								
0	Subprovider - IPF									4
0	Subprovider – IRF									5
0	Subprovider - (Other)									6
0	Swing Beds - SNF									7
0	Swing Beds - NF									8
0	Hospital-Based SNF									9
00	Hospital-Based NF									10
00	Hospital-Based OLTC									11
00	Hospital-Based HHA									12
00	Separately Certified ASC									13
00	Hospi tal -Based Hospi ce									14
00	Hospital-Based Health Clinic - RHC		1							15
00	Hospital-Based Health Clinic - FQHC			1						16
00	Hospital-Based (CMHC) I									17
00	Renal Dialysis									18
	Other									19
		L	1			From:		То		
						1.00		2. (		1
00	Cost Reporting Period (mm/dd/yyyy)					12/17/20	021	12/31/		20
	Type of Control (see instructions)					4				21
					1.00	2.00		3. (	00	]
	Inpatient PPS Information									
00	Does this facility qualify and is it	3 01 3			N	N				22
	disproportionate share hospital adju			2						
	§412.106? In column 1, enter "Y" fo									
	facility subject to 42 CFR Section §		endment							
	hospital?) In column 2, enter "Y" fo									
01	Did this hospital receive interim UC				N	N				22
	this cost reporting period? Enter in									
	for the portion of the cost reportin									
	1. Enter in column 2, "Y" for yes or		ion of th	ne						
	cost reporting period occurring on o	r after October 1. (see								
	instructions)									
02	Is this a newly merged hospital that				N	N				22
	determined at cost report settlement			umn						
	1, "Y" for yes or "N" for no, for th									
	period prior to October 1. Enter in			no,						
	for the portion of the cost reportin	5 1								
03	Did this hospital receive a geograph				N	N		N		22
	rural as a result of the OMB standar									
	adopted by CMS in FY2015? Enter in c									
	for the portion of the cost reportin			er						
	in column 2, "Y" for yes or "N" for									
	reporting period occurring on or aft									
		100 but not more than 49								
			3. "Y" fo	pr						
	counted in accordance with 42 CFR 41	2.105)? Enter in column	-,							
	counted in accordance with 42 CFR 41 yes or "N" for no.			1						22
04	counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph	ic reclassification from	urban to							
04	counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OMB	ic reclassification from delineations for statis	urban to stical are	eas						
04	counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OMB adopted by CMS in FY 2021? Enter in	ic reclassification from delineations for statis column 1, "Y" for yes or	urban to tical are "N" for	eas no						
04	counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OMB adopted by CMS in FY 2021? Enter in for the portion of the cost reportin	ic reclassification from delineations for statis column 1, "Y" for yes or g period prior to Octobe	urban to tical are "N" for er 1. Ente	eas no						
04	counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OMB adopted by CMS in FY 2021? Enter in for the portion of the cost reportin in column 2, "Y" for yes or "N" for	ic reclassification from delineations for statis column 1, "Y" for yes or g period prior to Octobe no for the portion of th	urban to tical are "N" for er 1. Ente e cost	eas no						
04	counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OMB adopted by CMS in FY 2021? Enter in for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft	ic reclassification from delineations for statis column 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr	urban to tical are "N" for r 1. Ente e cost ructions)	eas no er						
04	counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OMB adopted by CMS in FY 2021? Enter in for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least	ic reclassification from delineations for statis column 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 49	urban to tical are "N" for r 1. Ente le cost uctions) 9 beds (a	eas no er						
04	counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OMB adopted by CMS in FY 2021? Enter in for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41	ic reclassification from delineations for statis column 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 49	urban to tical are "N" for r 1. Ente le cost uctions) 9 beds (a	eas no er						
	counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OMB adopted by CMS in FY 2021? Enter in for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no.	ic reclassification from delineations for statis column 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 49 2.105)? Enter in column	urban to tical are "N" for r 1. Ente e cost ructions) 9 beds (a 13, "Y" f	eas no er as for						
	counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OMB adopted by CMS in FY 2021? Enter in for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Which method is used to determine Me	ic reclassification from delineations for statis column 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 49 2.105)? Enter in column dicaid days on lines 24	urban to tical are "N" for r 1. Ente le cost "uctions) 9 beds (a 3, "Y" 1 and/or 25	eas no er as for		3 N				23
04	counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OMB adopted by CMS in FY 2021? Enter in for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Which method is used to determine Me below? In column 1, enter 1 if date	ic reclassification from delineations for statis column 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 49 2.105)? Enter in column dicaid days on lines 24 of admission, 2 if censu	urban to tical are "N" for rr 1. Ente uctions) 9 beds (a 1 3, "Y" f and/or 25 s days, c	eas no er as for or 3		3 N				23
	counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OMB adopted by CMS in FY 2021? Enter in for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Which method is used to determine Me	ic reclassification from delineations for statis column 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 49 2.105)? Enter in column dicaid days on lines 24 of admission, 2 if censu of identifying the days	urban to tical are "N" for r 1. Ente ructions) 9 beds (a 3, "Y" 1 and/or 25 is days, o in this o	eas no er as for or 3		3 N				23

	TAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider CC	N: 15-3049		i od:	7/2021		ieet S-2	2
					To	m 12/11 12/3	1/2022		ime Pre 2023 3:1	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days 2.00	Out-of State Medicaid paid days	Sta Medi elig unp	c-of ate caid jible paid	Medicai HMO day	d	Other di cai d days	_
. 00	If this provider is an IPPS hospital, enter the	0		3.00		00	5.00	0	<u>6.00</u>	24.
5. 00	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 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.	92	0	0		O		193		25.
		1	1	1	U		ural S			
. 00	Enter your standard geographic classification (not wa	ade) status	at the bec	unning of 1	the	1.0	0 1	2.	00	26.
7.00	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not we reporting period. Enter in column 1, "1" for urban of enter the effective date of the geographic reclassifi	r rural. age) status r "2" for r ication in	at the end ural. If ap column 2.	l of the cos oplicable,	st		1			27.
. 00	If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	to reamun s	periods SC	n status Ir	1		U			35.
					_	Beginn 1. C			i ng: 00	-
. 00	Enter applicable beginning and ending dates of SCH si		cript line	36 for numb	ber					36.
of periods in excess of one and enter subsequent dates. .00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status										37
01	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the accordance with FY 2016 OPPS final rule? Enter "Y" for									37
00	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.									38
					_	Y/I 1. C			/N 00	-
	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 accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii) or "N" for no. (see instructions)	), (İi), or the mileage ii)? Enter	(iii)? Ent requiremen in column 2	er in colum nts in ?"Y" for ye	nn es	N			N	39.
. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob	ber 1. Ente	r "Y" for y			IN			IN	40
	no in column 2, for discharges on or after October 1.	(see inst	ructions)				V	XVIII	XIX	
	Dragnastive Doumant System (DDS) Canital						1.00	2.00		
00	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymen	nt for disp	roporti onat	e share in	accor	dance	N	N	N	45
_	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wks						N	N	N	46
00	Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS of				for		N	N	N	47
	15 LIIIS A NEW NOSPILAI UNUEL 42 CIR 9412. 300(D) FF3 (	capital? F	nter "Y for	ryes or "N'		no.			N	48
00	Is the facility electing full federal capital payment					no.	N	N		1
00 00	Is the facility electing full federal capital payment Teaching Hospitals Is this a hospital involved in training residents in 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 co involved in training residents in approved GME progra and are you are impacted by CR 11642 (or applicable of	t? Enter " approved G "Y" for yes r 27, 2020, olumn 1 is ams in the CRs) MA dir	Y" for yes ME programs or "N" for under 42 C "Y", or if prior year	or "N" for ? For cost no in colu FR 413.78(k this hospit or penultin	no. repor umn 1. o)(2), tal wa nate y	ting For see as /ear,	N N			56
. 00 . 00	Is the facility electing full federal capital payment Teaching Hospitals Is this a hospital involved in training residents in 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 co involved in training residents in approved GME progra	t? Enter " approved G 'Y" for yes r 27, 2020, olumn 1 is ams in the CRS) MA dir er 27, 2020 residents n column 1. cost report e Worksheet applicable R 413.77(e on duty, i	Y" for yes ME programs or "N" for under 42 C "Y", or if prior year ect GME pay , if line 5 in approved If column ing period? E-4. If cc . For cost )(1)(iv) an f the respon	or "N" for S? For cost or o in colu FR 413.78(b this hospin or penultin ment reduct 66, column 2 i GME progra 1 is "Y", co 2 Enter "Y' olumn 2 is ' reporting p od (v), reganse to line	no. reporumn 1. b)(2), tal wanate y tion? I, is ams tr did 'for 'N", berioc ardles e 56 i	ting For see is /ear, Enter yes, -ained yes or is s of s "Y"	N			56

SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DAT	ΓΑ	Provider CC	F	eriod: rom 12/17/2021 o 12/31/2022	Worksheet S-2 Part I Date/Time Pre 5/17/2023 3:1 XVIII XIX	pared:
				1.00		
.00 Are costs claimed on line 100 of Worksheet A? If yes	, compl	ete Wkst. D-2,	Pt. I.	N		59.0
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
			1.00	2.00	3.00	
.00 Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent C adjustment? Enter "Y" for yes or "N" for no in colum	85? (s umn 1. R) NAHE	ee If column 1	N			60. (
	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
.00 Did your hospital receive FTE slots under ACA				0.00		61. C
<ul> <li>section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)</li> <li>.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)</li> </ul>						61. C
.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61. (
<ul> <li>.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)</li> <li>.04 Enter the number of unweighted primary care/or</li> </ul>						61.
surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). .05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's						61.
primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) .06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.
	Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE	
					Count	
.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME		1.00	2.00	3.00	4.00	61.
<ul> <li>FTE unweighted count.</li> <li>Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.</li> </ul>				0.00	0.00	61.2
			1	1	4.00	
ACA Provisions Affecting the Health Resources and Ser	vices A	dmi ni strati on	(HRSA)		1.00	
.00 Enter the number of FTE residents that your hospital	trai ned			od for which	0.00	62.0
your hospital received HRSA PCRE funding (see instruc .01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog	Teachi ram. (s	ee instruction		your hospital	0.00	62. (
Teaching Hospitals that Claim Residents in Nonprovide .00 Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ttings	during this co			N	63. (

lth Financial Systems FPITAL AND HOSPITAL HEAL	TH CARE COMPLE	<u>v</u>	gional Rehabilitatio		Period:	u of Form CMS- Worksheet S-2	
IT THE AND HOST THE HERE		A TELENTITICATION DF		F	rom 12/17/2021 o 12/31/2022	Part I	epared:
				Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
Section 5504 of the				This base year	is your cost r	reporti ng	
period that begins of 00 Enter in column 1, i in the base year per resident FTEs attrib settings. Enter in resident FTEs that t of (column 1 divideo	f line 63 is y riod, the numbe outable to rota column 2 the r crained in your	res, or your facili er of unweighted no utions occurring in umber of unweighter hospital. Enter in	ty trained residents n-primary care all nonprovider d non-primary care n column 3 the ratio		D 0. OC	0. 000000	64.0
		Program Name	Program Code	Unweighted	Unweighted	Ratio (col. 3/	/
				FTES	FTEs in	(col. 3 + col.	
				Nonprovi der	Hospi tal	4))	
		1.00	2.00	Si te 3. 00	4.00	5.00	-
00 Enter in column 1,	ifline 63	1.00	2.00	0.00			) 65 (
is yes, or your faci trained residents in year period, the pro associated with prin FTEs for each primar program in which you residents. Enter in the program code. Er column 3, the number unweighted primary of residents attributat rotations occurring non-provider setting column 4, the number unweighted primary of resident FTEs that t your hospital. Enter 5, the ratio of (col di vided by (column 3 4)). (see instruction	the base bgram name hary care by care in trained column 2, hter in of care FTE ble to in all gs. Enter in of care crained in in column umn 3 s + column			Unweighted	Unweighted	Ratio (col. 1/	
				FTEs Nonprovider Site 1.00	FTEs in Hospital	(col. 1 + col. 2)) 3.00	
Section 5504 of the	ACA Current Ye	ar FTE Residents i	n Nonprovider Setti				
beginning on or afte				.go 211001110 1	01 000t 1 opoi ti	ng por roue	
00 Enter in column 1 th FTEs attributable to Enter in column 2 th FTEs that trained in (column 1 divided by	o rotations occ ne number of un n your hospital	urring in all nonpo weighted non-prima . Enter in column 3	rovider settings. ry care resident 3 the ratio of	0.00	0. 00	0. 000000	0 66.0
		Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	-
00 Enter in column 1, t	he program		2.00	0.00			67.
name associated with your primary care pr which you trained re Enter in column 2, t code. Enter in colum number of unweighted care FTE residents a to rotations occurri non-provider setting column 4, the number unweighted primary oc resident FTEs that t your hospital. Enter 5, the ratio of (col	rograms in esidents. the program in 3, the d primary sttributable ng in all is. Enter in of care crained in						

	Financial Systems Bloomington Regional Rehabil AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Prov		N: 15-3049 P F	lr eriod: rom 12/17/ o 12/31/	2021	u of For Workshe Part I Date/Ti 5/17/20	et S-2 me Pre	pared:
					ŀ	1.0	0	
68.00	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 4 For a cost reporting period beginning prior to October 1, 2022, die MAC to apply the new DGME formula in accordance with the FY 2023 II (August 10, 2022)?	d you ob	tain permissio	on from you		N		68.00
					1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does i	it conta	in an IPF sub	provi der?	N			70.00
71.00	Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approved GME recent cost report filed on or before November 15, 2004? Enter "Y 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train res program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y Column 3: If column 2 is Y, indicate which program year began durin (see instructions)	teachin "forye sidents "forye	g program in s s or "N" for i in a new teacl s or "N" for i	the most no. (see ning no.			0	71.00
75.00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or doe	es it co	ntain an IRF		Y			75.00
	subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME recent cost reporting period ending on or before November 15, 2004' no. Column 2: Did this facility train residents in a new teaching µ CFR 412.424 (d)(1)(ii)(D)? Enter "Y" for yes or "N" for no. Column indicate which program year began during this cost reporting period	? Enter program n 3: lf	"Y" for yes ou in accordance column 2 is Y,	r "N" for with 42	Ν	N	0	76.00
					-	1.0	0	
<u>0000</u>	Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes and "I	N" for n	0			N		80.00
	Is this a LTCH co-located within another hospital for part or all of "Y" for yes and "N" for no. TEFRA Providers			period? Er	nter	N		81.00
86.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA Did this facility establish a new Other subprovider (excluded unit) §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				no.	N		85. 00 86. 00
87.00	Is this hospital an extended neoplastic disease care hospital class 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	sified u	nder section			N		87.00
				Approved Permane Adjustme (Y/N) 1.00	ent ent	Numbe Appro Perma Adjust	nved nent ments	
	Column 1: Is this hospital approved for a permanent adjustment to amount per discharge? Enter "Y" for yes or "N" for no. If yes, com 89. (see instructions)						0	88.00
	Column 2: Enter the number of approved permanent adjustments.		Wkst. A Line	Effecti ve	Date	Appro	ved	
			No.			Perma Adjust Amount Disch	nent ment Per	
89.00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line nur	mber	1.00	2.00		3. C		89.00
	on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting perior beginning date) for the permanent adjustment to the TEFRA target an per discharge.	d mount	0.00				0	07.00
	Column 3: Enter the amount of the approved permanent adjustment to TEFRA target amount per discharge.	tne						
				V 1.00		2. C		
	Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital servi	ices? En	ter "Y" for	N		N		90.00
	yes or "N" for no in the applicable column.							
92.00	Is this hospital reimbursed for title V and/or XIX through the cos full or in part? Enter "V" for yes or "N" for no in the applicable Are title XIX NF patients occupying title XVIII SNF beds (dual cer instructions) Enter "V" for yes or "N" for no in the applicable col	column. tificati		N		N N		91. 00 92. 00
	instructions) Enter "Y" for yes or "N" for no in the applicable col Does this facility operate an ICF/IID facility for purposes of tit		XIX? Enter	N		Ν		93.00
94.00	"Y" for yes or "N" for no in the applicable column. Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N"	" for no	in the	N		N		94.00
96.00	applicable column. If line 94 is "Y", enter the reduction percentage in the applicable Does title V or XIX reduce operating cost? Enter "Y" for yes or "N"			0. 00 N		0. C N		95. 00 96. 00
	applicable column. If line 96 is "Y", enter the reduction percentage in the applicable	e column		0.00		0.0	0	97.00

Health Financial Systems         Bloomington Regional Rehabilitation           HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA         Provider CC	N: 15-3049 P F	 eriod: rom 12/17/2021 o 12/31/2022	u of Form CMS Worksheet S- Part I Date/Time Pr	2 repared:
		V	5/17/2023 3: XI X	<u>18 pm</u>
		1.00	2.00	
98.00 Does title V or XIX follow Medicare (title XVIII) for the interns and resi stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" column 1 for title V, and in column 2 for title XIX.		Y	Y	98.00
98.01 Does title V or XIX follow Medicare (title XVIII) for the reporting of cha C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in title XIX.		Y	Y	98.01
98.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of c bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no i for title V, and in column 2 for title XIX.		Y	Y	98.02
98.03 Does title V or XIX follow Medicare (title XVIII) for a critical access ho reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for r for title V, and in column 2 for title XIX.		N	N	98.03
98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101 outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for in column 2 for title XIX.	l% of title V, and	N	N	98.04
98.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE dis Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for ti column 2 for title XIX.		Y	Y	98. 05
98.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V column 2 for title XIX.		Y	Y	98.06
Rural Providers			<u> </u>	
105.00 Does this hospital qualify as a CAH? 106.00 If this facility qualifies as a CAH, has it elected the all-inclusive meth for outpatient services? (see instructions)	nod of payment	N		105.00 106.00
107.00 Column 1: If line 105 is Y, is this facility eligible for cost reimburseme training programs? Enter "Y" for yes or "N" for no in column 1. (see inst Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train L&Rs approved medical education program in the CAH's excluded IPF and/or IRF u	tructions) s in an			107.00
Enter "Y" for yes or "N" for no in column 2. (see instructions) 108.00 Is this a rural hospital qualifying for an exception to the CRNA fee sched CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	dule? See 42	N		108.00
Physi cal	Occupational	Speech	Respi ratory	_
1.00         109.00       If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	2.00	3.00	4.00	109.00
			1.00	_
110.00 Did this hospital participate in the Rural Community Hospital Demonstratic Demonstration)for the current cost reporting period? Enter "Y" for yes or complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, li applicable.	"N" for no. It	° yes,	N	110.00
				_
111.00 If this facility qualifies as a CAH, did it participate in the Frontier Co Health Integration Project (FCHIP) demonstration for this cost reporting p "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, e integration prong of the FCHIP demo in which this CAH is participating in Enter all that apply: "A" for Ambulance services; "B" for additional beds; for tele-health services.	period? Enter enter the column 2.	1.00 N	2.00	111.00
	1.00	2.00	3.00	-
112.00 Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N	2.00		112.00
113.00 Did this hospital participate in the Community Health Access and Rural Transformation (CHART) model for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no. Miscellaneous Cost Reporting Information				113.00
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N			0115.00
116.00 Is this facility classified as a referral center? Enter "Y" for yes or	N			116.00
"N" for no. 117.00 s this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00 Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	0			118. 00

ILTH Financial Systems SPITAL AND HOSPITAL HEALTH CARE COMPLE:		egional Rehabilitatic ATA Provider	CCN: 15-3049	Peri od:	ieu of Form CM Worksheet S	
				From 12/17/202 To 12/31/202	22 Date/Time F	
			Premi ums	Losses	5/17/2023 3	
3.01 List amounts of malpractice premiu	me and naid lossos		1.00	2.00	3.00	0118.
						0110.
3.02 Are malpractice premiums and paid	Lossos roportod in	a cost contor other	than the	1.00 N	2.00	118.
Administrative and General? If ye and amounts contained therein.				N		
9.00 DO NOT USE THIS LINE 0.00 DO NOT USE THIS LINE 0.00 Is this a SCH or EACH that qualifi §3121 and applicable amendments? ( "N" for no. Is this a rural hospit Hold Harmless provision in ACA §31 Enter in column 2, "Y" for yes or	see instructions) al with < 100 beds 21 and applicable	Enter in column 1, " that qualifies for	Y" for yes or the Outpatient		N	119. 120.
1.00 Did this facility incur and report	costs for high co	ost implantable devic	es charged to	N		121.
patients? Enter "Y" for yes or "N" 2.00Does the cost report contain healt Act?Enter "Y" for yes or "N" for n	hcare related taxe o in column 1. If	column 1 is "Y", ent				122.
the Worksheet A line number where 3.00Did the facility and/or its subpro			si onal			123.
services, e.g., legal, accounting, management/consulting services, fr	tax preparation,	bookkeeping, payroll	, and/or			
for yes or "N" for no.	om an unrerated or	gam zation? in colum	in i, enter i			
lf column 1 is "Y", were the major professional services expenses, fo						
located in a CBSA outside of the m "N" for no.	ain hospital CBSA?			-		_
<u>Certified Transplant Center Inform</u> 5.00 Does this facility operate a Medic	are-certified tran		"Y" for yes	N		125.
and "N" for no. If yes, enter cert 5.00 f this is a Medicare-certified ki			tification dat	e		126.
in column 1 and termination date,	if applicable, in	column 2.				
7.00 f this is a Medicare-certified he in column 1 and termination date,			incation date	2		127.
3.00 f this is a Medicare-certified li in column 1 and termination date,			ification date	9		128.
9.00 If this is a Medicare-certified lu	ng transplant prog	ram, enter the certi	fication date			129.
in column 1 and termination date, 0.00 f this is a Medicare-certified pa			erti fi cati on			130.
date in column 1 and termination d	ate, if applicable	e, in column 2.				
1.00  f this is a Medicare-certified in date in column 1 and termination d			e certification	1		131.
2.00 If this is a Medicare-certified is			ification date	2		132.
in column 1 and termination date, 3.00 Removed and reserved	ir applicable, in	column 2.				133.
4.00 If this is a hospital-based organ in column 1 and termination date, All Providers			the OPO number	-		134.
D. 00 Are there any related organization chapter 10? Enter "Y" for yes or " are claimed, enter in column 2 the	N" for no in colum	n 1. If yes, and hom number. (see instru	ne office costs		HB1609	140.
1.00 If this facility is part of a chai	n organization, er	2.00 nter on lines 141 thr	rough 143 the	3.00 name and addres	s of the	
home office and enter the home off	<u>ice contractor nam</u>	ne and contractor num	nber.			1 4 4
.00 Name: ERNEST HEALTH INC 2.00 Street:1024 N GALLOWAY AVE	PO Box:	Name: NOVITAS SOLUTIO	JNS Contract	or's Number: 04	1011	141. 142.
3.00 City: MESQUITE	State:	TX	Zi p Code	e: 75	5149	143.
					1.00	
4.00 Are provider based physicians' cos	ts included in Wor	ksheet A?			N	144.
				1.00	2.00	
5.00 If costs for renal services are cl						145.
inpatient services only? Enter "Y" no, does the dialysis facility inc	lude Medicare util	ization for this cos				
period? Enter "Y" for yes or "N" 5.00Has the cost allocation methodolog	for no in column 2	2.		NI		146.
a voltas the cost allocation methodolog	v changed from the	N DEPUTUUSIV FLIER CO	IST THOUTT?	N	1	1146

HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA		Provider CC	N: 15-3049		eriod: rom 12/17/20: p 12/31/20:		repared:
							1.00	
147.00Was there a change in the statisti	cal basis? Enter "Y" f	for ves	or "N" for	no.			N	147.00
148.00Was there a change in the order of							N	148.00
149.00Was there a change to the simplifi	ed cost finding method	d? Enter	- "Y" for y∈	s or "N"	for n	10.	N	149.00
			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 ' 55.00Hospital	N FOF NO FOF each cor	mponent	N	and Part N	B. (3	N	N	155. 0
56. 00 Subprovi der – TPF			N	N N		N	N	156.0
57.00 Subprovider - IRF			N	N		N	N	157.0
58. OO SUBPROVI DER								158.0
59.00 SNF			Ν	N		N	N	159.0
60.00 HOME HEALTH AGENCY			Ν	N		N	N	160. 0
61. 00 CMHC				N		N	N	161. 0
								_
Multicampus							1.00	_
65.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	impus hospital that has	s one or	r more campu	ıses in di	ffere	ent CBSAs?	N	165. 0
	Name	(	County	State	Zip	Code CBSA	FTE/Campus	
	0		1.00	2.00	3.	00 4.00		
66.00 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)							0.1	00 166. 0
							1.00	-
Health Information Technology (HI	) incentive in the Ame	erican I	Recovery and	d Reinvest	tment	Act		
67.00 is this provider a meaningful user 68.00 if this provider is a CAH (line 10 reasonable cost incurred for the H	05 is "Y") and is a mea	ani ngful				enter the	N	167. 0 168. 0
68.01 If this provider is a CAH and is r exception under §413.70(a)(6)(ii)	not a meaningful user, 'Enter "Y" for yes or	does th "N" for	no. (see i	nstructio	ons)			168. 0
69.00 If this provider is a meaningful utransition factor. (see instruction		and is	not a CAH (	line 105	is "N	l"), enter th	e 0.	00169. 0
						Begi nni ng	Endi ng	
1						1.00	2.00	
70.00 Enter in columns 1 and 2 the EHR b period respectively (mm/dd/yyyy)	beginning date and endi	ing date	e for the re	eporting				170. 0
						1.00	2.00	_
71.00 If line 167 is "Y", does this prov	ider have any days for	r indivi	duals enrol	led in		1.00	2.00	0171.0
section 1876 Medicare cost plans n "Y" for yes and "N" for no in colu 1876 Medicare days in column 2. (s	reported on Wkst. S-3, mn 1. If column 1 is y	Pt. I,	line 2, col	. 6? Ente		14		

OSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-3049	Peri od:	Worksheet S-	2
				From 12/17/2021 To 12/31/2022	Part II Date/Time Pr 5/17/2023 3:	
				Y/N	Date	
				1.00	2.00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSE General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS			er all dates in t	he	_
	Provider Organization and Operation					
. 00	Has the provider changed ownership immediately prior to the			N		1.0
	reporting period? If yes, enter the date of the change in c	column 2. (see	Y/N	Date	V/I	
			1.00	2.00	3.00	
. 00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.		N			2.0
. 00	Is the provider involved in business transactions, includir contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug der or its of the board	Y			3.0
		-	Y/N	Туре	Date	
			1.00	2.00	3.00	
. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	°or Compiled,	Y	A		4.0
. 00	Are the cost report total expenses and total revenues diffe		N			5.0
	those on the filed financial statements? If yes, submit rec	conciliation.		V /N	Logal Open	-
				Y/N 1.00	Legal Oper. 2.00	-
	Approved Educational Activities			1.00	2.00	
. 00	Column 1: Are costs claimed for a nursing program? Column the legal operator of the program?	-	s the provider			6.0
. 00 . 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions.		ved during the	e N		7.0 8.0
. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction	is.		Ν		9.0
0. 00	Was an approved Intern and Resident GME program initiated c cost reporting period? If yes, see instructions.	or renewed in 1	the current	N		10.0
1. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N		11.0
					Y/N 1.00	
	Bad Debts				1.00	
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p			ost reporting	Y N	12. C
4.00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsura instructions.	ance amounts wa	aived? If yes,	see	Ν	14.0
5 00	Bed Complement Did total beds available change from the prior cost reporti	ng poriod2 lf	vos soo inst	ructions	N	15.0
5.00	The form beds available change from the piror cost report		rt A	Par		15.0
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
6. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through	Y	04/21/2023	Y	04/21/2023	16.0
7.00	date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If	Ν		Ν		17. C
8. 00	either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18.0
0.00	Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.					
9.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19. (

	Financial Systems Bloomington Regional AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNALRE	Provider CCN:		Period: From 12/17/2021 To 12/31/2022	Worksheet S Part II Date/Time P 5/17/2023 3	repare
		Descript	i on	Y/N	Y/N	
		0		1.00	3.00	
. 00	If line 16 or 17 is yes, were adjustments made to PS&R			N	N	20
	Report data for Other? Describe the other adjustments:					
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
. 00	Was the cost report prepared only using the provider's	N		N		21
	records? If yes, see instructions.					
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS HOSE	PI TALS)			
	Capital Related Cost					
00	Have assets been relifed for Medicare purposes? If yes, see	e instructions				22
00	Have changes occurred in the Medicare depreciation expense		s made dui	ring the cost		23
	reporting period? If yes, see instructions.			0		
00	Were new leases and/or amendments to existing leases entere	ed into during thi	s cost re	eporting period?		24
	If yes, see instructions	C C				
00	Have there been new capitalized leases entered into during	the cost reportin	ng periodí	?lfyes, see		25
	instructions.					
00	Were assets subject to Sec. 2314 of DEFRA acquired during th	ne cost reporting	period? I	fyes, see		26
	instructions.					
00	Has the provider's capitalization policy changed during the	e cost reporting p	period? It	f yes, submit		27
	сору.					
	Interest Expense					
00	Were new loans, mortgage agreements or letters of credit en	ntered into during	g the cost	t reporting		28
	period? If yes, see instructions.					
00	Did the provider have a funded depreciation account and/or		Servi ce l	Reserve Fund)		29
	treated as a funded depreciation account? If yes, see instr					
00	Has existing debt been replaced prior to its scheduled matu	urity with new deb	ot? If yes	s, see		30
	instructions.					
00	Has debt been recalled before scheduled maturity without is	ssuance of new deb	ot? If yes	s, see		31
	instructions.					_
	Purchased Services					
00	Have changes or new agreements occurred in patient care ser		through co	ontractual		32
	arrangements with suppliers of services? If yes, see instru					
00	If line 32 is yes, were the requirements of Sec. 2135.2 app	blied pertaining f	to competi	tive bidding? If		33
	no, see instructions.					_
~ ~	Provi der-Based Physi ci ans			0		_
00	Were services furnished at the provider facility under an a	arrangement with p	provi der-t	based physicians?		34
	If yes, see instructions.					
00	If line 34 is yes, were there new agreements or amended exi		with the	provi der-based		3!
	physicians during the cost reporting period? If yes, see in	ISTRUCTIONS.		V /N	Data	
				Y/N 1.00	Date	_
	Home Office Costs			1.00	2.00	_
00						- 24
	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pr	constant by the bar		2		30
00	5 .	epareu by the hor		:		3
00	If yes, see instructions.	fice different for	m that at	F		38
00	If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end					30
00	If line 36 is yes, did the provider render services to othe					39
50	see instructions.					33
00	If line 36 is yes, did the provider render services to the	home office? If	VAS SAA			40
50	instructions.	Home Office: II	JC3, 300			40
		1.00		2	00	
	Cost Report Preparer Contact Information	1.00		۷.		
	· · · ·	Mary		Pi tcock		41
00				IT COOK		-
00	held by the cost report preparer in columns 1, 2, and 3					
00	held by the cost report preparer in columns 1, 2, and 3, respectively.					
	respectivel y.	FRNEST HEALTH INC				1 43
00	respectively. Enter the employer/company name of the cost report	ERNEST HEALTH INC	;			42
00	respectively. Enter the employer/company name of the cost report preparer.	ERNEST HEALTH INC	;	marykay@ernest	health com	42

Heal th	Financial Systems	Bloomington Regional	Rehabilita	ation Hosp		In Lieu	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSE	MENT QUESTI ONNAI RE	Provi c	ler CCN: 15-3049		i od:	Worksheet S-2	
					То	0m 12/17/2021 12/31/2022		pared: 8 pm
				3.00				
	Cost Report Preparer Contact Informat	i on						
41.00	Enter the first name, last name and <sup>.</sup>	the title/position	Rei mburser	ment Manager				41.00
	held by the cost report preparer in a	columns 1, 2, and 3,						
	respecti vel y.							
42.00	Enter the employer/company name of the	ne cost report						42.00
	preparer.							
43.00	Enter the telephone number and email	address of the cost						43.00
	report preparer in columns 1 and 2, 1	respecti vel y.						

OSPI I	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	CN: 15-3049	Period: From 12/17/2021 To 12/31/2022	Worksheet S-3 Part I Date/Time Pre 5/17/2023 3:13	pared
	Component	Worksheet A	No. of Beds	Bed Days Avai I abl e		I/P Days / O/P Visits / Trips Title V	
		Line No. 1.00	2.00	3. 00	4.00	5.00	<u> </u>
	PART I - STATISTICAL DATA	1.00	2.00	0.00	1.00	0.00	
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30. 00	40	15, 2	0. 00	0	1.(
. 00 . 00	HMO and other (see instructions) HMO IPF Subprovider						2. 3.
. 00 . 00 . 00 . 00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation		40	15, 2	0. 00	0 0 0	4. ( 5. ( 6. ( 7. (
. 00 . 00 0. 00 1. 00 2. 00	beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						8. ( 9. ( 10. ( 11. ( 12. ( 13. (
3.00 4.00 5.00 6.00 7.00 8.00	NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER		40	15, 24	0. 00	0 0	13. 14. 15. 16. 17. 18.
9.00 9.00 0.00	SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE	44.00	0		0	0	10. 19. 20. 21.
. 00 . 00 . 00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P. ) HOSPICE	101. 00				0	22. 23. 24.
. 10 . 00 . 00	HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC	30.00					24. 25. 26.
. 25 . 00 . 00 . 00	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips	89.00	40			0	26. 27. 28. 29.
00 00 00 00	Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary Labor & delivery room		Ο		0		30. 31. 32. 32.
. 00 . 01	outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges						33 33

PITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC		Provider CC		Period: From 12/17/2021 To 12/31/2022	Date/Time Pre 5/17/2023 3:1	par
	I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Payrol I	
	6.00	7.00	8.00	9.00	10.00	
PART I - STATISTICAL DATA Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	3, 338	92	6, 43	33		1
0 HMO and other (see instructions) 0 HMO IPF Subprovider	1, 147 0	493 0				2
0 HMO IRF Subprovider 0 Hospital Adults & Peds. Swing Bed SNF 0 Hospital Adults & Peds. Swing Bed NF	0 0	0 0 0		0		4
<ul> <li>Integrite Adults and Peds. (exclude observation beds) (see instructions)</li> <li>INTENSIVE CARE UNIT</li> <li>CORONARY CARE UNIT</li> </ul>	3, 338	92	6, 43	33		8
0 EURNIART CARE UNIT 00 BURN INTENSIVE CARE UNIT 00 SURGICAL INTENSIVE CARE UNIT 00 OTHER SPECIAL CARE (SPECIFY) 00 NURSERY						1( 11 12 13
00 Total (see instructions) 00 CAH visits 00 SUBPROVIDER - IPF 00 SUBPROVIDER - IRF	3, 338 0	92 0	6, 43	0. 00 0	71.24	1 1 1 1 1
00 SUBPROVIDER 00 SKILLED NURSING FACILITY 00 NURSING FACILITY 00 OTHER LONG TERM CARE	0	0		0 0.00	0.00	1 1 2 2
00 HOME HEALTH AGENCY 00 AMBULATORY SURGICAL CENTER (D. P. ) 00 HOSPICE	0	0		0 0.00	0.00	
10 HOSPICE (non-distinct part) 00 CMHC - CMHC 00 RURAL HEALTH CLINIC				0		24 2! 20
25 FEDERALLY QUALIFIED HEALTH CENTER 20 Total (sum of lines 14-26) 20 Observation Bed Days	0	0		0 0.00 0.00 0.00		2
00 Ambulance Trips 00 Employee discount days (see instruction) 00 Employee discount days - IRF	0	Ū		0		20
00 Labor & delivery days (see instructions) 01 Total ancillary labor & delivery room outpatient days (see instructions)	0	0		0		3:
00 LTCH non-covered days 01 LTCH site neutral days and discharges 00 Temporary Expansion COVID-19 PHE Acute Care	0 0 0	0		0		3

OSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC		Provider C		Period: From 12/17/2021 To 12/31/2022	Worksheet S-3 Part I Date/Time Pre 5/17/2023 3:1	pare
		Full Time		Di s	charges		
		Equivalents			T: 11 - 21 2	T 1 1 411	
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I – STATISTICAL DATA	11.00	12.00	10.00	11.00	10.00	
00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	24	45 6	449	1 1.
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
00	HMO and other (see instructions)				77 34		2
00	HMO IPF Subprovider				0		3
00	HMO IRF Subprovider				0		4
00	Hospital Adults & Peds. Swing Bed SNF						5
00	Hospital Adults & Peds. Swing Bed NF						6
00	Total Adults and Peds. (exclude observation						7
	beds) (see instructions)						
00	INTENSIVE CARE UNIT						8
00	CORONARY CARE UNI T						9
0. 00	BURN INTENSIVE CARE UNIT						10
I. 00	SURGICAL INTENSIVE CARE UNIT						11
2.00	OTHER SPECIAL CARE (SPECIFY)						12
3.00	NURSERY		_				13
1.00	Total (see instructions)	0.00	0	24	45 6	449	
5.00	CAH visits						15
5.00	SUBPROVIDER - IPF						16
7.00	SUBPROVIDER - IRF						17
3.00	SUBPROVI DER	0.00					18
9.00	SKILLED NURSING FACILITY	0.00					19
0.00	NURSING FACILITY						20
1.00	OTHER LONG TERM CARE	0.00					21
2.00	HOME HEALTH AGENCY	0.00					22
3.00 1.00	AMBULATORY SURGICAL CENTER (D. P. ) HOSPICE						23
4.00 4.10	HOSPICE HOSPICE (non-distinct part)						24
5.00	CMHC - CMHC						24
5.00	RURAL HEALTH CLINIC						26
5.00 5.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26
7.00	Total (sum of lines 14-26)	0.00					20
3.00	Observation Bed Days	0.00					28
9.00	Ambul ance Trips						29
). 00	Employee discount days (see instruction)						30
1.00	Employee discount days (see fisting to the second s						31
2.00	Labor & delivery days (see instructions)						32
2.00	Total ancillary labor & delivery room						32
	outpatient days (see instructions)						52
3. 00	LTCH non-covered days				0		33
3.01	LTCH site neutral days and discharges				0		33
	Temporary Expansi on COVID-19 PHE Acute Care				~		34

Heal th	Financial Systems Bloomin	igton Regional Re	ehabilitation	Hosp	In Lie	u of Form CMS-:	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider C		Period:	Worksheet A	
					From 12/17/2021		
					To 12/31/2022	Date/Time Pre 5/17/2023 3:1	
	Cost Center Description	Sal ari es	Other	Total (col 1	Recl assi fi cati	Reclassi fi ed	
	cost center bescription	Salaries	other	+ col. 2)	ons (See A-6)	Trial Balance	
				+ (01. 2)	UII3 (JEE A-U)	(col. 3 +-	
						col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS		2100	0.00		0100	
1.00	00100 CAP REL COSTS-BLDG & FIXT		1,048,672	1, 048, 67	2 52, 491	1, 101, 163	1 1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		2,012,788			2, 016, 770	
3.00	00300 OTHER CAP REL COSTS		56, 473				
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	354, 696	686, 412			1, 041, 108	
5.00	00500 ADMINI STRATI VE & GENERAL	1, 505, 570	1, 287, 112			2, 792, 682	
7.00	00700 OPERATION OF PLANT	61, 678	451, 240			512, 918	•
8.00	00800 LAUNDRY & LINEN SERVICE	0	21, 209			21, 209	
9.00	00900 HOUSEKEEPI NG	77, 121	69, 576			146, 697	•
10.00	01000 DI ETARY	286, 561	214, 736			501, 297	
13.00	01300 NURSI NG ADMI NI STRATI ON	299, 302	30, 664			329, 966	•
16.00	01600 MEDICAL RECORDS & LIBRARY	84,006	12, 464			96, 470	
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	01,000	12, 101	,0, 11	<u> </u>	70, 170	10.00
30.00	03000 ADULTS & PEDIATRICS	1, 768, 033	957, 309	2, 725, 34	2 0	2, 725, 342	30.00
44.00	04400 SKILLED NURSING FACILITY	0	0		0 0		44.00
	ANCI LLARY SERVICE COST CENTERS	-1				-	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	31, 400	31, 40	0 -1, 740	29, 660	54.00
57.00	05700 CT SCAN	0	0		1,740	1, 740	57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 0	0	58.00
60.00	06000 LABORATORY	0	67, 376	67, 37	6 0	67, 376	60.00
65.00	06500 RESPI RATORY THERAPY	94, 359	39, 749			134, 108	•
66.00	06600 PHYSI CAL THERAPY	426, 424	31,007	457, 43	1 -15, 447	441, 984	66.00
67.00	06700 OCCUPATI ONAL THERAPY	351,065	15, 133	366, 19	8 17, 812	384, 010	67.00
68.00	06800 SPEECH PATHOLOGY	161, 245	15, 613			183, 535	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	45,025	107, 651	152, 67	6 0	152, 676	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	184, 925	166, 947	351, 87	2 0	351, 872	73.00
74.00	07400 RENAL DIALYSIS	0	-2,000			-2,000	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	-5, 494	-5, 49	4 0	-5, 494	76.00
	OUTPATIENT SERVICE COST CENTERS			•			1
91.00	09100 EMERGENCY	0	0		0 0	0	91.00
91.01	04951 OUTPATI ENT THERAPY	8, 222	820	9, 04	2 -9, 042	0	91.01
93.00	04950 OUTPATIENT WOUND CENTER	О	0		0 0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0	0		0 C	0	95.00
101.00	10100 HOME HEALTH AGENCY	0	0		0 0	0	101.00
	SPECIAL PURPOSE COST CENTERS						
117.00	06950 OTHER SPECIAL PURPOSE COST CENTERS	0	0		0 0	0	117.00
118.00		5, 708, 232	7, 316, 857	13, 025, 08	9 0	13, 025, 089	118.00
	NONREI MBURSABLE COST CENTERS						
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0		0 0		192.00
	07950 MARKETI NG	0	0		0 C		194.00
	07951 OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0		194. 01
200.00	TOTAL (SUM OF LINES 118 through 199)	5, 708, 232	7, 316, 857	13, 025, 08	9 0	13, 025, 089	200. 00

RECLASS	IFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CC	CN: 15-3049	Period: From 12/17/2021 To 12/31/2022	Worksheet A Date/Time Pr 5/17/2023 3:	epared: 18 pm
	Cost Center Description	Adjustments	Net Expenses				
			For Allocation				
		6.00	7.00				
	GENERAL SERVICE COST CENTERS	444.000	1 01 ( 055				
	00100 CAP REL COSTS-BLDG & FIXT	114, 892					1.00
	00200 CAP REL COSTS-MVBLE EQUIP	-6, 766					2.00
	00300 OTHER CAP REL COSTS	0	0				3.00
	00400 EMPLOYEE BENEFITS DEPARTMENT	-8, 820	1, 032, 288				4.00
	00500 ADMINISTRATIVE & GENERAL	900, 500	3, 693, 182				5.00
	DO700 OPERATION OF PLANT	-12, 131	500, 787				7.00
	DO800 LAUNDRY & LINEN SERVICE	0	21, 209				8.00
9.00 0	00900 HOUSEKEEPI NG	0	146, 697				9.00
10.00 0	D1000 DI ETARY	-24, 472	476, 825				10.00
13.00 0	01300 NURSING ADMINISTRATION	0	329, 966				13.00
16.00 C	01600 MEDICAL RECORDS & LIBRARY	- 3	96, 467				16.00
	NPATIENT ROUTINE SERVICE COST CENTERS		· · · · ·				
30.00	03000 ADULTS & PEDI ATRI CS	-533	2, 724, 809				30,00
44. 00 C	04400 SKILLED NURSING FACILITY	0					44.00
	NCILLARY SERVICE COST CENTERS						
	05400 RADI OLOGY-DI AGNOSTI C	0	29, 660				54.00
	05700 CT SCAN	0	1, 740				57.00
	D5800 MAGNETIC RESONANCE I MAGING (MRI)	0	0				58.00
	06000 LABORATORY	0	67, 376				60,00
	06500 RESPI RATORY THERAPY	-104	134,004				65.00
	06600 PHYSI CAL THERAPY	0	441, 984				66.00
	06700 OCCUPATI ONAL THERAPY	0	384, 010				67.00
	06800 SPEECH PATHOLOGY	0	183, 535				68.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-1, 254	151, 422				71.00
	07300 DRUGS CHARGED TO PATIENTS	-1,234	351, 872				73.00
	07400 RENAL DIALYSIS	2,000	331, 872				74.00
		6,000	506				76.00
	03950 OTHER ANCI LLARY SERVICE COST CENTERS	6,000	500				/0.00
	DUTPATIENT SERVICE COST CENTERS	0	0				91.00
		0					
	04951 OUTPATIENT THERAPY	0	0				91.01
	04950 OUTPATIENT WOUND CENTER	0	0				93.00
	THER REIMBURSABLE COST CENTERS	-	-				
	09500 AMBULANCE SERVICES	0					95.00
	10100 HOME HEALTH AGENCY	0	0				101.00
	SPECIAL PURPOSE COST CENTERS						
	06950 OTHER SPECIAL PURPOSE COST CENTERS	0	0				117.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	969, 309	13, 994, 398				118.00
	IONREI MBURSABLE COST CENTERS						
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0				192.00
194. 00 C	07950 MARKETI NG	0	0				194.00
194. 01 C	07951 OTHER NONREIMBURSABLE COST CENTERS	0	0				194.01
200.00	TOTAL (SUM OF LINES 118 through 199)	969, 309	13, 994, 398				200.00

Heal th	Financial Systems	Bloomi	ngton Regional	Rehabilitatior	n Hosp	In Lie	u of Form CMS	-2552-10
RECLAS	SI FI CATI ONS			Provider C	CN: 15-3049	Period: From 12/17/2021 To 12/31/2022	Worksheet A- Date/Time Pr 5/17/2023 3:	repared:
		Increases						
	Cost Center	Line #	Salary	0ther				
	2.00	3.00	4.00	5.00				
	A – RCLS PCT THERAPY							
1.00	OCCUPATI ONAL THERAPY	67.00	12, 413	1, 662				1.00
2.00	SPEECH PATHOLOGY	68.00	4, 653	624				2.00
	TOTALS		17,066	2, 286				
	B - RCLS O/P THERAPY							
1.00	PHYSI CAL THERAPY	66.00	3, 551	354				1.00
2.00	OCCUPATI ONAL THERAPY	67.00	3, 398	339				2.00
3.00	SPEECH PATHOLOGY	68.00	1, 273	127				3.00
	TOTALS		8, 222	820				
	C - RCLS CT FROM RADIOLOGY							
1.00	CT_SCAN	57.00	0	1, 740				1.00
	TOTALS		0	1, 740				
500.00	Grand Total: Increases		25, 288	4, 846				500.00

Heal th	Financial Systems	BLoomi	ngton Regional	Rehabilitatio	n Hosp	In Lie	u of Form CMS	-2552-10
RECLAS	SIFICATIONS			Provider (	CCN: 15-3049	Period:	Worksheet A-	6
						From 12/17/2021 To 12/31/2022	Date/Time Pr 5/17/2023 3:	epared: 18 pm
		Decreases						
	Cost Center	Line #	Salary	Other	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	17, 066	2, 286		0		1.00
2.00		0.00	0	0		0		2.00
	TOTALS		17,066	2,286		7		
	B – RCLS O/P THERAPY	· ·	· · · · ·			·		
1.00	OUTPATIENT THERAPY	91.01	8, 222	820		0		1.00
2.00		0.00	0	0		0		2.00
3.00		0.00	0	0		0		3.00
	TOTALS		8, 222	820		7		
	C - RCLS CT FROM RADIOLOGY							
1.00	RADI OLOGY-DI AGNOSTI C	54.00	0	1, 740		0		1.00
	TOTALS		0	1, 740				
500.00	Grand Total: Decreases		25, 288	4, 846				500.00

	Financial Systems Bloomir	ngton Regional I	Provider CC		Perio From To		Worksheet A-7 Part I	2552-10 pared: 8 pm
				Acqui si ti on	IS			
		Begi nni ng Bal ances	Purchases	Donati on		Total	Disposals and Retirements	
		1.00	2.00	3.00		4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	F BALANCES						
1.00	Land	0	0		0	0	0	1.00
2.00	Land Improvements	0	0		0	0	0	2.00
3.00	Buildings and Fixtures	0	17, 045, 633		0	17, 045, 633	0	3.00
4.00	Building Improvements	0	0		0	0	0	4.00
5.00	Fixed Equipment	0	-4, 261		0	-4, 261	0	5.00
6.00	Movable Equipment	0	1, 292, 831		0	1, 292, 831	0	6.00
7.00	HIT designated Assets	0	0		0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	0	18, 334, 203		0	18, 334, 203	0	8.00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	0	18, 334, 203		0	18, 334, 203	0	10.00
		Ending Balance	Fully					
		Ű	Depreciated					
			Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	F BALANCES						
1.00	Land	0	0					1.00
2.00	Land Improvements	0	0					2.00
3.00	Buildings and Fixtures	17, 045, 633	0					3.00
4.00	Building Improvements	0	0					4.00
5.00	Fixed Equipment	-4, 261	0					5.00
6.00	Movable Equipment	1, 292, 831	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	18, 334, 203	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	18, 334, 203	0					10.00

Heal th	Financial Systems Bloomin	ngton Regional	Rehabilitation	Hosp	In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS	_	Provider C	CN: 15-3049	Period: From 12/17/2021 To 12/31/2022	Worksheet A-7 Part II Date/Time Pre 5/17/2023 3:15	pared:
			SL	JMMARY OF CAPI	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	SHEET A, COLUN	/N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	797, 997	0	250, 67	'5 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	69, 442	1, 943, 346	,	0 0	0	2.00
3.00	Total (sum of lines 1-2)	867, 439	1, 943, 346	250, 67	5 0	0	3.00
		SUMMARY C	OF CAPITAL				
	Cost Center Description	Other	Total (1) (sum	1			
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	SHEET A, COLUN	NN 2, LINES 1 a	ind 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	1, 048, 672				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2, 012, 788				2.00
3.00	Total (sum of lines 1-2)	0	3, 061, 460	l l			3.00

	Financial Systems Blo	omington Regional	Provi der C		Period:	u of Form CMS-2 Worksheet A-7	
RECONC	TELATION OF CAPITAL COSTS CENTERS		Provider Co		From 12/17/2021	Part III	
					To 12/31/2022		pared:
						5/17/2023 3:18	8 pm
		COM	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
			1				
	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 COST	· · ·			1		
1.00	CAP REL COSTS-BLDG & FIXT	17, 041, 372					1.0
2.00	CAP REL COSTS-MVBLE EQUIP	1, 292, 831		.,,			2.0
3.00	Total (sum of lines 1-2)	18, 334, 203		10/001/200			3.0
		ALLOCA	TION OF OTHER (	CAPI TAL	SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Rel ate	cols. 5			
			d Costs	through 7)			
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COST	S CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	45, 780	0	52, 491	912, 889	0	1.C
2.00	CAP REL COSTS-MVBLE EQUIP	3, 473	0	3, 982	62, 676	1, 943, 346	2.0
3.00	Total (sum of lines 1-2)	49, 253	0	56, 473	975, 565	1, 943, 346	3. C
			SL	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
			instructions)		Capital -Relate		
					d Costs (see	through 14)	
					instructions)	in cage in	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COST						
1.00	CAP REL COSTS-BLDG & FIXT	250, 675	6, 711	45, 780	0 0	1, 216, 055	1.0
2.00	CAP REL COSTS-MVBLE EQUIP	0				2, 010, 004	2.0
3.00	Total (sum of lines 1-2)	250, 675				3, 226, 059	3.0

Health Financial Systems

	inancial Systems	BI oomi ng	gton Regional	Rehabilitation Hosp	In Lie	u of Form CMS-2	2552-10
ADJUSTME	ENTS TO EXPENSES				Period: From 12/17/2021 To 12/31/2022	Worksheet A-8 Date/Time Prep 5/17/2023 3:18	
				Expense Classification of To/From Which the Amount is			5 pm
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	<u>_</u>	1.00	2.00	3.00	4.00	5.00	
	nvestment income - CAP REL OSTS-BLDG & FIXT (chapter 2)		C	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
	nvestment income - CAP REL OSTS-MVBLE EQUIP (chapter 2)		C	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 1	nvestment income - other		C		0.00	0	3.00
4.00 T	chapter 2) rade, quantity, and time		C		0.00	0	4.00
	iscounts (chapter 8) efunds and rebates of		C		0.00	о	5.00
e	xpenses (chapter 8) ental of provider space by		C		0.00		6. 00
S	uppliers (chapter 8)		c c				
s	elephone services (pay tations excluded) (chapter 1)	A	-718	ADMI NI STRATI VE & GENERAL	5.00	0	7.00
	elevision and radio service chapter 21)	A	-9, 375	OPERATION OF PLANT	7.00	0	8.00
9.00 P	arking lot (chapter 21) rovider-based physician	A-8-2	C		0.00	0	9. 00 10. 00
а	djustment ale of scrap, waste, etc.	A-0-2	C		0.00		
(	chapter 23)		-		0.00		
	elated organization ransactions (chapter 10)	A-8-1	897, 959			0	12.00
13.00 L	aundry and linen service		0		0.00		
	afeteria-employees and guests ental of quarters to employee		-24,387 C	DI ETARY	10.00 0.00		14. 00 15. 00
16.00 S	nd others ale of medical and surgical upplies to other than		C		0.00	0	16. 00
17.00 S	atients ale of drugs to other than atients		C		0.00	О	17.00
18.00 S	ale of medical records and	В	-3	MEDI CAL RECORDS & LI BRARY	16.00	О	18.00
19.00 N	bstracts ursing and allied health		C		0.00	о	19. 00
	ducation (tuition, fees, ooks, etc.)						
	ending machines		C		0.00		20.00
i	ncome from imposition of nterest, finance or penalty harges (chapter 21)		C		0.00	0	21.00
0	nterest expense on Medicare verpayments and borrowings to		C		0.00	0	22.00
23.00 A	epay Medicare overpayments djustment for respiratory herapy costs in excess of	A-8-3	C	RESPI RATORY THERAPY	65.00		23. 00
24.00 A	imitation (chapter 14) djustment for physical herapy costs in excess of	A-8-3	C	PHYSI CAL THERAPY	66.00		24.00
25.00 U	imitation (chapter 14) tilization review – hysicians' compensation		C	*** Cost Center Deleted ***	114.00		25.00
(	chapter 21) epreciation - CAP REL		C	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 D	OSTS-BLDG & FIXT epreciation - CAP REL		C	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
	OSTS-MVBLE EQUIP on-physician Anesthetist		C	*** Cost Center Deleted ***	19.00		28.00
	hysicians' assistant	492	C		0.00		29. 00 30. 00
t	djustment for occupational herapy costs in excess of imitation (chapter 14)	A-8-3	L. L.	OCCUPATI ONAL THERAPY	67.00		30.00
30. 99 H	ospice (non-distinct) (see nstructions)		C	ADULTS & PEDIATRICS	30.00		30. 99
31.00 A	djustment for speech athology costs in excess of	A-8-3	C	SPEECH PATHOLOGY	68.00		31.00
32.00 C	imitation (chapter 14) AH HIT Adjustment for epreciation and Interest		C		0.00	0	32.00
	NTEREST INCOME	В	-3,044	ADMI NI STRATI VE & GENERAL	5.00	о	33.00

	TTHANCTAL SYSTEMS	BI UUIII I	igton kegi onai	Reliabilitation nosp			
ADJUST	MENTS TO EXPENSES				eri od:	Worksheet A-8	
					rom 12/17/2021 o 12/31/2022	Date/Time Pre	narod
				1	0 12/31/2022	5/17/2023 3:1	
				Expense Classification on	Worksheet A	0/11/2020 0.1	
				To/From Which the Amount is			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.02	MISC INCOME	В	-16, 238	ADMI NI STRATI VE & GENERAL	5.00	0	33.02
33.04	PRE-OPENING AMORTIZATION - CAP	A	79, 562	CAP REL COSTS-BLDG & FIXT	1.00	9	33.04
33.05	PRE-OPENING AMORTIZATION - A&G	A		ADMI NI STRATI VE & GENERAL	5.00		33.05
33.11	OTHER	A		ADMI NI STRATI VE & GENERAL	5.00		•
	EXPENSE-ADVERTI SI NG/MARKETI NG-						
33.13	OTHER	A	-35,027	ADMI NI STRATI VE & GENERAL	5.00	0	33.13
	EXPENSE-ADVERTI SI NG/MARKETI NG-						
33.29	BAD DEBT EXPENSE-BAD DEBT	A	-100, 225	ADMI NI STRATI VE & GENERAL	5.00	0	33.29
33.54	OTHER EXPENSE-CASH AWARDS	A	-50	DI ETARY	10.00	0	33.54
33.82	OTHER EXPENSE-CONTRIBUTIONS /	A	-1,000	ADMI NI STRATI VE & GENERAL	5.00	0	33.82
	SPONSO						
33.83	OTHER EXPENSE-CONTRIBUTIONS /	A	-700	ADMI NI STRATI VE & GENERAL	5.00	0	33.83
	SPONSO						
33.91	OTHER EXPENSE-FLOWERS &	A	-867	ADMI NI STRATI VE & GENERAL	5.00	0	33.91
	GI FTS						
33.93	OTHER EXPENSE-FLOWERS &	A	-121	ADMINISTRATIVE & GENERAL	5.00	0	33.93
	GI FTS						
34.18	TAXES-FRANCHI SE FEES/BUSI NESS	A	-795	ADMI NI STRATI VE & GENERAL	5.00	0	34.18
	TAX						
34.21	OTHER EXPENSE-GI VEAWAYS	A		ADMI NI STRATI VE & GENERAL	5.00	0	
34.22	OTHER EXPENSE-GI VEAWAYS	A		ADMI NI STRATI VE & GENERAL	5.00	0	0
34.28	OTHER EXPENSE-GI VEAWAYS	A		DIETARY	10.00	0	
34.65	OTHER FEES-LATE FEES	A		OPERATION OF PLANT	7.00	0	
34.75	OTHER FEES-LATE FEES	A		ADULTS & PEDIATRICS	30.00	0	
34.77	OTHER FEES-LATE FEES	A	-1, 254	MEDICAL SUPPLIES CHARGED TO	71.00	0	34.77
				PATI ENTS			
34.82	OTHER FEES-LATE FEES	A		RESPI RATORY THERAPY	65.00		
34.93		A		ADMI NI STRATI VE & GENERAL	5.00		011.70
35.23	MARKETING EXPENSE	A		ADMI NI STRATI VE & GENERAL	5.00		
35.24	MARKETING BENEFITS	A		EMPLOYEE BENEFITS DEPARTMENT	4.00		00.21
35.25	TELEPHONE OPERATOR EXPENSE	A	-42, 208	ADMI NI STRATI VE & GENERAL	5.00	0	35.25
35.26	TELEPHONE BENEFIT EXPENSE	A		EMPLOYEE BENEFITS DEPARTMENT	4.00		
35.27	TELEVI SI ON LEASE	A		CAP REL COSTS-MVBLE EQUIP	2.00		
35.28	UNALLOWABLE LOBBYING % OF	A	-931	ADMI NI STRATI VE & GENERAL	5.00	0	35.28
	ASSOC DUES						
35.29	PRIOR PD ACCRUALS NOT REVERSED	A	6, 000	OTHER ANCILLARY SERVICE COST	76.00	0	35.29
				CENTERS			
35.32	PRIOR PD ACCRUALS NOT REVERSED			RENAL DIALYSIS	74.00	0	00.02
50.00	TOTAL (sum of lines 1 thru 49)		969, 309	4			50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)					1	

 column 6, line 200.)

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

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.
 B. Amount Received - if cost cannot be determined.

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

Heal th	Health Financial Systems         Bloomington Regional Rehabilitation Hosp         In Lieu of Form CMS-2552								
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO		Peri od:	Worksheet A-8	-1			
OFFICE	COSTS			From 12/17/2021 To 12/31/2022	Date/Time Pre 5/17/2023 3:1				
	Line No.	Cost Center	Expense Items	Amount of	Amount				
				Allowable Cost					
					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 OF	RGANIZATIONS OR	CLAI MED				
	HOME OFFICE COSTS:								
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HO Alloc - Cap Rel Bldg	32, 642	0	1.00			
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HO Alloc - Cap Rel Equipment	27, 796	0	2.00			
3.00	5.00	ADMINISTRATIVE & GENERAL	HO Alloc - Cap Rel A&G	1, 179, 259	0	3.00			
4.00	5.00	ADMINISTRATIVE & GENERAL	Intercompany Management Fees	0	383, 181	4.00			
4.04	5.00	ADMINISTRATIVE & GENERAL	Pre-opening Amortization - H		0	4.04			
4.05	1.00	CAP REL COSTS-BLDG & FIXT	Pre-opening Amortization - H			4.05			
5.00	0		0	1, 281, 140		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

1 CT IIIDUI						
6.00	В		0. 00 EF	RNEST 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 provider.

Health Financial Systems	Bloomington Regional Rehabilitation Hosp	In Lieu of Form CMS-2552-10			
STATEMENT OF COSTS OF SERVICES FROM RELATED OFFICE COSTS	ORGANIZATIONS AND HOME Provider CCN: 15-3049	Period:         Worksheet A           From 12/17/2021         Date/Time P           To         12/31/2022         Date/Time P	repared:		
Not What A 7 Dof					

	Net	Wkst. A-7 Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6.00	7.00		
	A. COSTS INCUR	RED AND ADJUSTN	IENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED	
	HOME OFFICE CO	STS:		
1.00	32, 642	9		1.00
2.00	27, 796	9		2.00
3.00	1, 179, 259	0		3.00
4.00	-383, 181	0		4.00
4.04	38, 755	0		4.04
4.05	2, 688	9		4.05
5.00	897, 959			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.

nus no	been posted to norksheet A,		
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	51		
	6.00		
	B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

1 CT IIIDG			
6.00	HOME OFFICE		6.00
7.00			7.00
8.00		3	8.00
9.00			9.00
10.00		10	0.00
7.00 8.00 9.00 10.00 <u>100.00</u>		100	0.00

(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.

In Lieu	u of Form CMS-2552-10
od:	Worksheet B
12/17/2021	Part I Dato/Timo Bronarod:
12/21/2022	Data/Tima Dranaradi

				T	o 12/31/2022	Date/Time Pre	pared:
			CAPI TAL REL	ATED COSTS		5/17/2023 3:1	
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
		0	1.00	2.00	4.00	4A	
	GENERAL SERVICE COST CENTERS				· · · · · · · · · · · · · · · · · · ·		
1.00	00100 CAP REL COSTS-BLDG & FIXT	1, 216, 055	1, 216, 055				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	2, 010, 004		2, 010, 004			2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 032, 288	4, 772	7, 888	1, 044, 948		4.00
5.00	00500 ADMINI STRATI VE & GENERAL	3, 693, 182	106, 343	175, 773	293, 869	4, 269, 167	5.00
7.00	00700 OPERATION OF PLANT	500, 787	298, 838	493, 946	12, 039	1, 305, 610	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	21, 209	0	0	o	21, 209	8,00
9.00	00900 HOUSEKEEPI NG	146, 697	31, 557	52, 159	15, 053	245, 466	9,00
10.00	01000 DI ETARY	476, 825	112, 526	185, 993		831, 277	10.00
13.00	01300 NURSI NG ADMI NI STRATI ON	329, 966	14, 316	23, 663		426, 365	
16.00	01600 MEDI CAL RECORDS & LI BRARY	96, 467	12, 109	20, 016		144, 989	16.00
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	70, 107	12,107	20,010	10,077	111, 707	10.00
30, 00	03000 ADULTS & PEDIATRICS	2, 724, 809	498, 285	823, 609	345, 101	4, 391, 804	30.00
44.00	04400 SKI LLED NURSI NG FACI LI TY	2,721,007	0			0	44.00
11.00	ANCI LLARY SERVICE COST CENTERS	0	0	0	U 01	0	11.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	29, 660	0	0	0	29, 660	54.00
57.00	05700 CT SCAN	1, 740	0	0	0	1, 740	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1,740	0	0	0	1, 740	58.00
60.00	06000 LABORATORY	67, 376	1, 539	2, 544	0	71, 459	
65.00	06500 RESPIRATORY THERAPY	134,004	5, 054	8, 354	18, 418	165, 830	•
66.00	06600 PHYSI CAL THERAPY	441, 984	47, 566	78, 621	80, 595	648, 766	•
67.00	06700 OCCUPATI ONAL THERAPY	384, 010	45, 488	75, 186		576, 294	•
68.00	06800 SPEECH PATHOLOGY	183, 535	5, 747	9, 499		231, 411	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	151, 422	13, 880	22, 942		197, 032	•
73.00	07300 DRUGS CHARGED TO PATTENTS	351, 872	17, 625	22, 942		434, 725	
74.00	07400 RENAL DI ALYSI S	331, 872	17,025	27, 133		434, 725	74.00
74.00	03950 OTHER ANCI LLARY SERVICE COST CENTERS	506	0	-	-	506	
70.00	OUTPATIENT SERVICE COST CENTERS	500	0	0	U0	500	78.00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
91.00 91.01	04951 OUTPATIENT THERAPY	0	0	0	-	0	
91.01 93.00	04950 OUTPATIENT THERAPY	0	0	-	-	0	
93.00	OTHER REIMBURSABLE COST CENTERS	U	0	0	UU	0	93.00
05 00			0	0		0	
	09500 AMBULANCE SERVICES	0	0		-	0	
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
117 00	SPECIAL PURPOSE COST CENTERS 06950 OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
		-	-	-	-		
118.00		13, 994, 398	1, 215, 645	2, 009, 326	1, 044, 948	13, 993, 310	118.00
400.00	NONREI MBURSABLE COST CENTERS			0			100.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0				192.00
	07950 MARKETI NG	0	410	678	0		194.00
	07951 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194.01
200.00			-	_	_		200.00
201.00		40.004	0	0	0	0	
202.00	TOTAL (sum lines 118 through 201)	13, 994, 398	1, 216, 055	2, 010, 004	1, 044, 948	13, 994, 398	202.00

Heal th	Financial Systems Bloomi	ngton Regional I	Rehabilitation	Hosp	In Lie	u of Form CMS-	2552-10
COST AL	LOCATION - GENERAL SERVICE COSTS	0 0	Provider C	CN: 15-3049	Peri od:	Worksheet B	
					From 12/17/2021	Part I	norod.
					To 12/31/2022	Date/Time Pre 5/17/2023 3:1	areu: 8 nm
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVIC			
		5.00	7.00	8.00	9.00	10.00	
C	GENERAL SERVICE COST CENTERS			•			
1.00	DO100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	DO200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 0	DO400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 0	DO500 ADMINISTRATIVE & GENERAL	4, 269, 167					5.00
7.00 0	DO700 OPERATION OF PLANT	573, 134	1, 878, 744				7.00
8.00 0	DO800 LAUNDRY & LINEN SERVICE	9, 310	0	30, 51	9		8.00
9.00 0	DO900 HOUSEKEEPI NG	107, 754	73, 547		0 426, 767		9.00
10.00 (	D1000 DI ETARY	364, 912	262, 259		0 62,001	1, 520, 449	10.00
13.00 (	D1300 NURSING ADMINISTRATION	187, 165	33, 365		0 7,888	0	13.00
16.00 (	D1600 MEDICAL RECORDS & LIBRARY	63, 647	28, 223		0 6, 672	0	16.00
I	NPATIENT ROUTINE SERVICE COST CENTERS			•			1
30.00	D3000 ADULTS & PEDIATRICS	1, 927, 910	1, 161, 328	30, 51	9 274, 551	1, 520, 449	30.00
44.00 0	04400 SKILLED NURSING FACILITY	0	0		0 0	0	44.00
A	ANCILLARY SERVICE COST CENTERS						
54.00	05400 RADI OLOGY-DI AGNOSTI C	13, 020	0		0 0	0	54.00
57.00 0	D5700 CT SCAN	764	0		0 0	0	57.00
58.00 0	D5800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58.00
60.00	D6000 LABORATORY	31, 369	3, 588	1	0 848	0	60.00
65.00 0	06500 RESPI RATORY THERAPY	72, 796	11, 780	1	0 2,785	0	65.00
66.00 (	D6600 PHYSI CAL THERAPY	284, 794	110, 859		0 26, 208	0	66.00
67.00 (	06700 OCCUPATI ONAL THERAPY	252, 980	106, 016		0 25, 063	0	67.00
68.00 (	D6800 SPEECH PATHOLOGY	101, 584	13, 394		0 3, 166	0	68.00
71.00 (	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	86, 493	32, 349		0 7,648	0	71.00
73.00 0	D7300 DRUGS CHARGED TO PATIENTS	190, 835	41, 079		0 9, 711	0	73.00
74.00	07400 RENAL DIALYSIS	0	0		0 0	0	74.00
76.00 (	03950 OTHER ANCILLARY SERVICE COST CENTERS	222	0		0 0	0	76.00
C	DUTPATIENT SERVICE COST CENTERS			_			
	D9100 EMERGENCY	0	0		0 0		
	04951 OUTPATI ENT THERAPY	0	0		0 0		
	04950 OUTPATIENT WOUND CENTER	0	0		0 0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVI CES	0	0		0 0		
	10100 HOME HEALTH AGENCY	0	0		0 0	0	101.00
	SPECIAL PURPOSE COST CENTERS				_		
	06950 OTHER SPECIAL PURPOSE COST CENTERS	0	0		0 0		117.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	4, 268, 689	1, 877, 787	30, 51	9 426, 541	1, 520, 449	118.00
	NONREI MBURSABLE COST CENTERS						
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		192.00
	07950 MARKETI NG	478	957		0 226		194.00
	D7951 OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0	0	194.01
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0		0 0		201.00
202.00	TOTAL (sum lines 118 through 201)	4, 269, 167	1, 878, 744	30, 51	9 426, 767	1, 520, 449	202.00

COST ALLOCATION - GE		ngton Regional R	Provider CC		Peri od:	u of Form CMS- Worksheet B	2002 10
SUCT ALLOGATION OF					From 12/17/2021	Part I	
					To 12/31/2022	Date/Time Pre	
Cost Cen	ter Description	NURSI NG	MEDI CAL	Subtotal	Intern &	5/17/2023 3:1 Total	
0031 001		ADMI NI STRATI ON	RECORDS &	Subtotui	Residents Cost	lotal	
			LIBRARY		& Post		
					Stepdown		
					Adjustments		
		13.00	16.00	24.00	25.00	26.00	
	CE COST CENTERS	1 1					1
	COSTS-BLDG & FIXT						1.00
	COSTS-MVBLE EQUI P						2.00
	BENEFITS DEPARTMENT						4.00
	RATIVE & GENERAL						5.00
7.00 00700 OPERATI 0							7.00
	& LINEN SERVICE						8.00
9.00 00900 HOUSEKEE	PING						9.00
10.00 01000 DI ETARY		(54 702					10.00
13.00 01300 NURSI NG		654, 783	242 521				13.00
	RECORDS & LI BRARY	0	243, 531				16.00
30. 00 03000 ADULTS &		654, 783	107, 809	10, 069, 1	53 0	10, 069, 153	30.00
	NURSI NG FACI LI TY	034,783	107, 809	10,009,1	0 0	10, 007, 153	1
	I CE COST CENTERS	U	0		0 0	0	44.00
54.00 05400 RADI OLOG		0	7, 143	49, 8	23 0	49, 823	54.00
57.00 05700 CT SCAN		0	419	2, 9		2, 923	
	RESONANCE IMAGING (MRI)	0	0	2, 7.	0 0	0	
60.00 06000 LABORATO		0	12, 224	119, 4	-	119, 488	
65. 00 06500 RESPI RAT		0	17, 703	270, 8		270, 894	
66. 00 06600 PHYSI CAL		0	28, 045	1, 098, 6		1, 098, 672	
67.00 06700 0CCUPATI		0	26, 831	987, 1		987, 184	
68.00 06800 SPEECH P		0	10, 056	359, 6		359, 611	
	SUPPLIES CHARGED TO PATIENTS	0	639	324, 1		324, 161	
	ARGED TO PATIENTS	0	32, 662	709, 0		709, 012	
74.00 07400 RENAL DI		0	0		0 0	0	
76.00 03950 OTHER AN	CILLARY SERVICE COST CENTERS	0	0	7	28 0	728	76.00
OUTPATIENT SER	RVICE COST CENTERS						
91.00 09100 EMERGENC	Y	0	0		0 0	0	91.00
91.01 04951 OUTPATIE	NT THERAPY	0	0		0 0	0	91.01
93.00 04950 OUTPATIE	NT WOUND CENTER	0	0		0 0	0	93.00
	SABLE COST CENTERS						
95.00 09500 AMBULANC		0	0		0 0	0	
101.00 10100 HOME HEA		0	0		0 0	0	101.00
	SE COST CENTERS						
	ECIAL PURPOSE COST CENTERS	0	0		0 0		117. OC
	S (SUM OF LINES 1 through 117)	654, 783	243, 531	13, 991, 6	49 0	13, 991, 649	118.00
	E COST CENTERS					-	1.00.00
192.00 19200 PHYSI CI A		0	0		0 0		192.00
194.0007950 MARKETI N		0	0	2, 7			194.00
	NREIMBURSABLE COST CENTERS	0	0		0 0		194.01
	ot Adjustments		_		0 0		200.00
	Cost Centers	0	0	40.001.0	0 0		201.00
202.00 TOTAL (s	um lines 118 through 201)	654, 783	243, 531	13, 994, 3	98 0	13, 994, 398	1202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-3049 Pe	eriod: rom 12/17/2021 o 12/31/2022	Worksheet B Part II Date (Time Dree	paradi
			10	J 12/31/2022	Date/Time Pre 5/17/2023 3:1	pareu. 8 nm
		CAPI TAL REL	ATED COSTS		071772020 0.1	
		0/11/1/12 1122	51125 00010			
Cost Center Description	Di rectl y	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	Assigned New				<b>BENEFITS</b>	
	Capi tal				DEPARTMENT	
	Related Costs					
	0	1.00	2.00	2A	4.00	
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	0	4, 772	7, 888	12, 660	12, 660	4.00
5. 00 00500 ADMINI STRATI VE & GENERAL	0	106, 343	175, 773	282, 116	3, 561	5.00
7.00 00700 OPERATION OF PLANT	0	298, 838	493, 946	792, 784	146	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00 00900 HOUSEKEEPI NG	0	31, 557	52, 159	83, 716	182	9.00
10. 00 01000 DI ETARY	0	112, 526	185, 993	298, 519	678	10.00
13.00 01300 NURSING ADMINISTRATION	0	14, 316	23, 663	37, 979	708	13.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	12, 109	20, 016	32, 125	199	16.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	Ŭ	12/10/	20/010	02,120		101.00
30. 00 03000 ADULTS & PEDI ATRI CS	0	498, 285	823, 609	1, 321, 894	4, 180	30.00
44. 00 04400 SKI LLED NURSI NG FACI LI TY	0	0	020,007	0	1, 100	44.00
ANCI LLARY SERVICE COST CENTERS		0				11.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	0	o	0	54.00
57. 00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60. 00 06000 LABORATORY	0	1, 539	2, 544	4, 083	0	60.00
65. 00 06500 RESPIRATORY THERAPY	0	5, 054	8, 354	13, 408	223	65.00
66. 00 06600 PHYSI CAL THERAPY	0	47, 566	78, 621	126, 187	977	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	45, 488	75, 186	120, 674	868	
68. 00 06800 SPEECH PATHOLOGY	0	5, 747	9, 499	15, 246	395	68.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	13, 880	22, 942	36, 822	106	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	17, 625	22, 942	46, 758	437	73.00
74. 00 07400 RENAL DIALYSIS	0	17,025	27, 133	40, 738	437	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS	0	0	0	U	0	70.00
91. 00 09100 EMERGENCY	0	0	0	0	0	91.00
91. 01 04951 OUTPATIENT THERAPY	0	0	0	0	0	91.00
93. 00 04950 OUTPATIENT WOUND CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS	0	0	0	U	0	93.00
	0	0	0	0	0	05 00
95. 00 09500 AMBULANCE SERVICES	0		0	0	0	
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						447.00
117.00 06950 OTHER SPECIAL PURPOSE COST CENTERS	0		0	0		117.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	1, 215, 645	2, 009, 326	3, 224, 971	12, 660	118.00
NONREI MBURSABLE COST CENTERS						100.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	0	0		192.00
194.00 07950 MARKETING	0	410	678	1, 088		194.00
194. 01 07951 OTHER NONREI MBURSABLE COST CENTERS	0	0	0	0	0	194.01
200.00 Cross Foot Adjustments		_	_	0	_	200.00
201.00 Negative Cost Centers	_	0	0	0		201.00
202.00   TOTAL (sum lines 118 through 201)	0	1, 216, 055	2, 010, 004	3, 226, 059	12, 660	202.00

Heal th	Financial Systems Bloomi	ngton Regional	Rehabilitation	Ноѕр	In Lie	u of Form CMS-	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider C		Peri od:	Worksheet B	
					From 12/17/2021	Part II	
					To 12/31/2022	Date/Time Pre 5/17/2023 3:1	epared:
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	Cost center beschiption	& GENERAL	PLANT	LINEN SERVIC		DIEIARI	
		5.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1 1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINI STRATI VE & GENERAL	285, 677					5.00
7.00	00700 OPERATION OF PLANT	38, 352	831, 282				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	623	0	62	3		8.00
9.00	00900 HOUSEKEEPI NG	7, 211	32, 542		0 123, 651		9.00
10.00	01000 DI ETARY	24, 419	116, 041		0 17,964	457, 621	10.00
13.00	01300 NURSI NG ADMI NI STRATI ON	12, 524	14, 763		0 2,285	0	13.00
16.00	01600 MEDICAL RECORDS & LIBRARY	4, 259	12, 488		0 1,933	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS			r		I	1
30.00	03000 ADULTS & PEDIATRICS	129,007	513, 852	62	3 79, 547	457, 621	30.00
44.00	04400 SKILLED NURSING FACILITY	0	0		0 0		
	ANCILLARY SERVICE COST CENTERS						
54.00	05400 RADI OLOGY-DI AGNOSTI C	871	0		0 0	0	54.00
57.00	05700 CT SCAN	51	0		0 0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58.00
60.00	06000 LABORATORY	2,099	1, 587		0 246	0	60.00
65.00	06500 RESPI RATORY THERAPY	4, 871	5, 212		0 807	0	65.00
66.00	06600 PHYSI CAL THERAPY	19,058	49, 051		0 7, 594	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	16, 929	46, 908		0 7,262	0	67.00
68.00	06800 SPEECH PATHOLOGY	6, 798	5, 926		0 917	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5, 788	14, 313		0 2,216	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	12, 770	18, 176		0 2,814	0	73.00
74.00	07400 RENAL DI ALYSI S	0	0		0 0	0	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	15	0		0 0	0	76.00
	OUTPATIENT SERVICE COST CENTERS					•	1
91.00	09100 EMERGENCY	0	0		0 0	0	91.00
91.01	04951 OUTPATI ENT THERAPY	0	0		0 0	0	91.01
93.00	04950 OUTPATIENT WOUND CENTER	0	0		0 0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						1
95.00	09500 AMBULANCE SERVICES	0	0		0 0	0	95.00
101.00	10100 HOME HEALTH AGENCY	0	0		0 0	0	101.00
	SPECIAL PURPOSE COST CENTERS						
117.00	06950 OTHER SPECIAL PURPOSE COST CENTERS	0	0		0 0	0	117.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	285, 645	830, 859	62	3 123, 585	457, 621	118.00
	NONREIMBURSABLE COST CENTERS						
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	0	192.00
	07950 MARKETI NG	32	423		0 66	0	194.00
	07951 OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0	0	194.01
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0		0 0		201.00
202.00	TOTAL (sum lines 118 through 201)	285, 677	831, 282	62	3 123, 651	457, 621	202.00

Heal th	Fi nar	nci a	al S	yste	ms		
	TLON		CADI	TAI	DEI	ATED	C

Heal th	Financial Systems Bloomin	ngton Regional F	Rehabilitation	Hosp	In Lie	u of Form CMS-	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-3049	Period:	Worksheet B	
					From 12/17/2021	Part II	
					To 12/31/2022		
						5/17/2023 3:1	18 pm
	Cost Center Description	NURSI NG	MEDI CAL	Subtotal	Intern &	Total	
		ADMI NI STRATI ON	RECORDS &		Residents Cost		
			LI BRARY		& Post		
					Stepdown		
					Adjustments		
		13.00	16.00	24.00	25.00	26.00	
	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 ADMINI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8,00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
13.00	01300 NURSI NG ADMI NI STRATI ON	68, 259					13.00
	01600 MEDICAL RECORDS & LIBRARY	00,239	51, 004				16.00
10.00		0	31,004				10.00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	(0.250	22 501	2 507 54	4	2 507 5/4	1 20 00
30.00	03000 ADULTS & PEDIATRICS	68, 259	22, 581	2, 597, 56			
44.00	04400 SKILLED NURSING FACILITY	0	0		0 0	0	44.00
	ANCILLARY SERVICE COST CENTERS	1					
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	1, 496	2, 36	57 0	2, 367	54.00
57.00	05700 CT SCAN	0	88	13	39 0	139	57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 0	0	58.00
60.00	06000 LABORATORY	0	2, 560	10, 57	75 0	10, 575	60.00
65.00	06500 RESPI RATORY THERAPY	0	3, 707	28, 22	28 0	28, 228	65.00
66.00	06600 PHYSI CAL THERAPY	0	5, 873	208, 74	40 0	208, 740	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	5, 619	198, 26	50 0	198, 260	67.00
68.00	06800 SPEECH PATHOLOGY	0	2, 106	31, 38		31, 388	•
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	134	59, 37		59, 379	
	07300 DRUGS CHARGED TO PATIENTS	0	6, 840	87, 79		87, 795	
74.00	07400 RENAL DIALYSIS	0	0, 010	07,7	0 0	0,,,,,	
76.00	03950 OTHER ANCI LLARY SERVICE COST CENTERS	0	0		15 0		
70.00	OUTPATIENT SERVICE COST CENTERS	0	0		15 0	10	70.00
91.00	09100 EMERGENCY	0	0		0 0	C	91.00
	04951 OUTPATIENT THERAPY	0	0		0 0		
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
	SPECIAL PURPOSE COST CENTERS						
117.00	06950 OTHER SPECIAL PURPOSE COST CENTERS	0	0		0 0		117.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	68, 259	51, 004	3, 224, 45	50 0	3, 224, 450	118.00
	NONREIMBURSABLE COST CENTERS						
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	C	192.00
	07950 MARKETI NG	0	0	1, 60	09 0		194.00
	07951 OTHER NONREI MBURSABLE COST CENTERS	0	0	.,	0 0		194.01
200.00		0	0		0 0		200.00
200.00	5	0	0		0 0		200.00
201.00		68, 259	51,004	3, 226, 05			
202.00	I I I I I I I I I I I I I I I I I I I	00, 209	51,004	3, 220, 03	0	3, 220, 059	1202.00

COST ALLOCATION - STATISTICAL BASIS			Provider C		Peri od:	Worksheet B-1	
					From 12/17/2021 To 12/31/2022	Date/Time Pre	narodi
					10 12/31/2022	5/17/2023 3:1	8 pm
		CAPI TAL REL	ATED COSTS				
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
		(SQUARE FEET)	(SQUARE FEET)	BENEFITS		& GENERAL	
				DEPARTMENT (GROSS		(ACCUM. COST)	
				SALARI ES)			
		1.00	2.00	4.00	5A	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT	47, 399					1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		47, 399				2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	186	186	5, 353, 537	7		4.00
5.00	00500 ADMINISTRATIVE & GENERAL	4, 145	4, 145	1, 505, 570	-4, 269, 167	9, 725, 231	5.00
7.00	00700 OPERATION OF PLANT	11, 648	11, 648	61, 679	9 0	1, 305, 610	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	(	-	21, 209	
9.00	00900 HOUSEKEEPI NG	1, 230	1, 230			245, 466	
10.00	01000 DI ETARY	4, 386	4, 386	286, 561		831, 277	
	01300 NURSING ADMINISTRATION	558				426, 365	
16.00	01600 MEDI CAL RECORDS & LI BRARY	472	472	84, 006	5 <u>0</u>	144, 989	16.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	10,400	10, 400	1 7(0 0)		4 201 004	20.00
	03000 ADULTS & PEDIATRICS	19, 422	19, 422				
44.00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	0	0	(	0	0	44.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	(	0	29, 660	54.00
	05700 CT SCAN	0	0		-	1, 740	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0			1, 740	58.00
	06000 LABORATORY	60	60			71, 459	
65.00	06500 RESPIRATORY THERAPY	197	197	94, 359		165, 830	
	06600 PHYSI CAL THERAPY	1,854	1, 854	412, 909		648, 766	
	06700 OCCUPATI ONAL THERAPY	1, 773	1, 773	366, 876		576, 294	
	06800 SPEECH PATHOLOGY	224	224	167, 171		231, 411	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	541	541	45, 025		197, 032	
73.00	07300 DRUGS CHARGED TO PATIENTS	687	687	184, 925	5 0	434, 725	73.00
74.00	07400 RENAL DIALYSIS	0	0	(	0 0	0	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	(	0 0	506	76.00
	OUTPATIENT SERVICE COST CENTERS				1		
	09100 EMERGENCY	0	0	(			
	04951 OUTPATI ENT THERAPY	0	0	(			
	04950 OUTPATIENT WOUND CENTER	0	0	(	0 0	0	93.00
	OTHER REI MBURSABLE COST CENTERS		0				05 00
	09500 AMBULANCE SERVICES	0					95.00
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	(	0 0	0	101.00
117 00	06950 OTHER SPECIAL PURPOSE COST CENTERS	0	0	(	0	0	117.00
117.00		47, 383					
110.00	NONREI MBURSABLE COST CENTERS	47,303	47,303	5, 555, 557	4,207,107	7,724,143	110.00
192.00	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	(	0 0	0	192.00
	07950 MARKETI NG	16	16	(			194.00
	07951 OTHER NONREI MBURSABLE COST CENTERS	0	0				194.01
200.00					-		200.00
201.00							201.00
202.00	Cost to be allocated (per Wkst. B,	1, 216, 055	2, 010, 004	1, 044, 948	3	4, 269, 167	202.00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	25. 655710	42. 406042	0. 195188	3	0. 438978	203.00
204.00				12, 660	)	285, 677	204.00
	Part II)						
205.00				0. 002365	þ	0. 029375	205.00
20/ 00	)						204 00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00							207.00
207.00	Parts III and IV)						207.00
		1	1	I	1	1	1

ST ALLOCAT	ION - STATISTICAL BASIS		Provider CO	1	Period: From 12/17/2021 To 12/31/2022	Worksheet B-1 Date/Time Pre	epare
	Cast Contar Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	5/17/2023 3:1 NURSI NG	8 pm
	Cost Center Description	PLANT	LINEN SERVICE		(TOTAL PATIENT)		
			(TOTAL PATIENT		DAYS)		·
			DAYS)		5,	(NURSI NG	
			,			SALARI ES)	
		7.00	8.00	9.00	10.00	13.00	
GENER	AL SERVICE COST CENTERS						
00100	CAP REL COSTS-BLDG & FIXT						1.
00200	CAP REL COSTS-MVBLE EQUIP						2.
	EMPLOYEE BENEFITS DEPARTMENT					1	4
00500	ADMINISTRATIVE & GENERAL					1	5
00700 00	OPERATION OF PLANT	31, 420				1	7
00800 00	LAUNDRY & LINEN SERVICE	0	6, 433			1	8
00900 00	HOUSEKEEPING	1,230	0	30, 190	C	1	9
00 01000	DI ETARY	4, 386	0	4, 380	6 6, 433		10
00 01300	NURSING ADMINISTRATION	558	0	558	8 0	1, 768, 033	13
00 01600	MEDICAL RECORDS & LIBRARY	472	0	472	2 0	0	16
I NPAT	ENT ROUTINE SERVICE COST CENTERS						
00 03000	ADULTS & PEDIATRICS	19, 422	6, 433	19, 422	2 6, 433	1, 768, 033	30
	SKILLED NURSING FACILITY	0			0 0	0	
	ARY SERVICE COST CENTERS				1 1		
	RADI OLOGY-DI AGNOSTI C	0	0	(	0 0	0	54
	CT SCAN	0	0		0 0	0	
	MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	
	LABORATORY	60	0	60		0	
	RESPI RATORY THERAPY	197		19		0	
	PHYSI CAL THERAPY	1, 854		1, 854		0	
	OCCUPATIONAL THERAPY	1, 773		1, 77:		0	
	SPEECH PATHOLOGY	224		224		0	
	MEDICAL SUPPLIES CHARGED TO PATIENTS	541		54	1	0	
	DRUGS CHARGED TO PATIENTS	687		68		0	
	RENAL DI ALYSI S	007			0 0	0	
	OTHER ANCILLARY SERVICE COST CENTERS	0			0 0	0	
	TIENT SERVICE COST CENTERS		<u>и</u> 0	· · · · · ·	<u> </u>	0	4 /0
	EMERGENCY	0	0	(	0 0	0	91
	OUTPATIENT THERAPY	0			0 0	0	
	OUTPATIENT WOUND CENTER				0 0	0	
	REIMBURSABLE COST CENTERS	0	<u> </u>		<u> </u>	0	73
	AMBULANCE SERVICES	0	0	( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( )	0 0	0	95
	HOME HEALTH AGENCY				0 0		101
	AL PURPOSE COST CENTERS	0	<u> </u>		<u> </u>	0	
	OTHER SPECIAL PURPOSE COST CENTERS	0	0	( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( )	0 0	0	117
	SUBTOTALS (SUM OF LINES 1 through 117)	31, 404		30, 174			
	MBURSABLE COST CENTERS	51,404	0,433	30, 17	+ 0, 433	1, 700, 033	
	PHYSICIANS' PRIVATE OFFICES	0	0	· · · · · · · · · · · · · · · · · · ·	0 0	0	192
	MARKETING	-					
		16		10			194
	OTHER NONREIMBURSABLE COST CENTERS	0	0		5 0	0	194
0.00	Cross Foot Adjustments					1	200
1.00	Negative Cost Centers	4 979 74					201
2.00	Cost to be allocated (per Wkst. B,	1, 878, 744	30, 519	426, 76	7 1, 520, 449	654, 783	202
	Part I)	50 70 /50 /					
3.00	Unit cost multiplier (Wkst. B, Part I)	59. 794526					
1.00	Cost to be allocated (per Wkst. B,	831, 282	623	123, 651	1 457, 621	68, 259	204
	Part II)						
5.00	Unit cost multiplier (Wkst. B, Part	26. 457097	0. 096844	4. 095760	0 71.136484	0. 038607	205
	11)						
	NAHE adjustment amount to be allocated	1	1		1		206
5. 00	5						
5.00 7.00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,						207

In Lieu of Form CMS-2552-10

ealth Financial Systems		igton Regional F	Rehabilitation Hosp		u of Form CMS-2552
OST ALLOCATION - STATIS	TCAL BASIS		Provider CCN: 15-3049	Peri od:	Worksheet B-1
				From 12/17/2021 To 12/31/2022	Date/Time Prepare
Cost Costor	) occari ati on	MEDICAL			5/17/2023 3:18 pm
Cost Center I	Description	MEDICAL RECORDS &			
		LIBRARY			
		(GROSS			
		CHARGES)			
	ST CENTEDS	16.00			
.00 <u>GENERAL SERVICE CO</u> .00 00100 CAP REL COST					1.
					2.
00 00400 EMPLOYEE BEN					4.
00 00500 ADMI NI STRATI 1					5.
00 00700 OPERATION OF					7.
00 00800 LAUNDRY & LII	VEN SERVICE				8.
00 00900 HOUSEKEEPI NG					9.
D. 00 01000 DI ETARY					10.
3. 00 01300 NURSING ADMII	NI STRATI ON				13.
5. 00 01600 MEDI CAL RECO	RDS & LI BRARY	15, 255, 861			16.
	SERVICE COST CENTERS	10/200/001			
0. 00 03000 ADULTS & PED		6, 753, 600			30.
. 00 04400 SKILLED NURS		0			44.
ANCI LLARY SERVI CE		0			
. 00 05400 RADI OLOGY-DI		447, 494			54
	AGNUSTIC				
2.00 05700 CT SCAN		26, 234			57.
	DNANCE IMAGING (MRI)	0			58
0.00 06000 LABORATORY		765, 771			60
. 00 06500 RESPI RATORY		1, 109, 013			65
5. 00 06600 PHYSI CAL THE	RAPY	1, 756, 845			66
7.00 06700 OCCUPATIONAL	THERAPY	1, 680, 820			67.
3. 00 06800 SPEECH PATHO	_OGY	629, 980			68.
1.00 07100 MEDICAL SUPP	LIES CHARGED TO PATIENTS	40, 024			71.
3. 00 07300 DRUGS CHARGEI		2,046,080			73.
4.00 07400 RENAL DIALYS		0			74.
	ARY SERVICE COST CENTERS	0			76.
OUTPATIENT SERVICE					
. 00 09100 EMERGENCY		0			91
01 04951 OUTPATIENT TI	HERAPY	0			91
3. 00 04950 OUTPATIENT W		0			93
OTHER REIMBURSABLE		0			73
5. 00 09500 AMBULANCE SE		0			95
		0			101
1.00 10100 HOME HEALTH A SPECIAL PURPOSE CO		U			
7. 00 06950 OTHER SPECIA		0			117
	JM OF LINES 1 through 117)	15, 255, 861			118
NONREI MBURSABLE CO		0			102
2. 00 19200 PHYSI CI ANS'	TRIVALE UFFICES	0			192
4. 00 07950 MARKETI NG		0			194
4.0107951 OTHER NONRELL		0			194
00.00 Cross Foot A					200
1.00 Negative Cos					201
	located (per Wkst. B,	243, 531			202
Part I)					
	tiplier (Wkst. B, Part I)	0. 015963			203
4.00 Cost to be a	located (per Wkst. B,	51, 004			204
Part II)					
	tiplier (Wkst. B, Part	0. 003343			205
11)					
	ent amount to be allocated				206.
(per Wkst. B					
	st multiplier (Wkst. D,				207.

Health Financial Systems Bloomin	ngton Regional	Rehabilitation	Hosp	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-3049	Period: From 12/17/2021 To 12/31/2022	Worksheet C Part I Date/Time Pre 5/17/2023 3:1	pared: 8 pm
		Title	XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj.		Di sal I owance		
	Part I, col.	-				
	26)					
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	10, 069, 153		10, 069, 15	3 0	10, 069, 153	30.00
44.00 04400 SKILLED NURSING FACILITY	0			0 0	0	44.00
ANCI LLARY SERVI CE COST CENTERS						
54. 00 05400 RADI OLOGY-DI AGNOSTI C	49, 823		49, 82		49, 823	
57.00 05700 CT SCAN	2, 923		2, 92	3 0	2, 923	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0			0 0	0	58.00
60. 00 06000 LABORATORY	119, 488		119, 48	8 0	119, 488	60.00
65. 00 06500 RESPI RATORY THERAPY	270, 894		270, 89		270, 894	
66. 00 06600 PHYSI CAL THERAPY	1, 098, 672	0	1, 098, 67	2 0	1, 098, 672	66.00
67.00 06700 OCCUPATI ONAL THERAPY	987, 184	0	987, 18	4 0	987, 184	
68.00 06800 SPEECH PATHOLOGY	359, 611	0	359, 61	1 0	359, 611	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	324, 161		324, 16		324, 161	
73.00 07300 DRUGS CHARGED TO PATIENTS	709, 012		709, 01	2 0	709, 012	
74.00 07400 RENAL DIALYSIS	0			0 0	0	
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	728		72	8 0	728	76.00
OUTPATIENT SERVICE COST CENTERS		•	-			
91.00 09100 EMERGENCY	0			0 0	0	,
91. 01 04951 OUTPATI ENT THERAPY	0			0 0	0	91.01
93.00 04950 OUTPATIENT WOUND CENTER	0			0 0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES	0			0 0		95.00
101.0010100 HOME HEALTH AGENCY	0			0	0	101.00
SPECIAL PURPOSE COST CENTERS						
117.00069500THER SPECIAL PURPOSE COST CENTERS	0			0	0	117.00
200.00 Subtotal (see instructions)	13, 991, 649	0	13, 991, 64	9 0	13, 991, 649	
201.00 Less Observation Beds	0			0		201.00
202.00 Total (see instructions)	13, 991, 649	0	13, 991, 64	9 0	13, 991, 649	202.00

Health Financial Systems Bloomi	ngton Regional I	Rehabilitation	Hosp	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 12/17/2021 To 12/31/2022	5/17/2023 3:1	
		Titl€	e XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	6, 753, 600		6, 753, 60	0		30.00
44.00 04400 SKILLED NURSING FACILITY	0			0		44.00
ANCI LLARY SERVI CE COST CENTERS			_			
54. 00 05400 RADI OLOGY-DI AGNOSTI C	447, 494	C	447,49	4 0. 111338	0. 000000	54.00
57.00 05700 CT SCAN	26, 234	C	26, 23	4 0. 111420	0.00000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C		0 0.000000	0. 000000	58.00
60. 00 06000 LABORATORY	765, 771	C	765, 77	1 0. 156036	0. 000000	60.00
65. 00 06500 RESPI RATORY THERAPY	1, 109, 013	C	1, 109, 01	3 0. 244266	0. 000000	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 735, 720	21, 125	1, 756, 84	5 0. 625366	0. 000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	1, 680, 820	C	1, 680, 82	0 0. 587323	0. 000000	67.00
68.00 06800 SPEECH PATHOLOGY	623, 155	6, 825	629, 98	0 0. 570829	0. 000000	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	40, 024	C	40, 02	4 8.099166	0.00000	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2,046,080	C	2, 046, 08	0 0. 346522	0.00000	73.00
74.00 07400 RENAL DIALYSIS	0	C		0 0.000000	0. 000000	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	C		0 0.000000	0. 000000	76.00
OUTPATIENT SERVICE COST CENTERS						1
91.00 09100 EMERGENCY	0	C	)	0 0.000000	0. 000000	91.00
91. 01 04951 OUTPATI ENT THERAPY	0	C		0 0.000000		
93.00 04950 OUTPATIENT WOUND CENTER	0	C		0 0.000000	0. 000000	93.00
OTHER REIMBURSABLE COST CENTERS						1
95.00 09500 AMBULANCE SERVICES	0	C	)	0 0.000000	0.00000	95.00
101.00 10100 HOME HEALTH AGENCY	0	C		0		101.00
SPECIAL PURPOSE COST CENTERS	· · · ·				-	1
117.0006950 OTHER SPECIAL PURPOSE COST CENTERS	0	C	)	0		117.00
200.00 Subtotal (see instructions)	15, 227, 911	27, 950	15, 255, 86	1		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	15, 227, 911	27, 950	15, 255, 86	1		202.00

Cost Center Description         PPS Inpatient Ratio 11.00         Title XVIII         Hospital         PPS           INPATLENT ROUTINE SERVICE COST CENTERS         30.00         03000 ADULTS & PEDIATRICS         30.00         30.00           44.00         Od4000 SKILLED NURSING FACILITY         44.00         44.00         44.00           ANCILLARY SERVICE COST CENTERS         54.00         05400 RADIOLOGY-DIAGNOSTIC         0.111338         57.00           54.00         05500 CT SCAN         0.111420         54.00         56.00           60.00         06000 LABORATORY         0.156036         60.00           60.00         06000 PHYSICAL THERAPY         0.244266         65.00           61.00         06000 PHYSICAL THERAPY         0.587323         67.00           62.00         06200 RDUS CHARGED TO PATIENTS         0.346522         73.00           71.00         07100 MEDICAL SUPPLIES CHARGED TO PATIENTS         0.346522         73.00           74.00         07300 REVAL DIALYSIS         0.000000         74.00         76.00           71.00         07100 ENCICAL SUPPLIES CHARGED TO PATIENTS         0.000000         74.00         73.00           71.00         07000 ENCERCHY         0.000000         74.00         73.00         73.00           <	COMPUTATION OF RATIO OF COSTS TO CHARGES	<u> </u>	Provi der CCN: 15-3049	Period: From 12/17/2021 To 12/31/2022	Worksheet C Part I Date/Time Pro 5/17/2023 3:	epared: 18 pm
Rait o         11.00           30.00         03000 ADULTS & PEDIATRICS         30.00           44.00         04400 SKILLED NURSING FACILITY         44.00           ANCILLARY SERVICE COST CENTERS         54.00           54.00         05400 RADIOLGY-DI AGNOSTIC         0.111338           57.00         05700 (T SCAN         0.111420           60.00         06000 LABORATORY         0.1156036           60.00         06000 LABORATORY         0.244266           61.00         06000 LABORATORY         0.625366           62.00         06500 RESPI RATORY THERAPY         0.242266           62.00         06000 LABORATORY         0.570829           66.00         066.00         06500 RESPI RATORY THERAPY         0.570829           67.00         00700 OCUPATI ONAL THERAPY         0.570829           68.00         06800 SPEECH PATHOLOGY         0.570829           71.00         07100 MEDICAL SUPPLIES CHARGED TO PATIENTS         0.346522           71.00         07100 DICAL SUPPLIES CHARGED TO PATIENTS         0.000000           74.00         07400 RENAL DIALYSIS         0.000000           74.00         07400 CENTERS         0.000000           91.01         04950 OUTPATIENT WOUND CENTER         0.000000      <			Title XVIII	Hospi tal	PPS	
INPATI ENT ROUTI NE SERVI CE COST CENTERS         30.00           0.00         03000 ADULTS & PEDI ATRI CS         30.00           44.00         04400 (Ski LLED NURSI NG FACI LI TY         44.00           ANCI LLARY SERVI CE COST CENTERS         54.00           54.00         05400 (RADI OLGGY-DI AGNOSTI C         0.111338           54.00         05400 (RADI OLGGY-DI AGNOSTI C         0.111340           58.00         05500 (LABORATORY         0.156036           60.00         06000 (LABORATORY         0.156036           60.00         06500 RESPI RATORY THERAPY         0.244266           60.00         06000 SPECH PATHOLOGY         0.570823           67.00         06700 OCCUPATI ONAL THERAPY         0.587323           67.00         06700 OCCUPATI ONAL THERAPY         0.570829           68.00         06800 SPECH PATHOLOGY         0.570829           71.00         07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS         0.346522           73.00         73.00         73.00           74.00         RANL DI ALYSI S         0.000000           74.00         OPAGE ONT CENTERS         0.000000           91.00         01700 EMERCANY SERVI CE COST CENTERS         95.00           95.00         04950 OUTPATI ENT THERAPY         0.0000	Cost Center Description					
INPATI ENT ROUTI NE SERVICE COST CENTERS         30.00         30.00         30.00           30.00         03000 ADULTS & PEDI ATRICS         30.00           44.00         SKILLED NURSING FACILLITY         44.00           ANCILLARY SERVICE COST CENTERS         54.00         05400 RADIOLOGY-DIAGNOSTIC         0.111338           54.00         05700 (CT SCAN         0.111420         54.00           58.00         05800 MAGNETIC RESONANCE I MAGI NG (MRI )         0.000000         60.00           60.00         06000 LABORATORY         0.156036         60.00           61.00         06700 CUTSTI CAL THERAPY         0.244266         65.00           62.00         06500 RESPI RATORY THERAPY         0.587323         67.00           64.00         06400 SPEECH PATHOLOGY         0.570829         68.00           65.00         07300 DRUGS CHARGED TO PATI ENTS         0.346522         73.00           71.00         07300 DRUGS CHARGED TO PATI ENTS         0.000000         74.00           70.00         07100 MEDI CAL SUPPLIES COST CENTERS         0.000000         74.00           70.00         07400 RENAL DI ALYSIS         0.000000         74.00           70.00         09500 THER ANCI LLARY SERVICE COST CENTERS         0.0000000         74.00						
30.00       03000 ADULTS & PEDIATRICS       30.00         44.00       04400 \$KILLED NURSING FACILITY       44.00         ARCULLARY SERVICE COST CENTERS       44.00         54.00       05400 RADIOLOGY-DIAGNOSTIC       0.111338         57.00       05700 CT SCAN       0.111420         58.00       05800 MAGNETIC RESONANCE IMAGING (MRI)       0.000000         60.00       06000 LABORATORY       0.165036         60.00       06000 PHYSI CAL THERAPY       0.244266         60.00       06000 PHYSI CAL THERAPY       0.525366         61.00       06000 SPEECH PATHOLOGY       0.570829         68.00       06800 SPEECH PATHOLOGY       0.570829         68.00       07300 DRUGS CHARGED TO PATIENTS       0.346522         71.00       07300 DRUGS CHARGED TO PATIENTS       0.340600         71.00       0.000000       74.00         71.00       000000       74.00         71.00       0.000000       74.00         71.00       0.000000       74.00         71.00       0.000000       74.00         71.00       0.000000       74.00         71.00       0.000000       74.00         71.00       0.0000000       74.00		11.00				
44.00       04400       SKI LLED NURSING FACI LI TY       44.00         ANCI LLARY SERVICE COST CENTERS       54.00       54.00       55.00       54.00       57.00       55.00       56.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       71.00       71.00       71.00       71.00       71.00       71.00       71.00       71.00       71.00       71.00       71.00       71.00       73.00       74.00       74.00       74.00		1 1				
ANCILLARY SERVICE COST CENTERS           54. 00         05400 [RADIOLOGY-DIAGNOSTIC         0.111338         54.00           57. 00         05700 [CT SCAN         0.111420         57.00           58. 00         05800 [MAGNETIC RESONANCE I MAGING (MRI)         0.000000         58.00           60. 00         06000 [ABORATORY         0.156036         60.00           65. 00         06500 [RSSPI RATORY THERAPY         0.244266         65.00           66. 00         06600 [PHYSI CAL THERAPY         0.625366         66.00           67. 00         06700 [OCCUPATI ONAL THERAPY         0.570829         67.00           68. 00         06800 [PEECH PATHOLOGY         0.570829         68.00           73. 00         07300 [DRUGS CHARGED TO PATI ENTS         8.099166         71.00           74. 00         7400 [RENAL DI ALYSI S         0.000000         74.00           74. 00         07400 [RENAL DI ALYSI S         0.000000         74.00           74. 00         07400 [RENAL DI ALYSI S         0.000000         74.00           75. 00         09500 [OTHER ABCI LLARY SERVICE COST CENTERS         0.000000         74.00           70. 00         07400 [RENAL DI ALYSI S         0.000000         74.00           76. 00         09500 [OTHER ABCI LLLARY S						
54.00       05400       RADI OLOGY-DI AGNOSTI C       0.111338       54.00         57.00       05700       CT SCAN       0.111420       57.00         58.00       05800       MAGRETI C RESONANCE I MAGI NG (MRI )       0.000000       58.00         60.00       06000       LABORATORY       0.156036       60.00         65.00       06500       RESPI RATORY THERAPY       0.242426       65.00         66.00       06500       PCUIPATI ONAL THERAPY       0.587323       67.00         68.00       06600       SPEECH PATHOLOGY       0.570829       68.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       8.099166       71.00         73.00       O7300       DRUGS CHARGED TO PATI ENTS       0.346522       73.00         74.00       07400       RENAL DI ALYSI S       0.000000       74.00         76.00       09500       OTHER ANCI LLARY SERVI CE COST CENTERS       0.000000       91.01         91.00       91.00       G9500       OTHER REI MBURSABLE COST CENTERS       91.00         91.00       9500       OTHER REI MBURSABLE COST CENTERS       91.00         91.00       9500       OTHER SPECI AL PURPOSE COST CENTERS       95.00         95.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td>44.00</td>						44.00
57.00       05700       CT SCAN       0.111420       57.00         58.00       05800       MAGNETIC RESONANCE I MAGING (MRI)       0.000000       58.00         60.00       LABORATORY       0.156036       60.00         65.00       06500       RESPI RATORY THERAPY       0.244266       65.00         66.00       06600       PHYSI CAL THERAPY       0.625366       66.00         67.00       06700       OCUPATI ONAL THERAPY       0.587323       67.00         68.00       06600       SPECH PATHOLOGY       0.570829       68.00       66.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       8.099166       71.00       73.00         74.00       07400       RENAL DI ALYSI S       0.000000       74.00       74.00         74.00       04951       OUTPATI ENT SERVICE COST CENTERS       0.000000       76.00       91.01         91.00       04950       OUTPATI ENT SUPPLIES       0.000000       91.01       91.00         93.00       OTHER REIMBURSABLE COST CENTERS       0.000000       91.01       93.00         0101.00       HOME HEALTH AGENCY       0.000000       91.01       91.00         95.00       OFSOO       AMBULANCE SERVICES						
58.00       05800       MAGNETIC RESONANCE I MAGING (MRI)       0.000000       58.00         60.00       06000       LABORATORY       0.156036       60.00         65.00       06600       PHYSICAL THERAPY       0.244266       66.00         67.00       06600       CUPATI ONAL THERAPY       0.587323       67.00         68.00       06800       SPEECH PATHOLOGY       0.570829       68.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       0.346522       73.00         74.00       07400       RENAL DI ALYSIS       0.000000       74.00         03950       OTHER ANCILLARY SERVICE COST CENTERS       0.000000       74.00         91.00       09100       EMERGENCY       0.000000       74.00         91.01       04951       OUTPATI ENT THERAPY       0.000000       74.00         91.00       09100       EMERGENCY       0.000000       91.01         93.00       OTHER REI MBURSABLE COST CENTERS       0.000000       91.01         94.00       0.9500       MBULANCE SERVICES       0.000000       91.01         95.00       09500       OTHER REI MBURSABLE COST CENTERS       101.00       101.00         95.00       09500       THER SP						
60.00       06000       LABORATORY       0. 156036       60.00         65.00       06500       RESPI RATORY THERAPY       0. 244266       65.00         66.00       06600       PHYSI CAL THERAPY       0. 625366       66.00         67.00       0CCUPATI ONAL THERAPY       0. 587323       67.00         68.00       06800       SPEECH PATHOLOGY       0. 570829       68.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       8.099166       71.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0. 346522       73.00         74.00       07400       RENAL DI ALYSI S       0. 000000       74.00         71.00       09100       EMERGENCY       0. 000000       76.00         91.00       09100       EMERGENCY       0. 000000       91.01         91.00       09100       EMERGENCY       0. 000000       91.01         93.00       OTHER REI MBURSABLE COST CENTERS       0. 000000       91.01         91.00       09500       OTHATI ENT WOUND CENTER       0. 000000       93.00         0110.00       10100       HOME HEALTH AGENCY       0. 000000       93.00         95.00       095000       OTHER SPECI AL PURPOSE COST	57.00 05700 CT SCAN	0. 111420				
65.00       06500       RESPI RATORY THERAPY       0.244266       65.00         66.00       06600       PHYSI CAL THERAPY       0.625366       66.00         67.00       0COUPATI ONAL THERAPY       0.587323       67.00         68.00       06800       SPEECH PATHOLOGY       0.570829       68.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       8.099166       71.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0.346522       73.00         74.00       07400       RENAL DI ALYSI S       0.000000       74.00         75.00       03950       OTHER ANCI LLARY SERVICE COST CENTERS       0.000000       91.01         91.00       09100       EMERGENCY       0.000000       91.01         91.01       04951       OUTPATI ENT THERAPY       0.000000       91.01         93.00       04950       OUTPATI ENT WOUND CENTER       0.000000       91.01         95.00       09500       AMBULANCE SERVI CES       0.000000       95.00         101.00       10100       HEM SABLE COST CENTERS       95.00       95.00         101.00       10100       HOME HEALTH AGENCY       101.00       95.00         101.00       10100 <td>58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)</td> <td>0. 000000</td> <td></td> <td></td> <td></td> <td>58.00</td>	58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000				58.00
66.00       06600       PHYSI CAL THERAPY       0.625366       66.00         67.00       06700       OCCUPATI ONAL THERAPY       0.587323       67.00         68.00       06800       SPEECH PATHOLOGY       0.570829       68.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       8.099166       71.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.346522       73.00         74.00       07400       RENAL DI ALYSI S       0.000000       74.00         76.00       093050       OTHER ANCI LLARY SERVICE COST CENTERS       0.000000       74.00         91.00       09100       EMERGENCY       0.000000       91.01         91.01       04951       OUTPATI ENT THERAPY       0.000000       91.01         93.00       OF500       OHBUSABLE COST CENTERS       0.000000       91.01         93.00       OF500       MBULANCE SERVI CES       0.000000       95.00       95.00         01.00       HOME HEALTH AGENCY       0.000000       95.00       95.00       01HER SPECI AL PURPOSE COST CENTERS       101.00         101.00       IOTOO HOME HEALTH AGENCY       0.000000       0.500000       95.00       101.00         101.00       OF500	60. 00 06000 LABORATORY	0. 156036				60.00
67.00       06700       0CCUPATI ONAL THERAPY       0.587323       67.00         68.00       06800       SPEECH PATHOLOGY       0.570829       68.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       8.099166       71.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.346522       73.00         74.00       07400       RENAL DI ALYSI S       0.000000       74.00         0.03950       OTHER ANCI LLARY SERVICE COST CENTERS       0.000000       76.00         001701       MERGENCY       0.000000       76.00         01702       DERREGENCY       0.000000       76.00         91.00       04950       OUTPATI ENT THERAPY       0.000000       91.01         93.00       04950       OUTPATI ENT WOUND CENTER       0.000000       91.01         93.00       04950       OUTPATI ENT WOUND CENTER       0.000000       91.01         95.00       09500       AMBULANCE SERVI CES       0.000000       95.00         101.00       10100       HOME HEALTH AGENCY       101.00       95.00         101.00       6950       OTHER SPECI AL PURPOSE COST CENTERS       101.00       200.00         200.00       Subtotal (see instructions)	65. 00 06500 RESPI RATORY THERAPY	0. 244266				65.00
68.00       06800       SPEECH PATHOLOGY       0.570829       68.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       8.099166       71.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.346522       73.00         74.00       07400       RENAL DI ALYSI S       0.000000       74.00         76.00       03950       OTHER ANCI LLARY SERVICE COST CENTERS       0.000000       74.00         70.00       09100       EMERGENCY       0.000000       74.00         91.00       09100       EMERGENCY       0.000000       91.01         93.00       04951       0UTPATI ENT THERAPY       0.000000       91.01         93.00       04950       0UTPATI ENT WOUND CENTER       0.000000       91.01         93.00       04950       0UTPATI ENT WOUND CENTER       0.000000       93.00         011.00       10100       HOME HEALTH AGENCY       93.00       95.00       101.00         101.00       10100       HOME HEALTH AGENCY       101.00       101.00       95.00       101.00       101.00         101.00       10100       HOME HEALTH AGENCY       101.00       101.00       101.00       101.00       101.00       200.00       20	66. 00 06600 PHYSI CAL THERAPY	0. 625366				66.00
71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       8.099166       71.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0.346522       73.00         74.00       07400       RENAL DIALYSIS       0.000000       74.00         76.00       03950       OTHER ANCILLARY SERVICE COST CENTERS       0.000000       74.00         01000       EMERGENCY       0.000000       70.00       70.00         91.00       04950       OUTPATIENT THERAPY       0.000000       91.01         93.00       04950       OUTPATIENT WOUND CENTER       0.000000       91.01         93.00       04950       OUTPATIENT WOUND CENTER       0.000000       93.00         01010       INDER REI MBURSABLE COST CENTERS       0.000000       93.00         01010       INDER REI MBURSABLE COST CENTERS       95.00       95.00         95.00       09500       AMBULANCE SERVICES       0.000000       95.00         101.00       IODE MERGENCY       101.00       101.00       10100       HOME HEALTH AGENCY       101.00         101.00       GOSOO       OUTPATIENT SERVICES       0.000000       101.00       101.00       101.00       101.00         101.00       HOME SECOST CENTERS	67.00 06700 OCCUPATI ONAL THERAPY	0. 587323				67.00
73.00       07300       DRUGS CHARGED TO PATIENTS       0.346522       73.00         74.00       07400       RENAL DI ALYSI S       0.000000       74.00         76.00       03950       OTHER ANCILLARY SERVICE COST CENTERS       0.000000       76.00         0UTPATIENT SERVICE COST CENTERS       0.000000       76.00       79.00         91.00       09100       EMERGENCY       0.000000       91.01         93.00       04950       OUTPATIENT THERAPY       0.000000       91.01         93.00       04950       OUTPATIENT WOUND CENTER       0.000000       93.00         0THER REIMBURSABLE COST CENTERS       0.000000       95.00       95.00         01.00       10100       HOME HEALTH AGENCY       0.000000       95.00         101.00       10100       HOME SERVICES       0.000000       95.00         101.00       10100       HOME SERVICES       0.000000       95.00         117.00       06950       OTHER SPECIAL PURPOSE COST CENTERS       117.00         200.00       Subtotal (see instructions)       200.00       201.00         201.00       Less Observation Beds       201.00       201.00	68.00 06800 SPEECH PATHOLOGY	0. 570829				68.00
74.00       07400       RENAL DI ALYSI S       0.000000       74.00         76.00       03950       OTHER ANCI LLARY SERVICE COST CENTERS       0.000000       76.00         0UTPATI ENT SERVICE COST CENTERS       0.000000       91.01       91.00         91.00       09100       EMERGENCY       0.000000       91.01         93.00       04950       0UTPATI ENT THERAPY       0.000000       93.00         93.00       04950       0UTPATI ENT WOUND CENTER       0.000000       93.00         0       04950       0UTPATI ENT WOUND CENTER       0.000000       93.00         0       04950       0HER REI MBURSABLE COST CENTERS       95.00       95.00       95.00         101.00       10100       HOME HEALTH AGENCY       0.000000       101.00       101.00       101.00       101.00       101.00       101.00       101.00       101.00       101.00       0.000000       95.00       101.00       101.00       101.00       006950       OTHER SPECIAL PURPOSE COST CENTERS       101.00       101.00       200.00       201.00       200.00       200.00       201.00       201.00       200.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       20	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	8. 099166				71.00
76.00         03950         OTHER ANCI LLARY SERVICE COST CENTERS         0.000000         76.00           0UTPATI ENT SERVICE COST CENTERS         0.000000         91.00         91.00         91.00         91.00         91.00         91.00         91.00         91.00         91.01         04951         0UTPATI ENT THERAPY         0.000000         91.01         93.00         93.00         91.01         93.00         93.00         91.01         93.00         95.00         00500         AMBULANCE SERVICES         0.000000         93.00         93.00         95.00         95.00         101.00         10100         HOME HEALTH AGENCY         95.00         101.00         200.00         200.00	73.00 07300 DRUGS CHARGED TO PATIENTS	0. 346522				73.00
OUTPATI ENT SERVICE COST CENTERS         0.00000         91.00           91.00         09100         EMERGENCY         0.000000         91.01           91.01         04951         OUTPATI ENT THERAPY         0.000000         91.01           93.00         04950         OUTPATI ENT WOUND CENTER         0.000000         93.00           0THER         REI MBURSABLE COST CENTERS         0.000000         93.00           010100         HOME HEALTH AGENCY         0.000000         95.00           101.00         IODHOME HEALTH AGENCY         0.000000         95.00           101.00         HOME HEALTH AGENCY         101.00         101.00           101.00         GOEGO COST CENTERS         117.00         101.00           200.00         Subtotal (see instructions)         200.00         201.00           201.00         Less Observation Beds         201.00         201.00	74.00 07400 RENAL DI ALYSI S	0. 000000				74.00
91. 00       09100       EMERGENCY       0.000000       91. 01         91. 01       04951       OUTPATI ENT THERAPY       0.000000       91. 01         93. 00       04950       OUTPATI ENT WOUND CENTER       0.000000       93. 00         0       04950       OUTPATI ENT WOUND CENTER       0.000000       93. 00         0       04950       OUTPATI ENT WOUND CENTER       0.000000       95. 00         0       09500       AMBULANCE SERVICES       0.000000       95. 00         101.00       1000       HOME HEALTH AGENCY       101. 00       101. 00         SPECIAL PURPOSE COST CENTERS       117. 00       06950       0THER SPECIAL PURPOSE COST CENTERS       117. 00         200. 00       Subtotal (see instructions)       200. 00       201. 00       201. 00       201. 00	76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000				76.00
91. 01       04951       0UTPATI ENT THERAPY       0.000000       91. 01         93. 00       04950       0UTPATI ENT WOUND CENTER       0.000000       93. 00         0THER REI MBURSABLE COST CENTERS       0.000000       95. 00       95. 00         101.00       10100       HOME HEALTH AGENCY       95. 00       95. 00         SPECI AL PURPOSE COST CENTERS       117. 00       117. 00       117. 00         200. 00       Subtotal (see instructions)       117. 00       200. 00       201. 00	OUTPATIENT SERVICE COST CENTERS					
93.00         04950         OUTPATI ENT WOUND CENTER         0.000000         93.00           OTHER REI MBURSABLE COST CENTERS         0.000000         95.00         95.00         95.00         95.00         95.00         101.00         10100         HOME HEALTH AGENCY         95.00         101.00         101.00         10100         HOME SPECIAL PURPOSE COST CENTERS         101.00         101.00         101.00         101.00         117.00         200.00         201.00 </td <td>91.00 09100 EMERGENCY</td> <td>0. 000000</td> <td></td> <td></td> <td></td> <td>91.00</td>	91.00 09100 EMERGENCY	0. 000000				91.00
OTHER         REI MBURSABLE         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         117.00           200.00         Subtotal         (see instructions)         200.00         201.00         201.00	91. 01 04951 OUTPATI ENT THERAPY	0. 000000				91.01
95. 00         09500         AMBULANCE SERVICES         0.000000         95. 00           101. 00         10100         HOME         HEALTH         AGENCY         101. 00           SPECI AL         PURPOSE         COST         CENTERS         117. 00           117. 00         06950         OTHER         SPECI AL         PURPOSE         COST         CENTERS           200. 00         Subtotal         (see instructions)         200. 00         201. 00         201. 00	93.00 04950 OUTPATIENT WOUND CENTER	0. 000000				93.00
101.00         HOME         HEALTH         AGENCY         101.00           SPECIAL         PURPOSE         COST         CENTERS         117.00           117.00         06950         OTHER         SPECIAL         PURPOSE         COST         CENTERS         117.00           200.00         Subtotal         (see instructions)         200.00         201.00 <td>OTHER REIMBURSABLE COST CENTERS</td> <td></td> <td></td> <td></td> <td></td> <td></td>	OTHER REIMBURSABLE COST CENTERS					
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	95.00 09500 AMBULANCE SERVICES	0. 000000				95.00
117. 00         06950         OTHER SPECIAL PURPOSE COST CENTERS         117. 00           200. 00         Subtotal (see instructions)         200. 00           201. 00         Less Observation Beds         201. 00	101.00 10100 HOME HEALTH AGENCY					101.00
200.00         Subtotal (see instructions)         200.00           201.00         Less Observation Beds         201.00	SPECIAL PURPOSE COST CENTERS					
201.00 Less Observation Beds 201.00	117.0006950 OTHER SPECIAL PURPOSE COST CENTERS					117.00
	200.00 Subtotal (see instructions)					200.00
202.00 Total (see instructions) 202.00	201.00 Less Observation Beds					201.00
	202.00 Total (see instructions)					202.00

Health Financial Systems Bloo	omington Regional	Rehabilitation	Hosp	In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 12/17/2021 To 12/31/2022	Worksheet C Part I Date/Time Pre 5/17/2023 3:1	pared: 8 pm
		Titl	e XIX	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst. B,	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	Part I, col. 26)					
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	10, 069, 153		10, 069, 15	3 0	10, 069, 153	30.00
44.00 04400 SKILLED NURSING FACILITY	0			0 0	0	44.00
ANCILLARY SERVICE COST CENTERS						
54.00 05400 RADI OLOGY-DI AGNOSTI C	49, 823		49, 82	3 0	49, 823	54.00
57.00 05700 CT SCAN	2, 923		2, 92	3 0	2, 923	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0			0 0	0	58.00
60. 00 06000 LABORATORY	119, 488		119, 48		119, 488	60.00
65. 00 06500 RESPI RATORY THERAPY	270, 894	0	270, 89	4 0	270, 894	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 098, 672	0	1, 098, 67	2 0	1, 098, 672	66.00
67.00 06700 OCCUPATI ONAL THERAPY	987, 184	0	987, 18	4 0	987, 184	67.00
68.00 06800 SPEECH PATHOLOGY	359, 611	0	359, 61	1 0	359, 611	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	324, 161		324, 16	1 0	324, 161	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	709, 012		709, 01	2 0	709, 012	73.00
74.00 07400 RENAL DIALYSIS	0			0 0	0	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	5 728		72	8 0	728	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	93.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0			0 0		95.00
101.00 10100 HOME HEALTH AGENCY	0			0	0	101.00
SPECIAL PURPOSE COST CENTERS						
117.00069500THER SPECIAL PURPOSE COST CENTERS	0			0		117.00
200.00 Subtotal (see instructions)	13, 991, 649	0	13, 991, 64	9 0	13, 991, 649	
201.00 Less Observation Beds	0			0	-	201.00
202.00  Total (see instructions)	13, 991, 649	0	13, 991, 64	9 0	13, 991, 649	202.00

Health Financial Systems         Bloomi           COMPUTATION OF RATIO OF COSTS TO CHARGES         COMPUTATION OF RATIO OF COSTS TO CHARGES	ngton Regional	Provider C		Period: From 12/17/2021 To 12/31/2022	Worksheet C Part I Date/Time Pre 5/17/2023 3:1	
			e XIX	Hospi tal	PPS	
		Charges				
Cost Center Description	Inpati ent	Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA Inpatient Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	6, 753, 600		6, 753, 60	00		30.00
44.00 04400 SKILLED NURSING FACILITY	0			0		44.00
ANCI LLARY SERVICE COST CENTERS						
54.00 05400 RADI OLOGY-DI AGNOSTI C	447, 494	C	447,49			
57.00 05700 CT SCAN	26, 234	C	26, 23	0. 111420	0.00000	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	C		0 0.000000	0.00000	58.00
60. 00 06000 LABORATORY	765, 771	C	765, 7	0. 156036	0.00000	
65. 00 06500 RESPI RATORY THERAPY	1, 109, 013	C	1, 109, 0		0.00000	
66. 00 06600 PHYSI CAL THERAPY	1, 735, 720	21, 125	1, 756, 84		0.00000	
67.00 06700 OCCUPATIONAL THERAPY	1, 680, 820	C	1, 680, 82		0.00000	
68.00 06800 SPEECH PATHOLOGY	623, 155	6, 825	629, 98			68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	40, 024	C	40, 02	8. 099166	0.00000	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 046, 080	C	2, 046, 08	0. 346522	0.00000	73.00
74.00 07400 RENAL DIALYSIS	0	C	)	0 0.000000	0.00000	74.00
76.00 03950 OTHER ANCI LLARY SERVICE COST CENTERS	0	C	)	0 0.000000	0.00000	76.00
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	0	C		0 0.000000		
91. 01 04951 OUTPATI ENT THERAPY	0	C	)	0 0.000000	0.00000	91.01
93.00 04950 OUTPATIENT WOUND CENTER	0	C	)	0 0.000000	0.00000	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES	0	C		0 0.000000	0.00000	
101.0010100 HOME HEALTH AGENCY	0	C	)	0		101.00
SPECIAL PURPOSE COST CENTERS						
117.0006950 OTHER SPECIAL PURPOSE COST CENTERS	0	C		0		117.00
200.00 Subtotal (see instructions)	15, 227, 911	27, 950	15, 255, 80	51		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	15, 227, 911	27, 950	15, 255, 80	51		202.00

In Lieu of Form CMS-2552-10

From 12/17/2021   Part I To 12/31/2022 Date/Time Pre 5/17/2023 3:1	
Title XIX Hospital PPS	
Cost Center Description PPS Inpatient	
Ratio	
11.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	
30. 00 03000 ADULTS & PEDIATRICS	30.00
44. 00 04400 SKILLED NURSING FACILITY	44.00
ANCI LLARY SERVI CE COST CENTERS	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 111338	54.00
57. 00 05700 CT SCAN 0. 111420	57.00
58. 00 05800 MAGNETIC RESONANCE I MAGI NG (MRI) 0. 000000	58.00
60. 00 06000 LABORATORY 0. 156036	60.00
65. 00 06500 RESPI RATORY THERAPY 0. 244266	65.00
66. 00 06600 PHYSI CAL THERAPY 0. 625366	66.00
67. 00 06700 OCCUPATIONAL THERAPY 0. 587323	67.00
68. 00 06800 SPEECH PATHOLOGY 0. 570829	68.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 8. 099166	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 346522	73.00
74. 00 07400 RENAL DI ALYSI S 0. 000000	74.00
76. 00 03950 OTHER ANCI LLARY SERVICE COST CENTERS 0. 000000	76.00
OUTPATIENT SERVICE COST CENTERS	
91. 00 09100 EMERGENCY 0. 000000	91.00
91. 01 04951 OUTPATIENT THERAPY 0. 000000	91.01
93. 00 04950 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
	200. 00
	201.00
202.00 Total (see instructions)	202.00

Health Financial Systems Bloomin	ngton Regional	Rehabilitation	Hosp	In Lie	u of Form CMS-:	2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RA REDUCTIONS FOR MEDICAID ONLY	TIOS NET OF	Provider C		Period: From 12/17/2021 To 12/31/2022	5/17/2023 3:1	
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Total Cost	Capital Cost	Operating Cos	st Capital	Operating Cost	
	(Wkst. B, Part	(Wkst. B, Part	Net of Capita	al Reduction	Reduction	
	I, col. 26)	II col. 26)	Cost (col. 1	-	Amount	
			col. 2)			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS			_			
54.00 05400 RADI OLOGY-DI AGNOSTI C	49, 823	2, 367	47, 45	6 0	0	54.00
57.00 05700 CT SCAN	2, 923	139	2, 78	34 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C		0 0	0	58.00
60. 00 06000 LABORATORY	119, 488	10, 575	108, 91	3 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	270, 894	28, 228	242, 66	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 098, 672	208, 740	889, 93	32 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	987, 184	198, 260	788, 92	24 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	359, 611	31, 388	328, 22	23 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	324, 161	59, 379	264, 78	32 0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	709, 012	87, 795	621, 21	7 0	0	73.00
74.00 07400 RENAL DI ALYSI S	0	C		0 0	0	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	728	15	7	3 0	0	76.00
OUTPATIENT SERVICE COST CENTERS				- <u> </u>		
91. 00 09100 EMERGENCY	0	C		0 0	0	91.00
91. 01 04951 OUTPATI ENT THERAPY	0	C		0 0	0	91.01
93.00 04950 OUTPATIENT WOUND CENTER	0	C		0 0	0	93.00
OTHER REIMBURSABLE COST CENTERS				<u> </u>		
95. 00 09500 AMBULANCE SERVICES	0	C		0 0	0	95.00
101.00 10100 HOME HEALTH AGENCY	0	C		0 0	0	101.00
SPECIAL PURPOSE COST CENTERS			1	- <u> </u>		
117.0006950 OTHER SPECIAL PURPOSE COST CENTERS	0	C		0 0	0	1117.00
200.00 Subtotal (sum of lines 50 thru 199)	3, 922, 496	626, 886	3, 295, 61	0 0		200.00
201.00 Less Observation Beds	0	0		0 0		201.00
202.00 Total (line 200 minus line 201)	3, 922, 496	626, 886	3, 295, 6	0 0		202.00
				1		

Health Financial Systems Bloomi	ngton Regional	Rehabilitation	Hosp	In Lie	u of Form CMS-	2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RA	ATIOS NET OF	Provider CO	CN: 15-3049	Peri od:	Worksheet C	
REDUCTIONS FOR MEDICALD ONLY				From 12/17/2021	Part II	
				To 12/31/2022	Date/Time Pre 5/17/2023 3:1	
		Ti †I	e XIX	Hospi tal	PPS	
Cost Center Description	Cost Net of	Total Charges				
		(Worksheet C,		ae		
	Operating Cost					
	Reduction	8)	/ col. 7)			
	6.00	7.00	8.00			
ANCILLARY SERVICE COST CENTERS						
54.00 05400 RADI OLOGY-DI AGNOSTI C	49, 823	447, 494	0. 11133	38		54.00
57.00 05700 CT SCAN	2, 923	26, 234	0. 11142	20		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.0000	00		58.00
60. 00 06000 LABORATORY	119, 488	765, 771	0. 15603	36		60.00
65. 00 06500 RESPI RATORY THERAPY	270, 894	1, 109, 013	0. 24426	56		65.00
66. 00 06600 PHYSI CAL THERAPY	1, 098, 672	1, 756, 845	0. 62536	56		66.00
67.00 06700 OCCUPATI ONAL THERAPY	987, 184	1, 680, 820	0. 58732	23		67.00
68.00 06800 SPEECH PATHOLOGY	359, 611	629, 980	0. 57082	29		68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	324, 161	40, 024	8. 09916	56		71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	709, 012	2, 046, 080	0. 34652	22		73.00
74.00 07400 RENAL DIALYSIS	0	0	0. 00000	00		74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	728	0	0. 00000	00		76.00
OUTPATIENT SERVICE COST CENTERS						1
91.00 09100 EMERGENCY	0	0	0.0000	00		91.00
91. 01 04951 OUTPATI ENT THERAPY	0	0	0.0000	00		91.01
93.00 04950 OUTPATIENT WOUND CENTER	0	0	0.0000	00		93.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES	0	0	0.0000	00		95.00
101.00 10100 HOME HEALTH AGENCY	0	0	0.0000	00		101.00
SPECIAL PURPOSE COST CENTERS						
117.0006950 OTHER SPECIAL PURPOSE COST CENTERS	0	0	0.0000	00		117.00
200.00 Subtotal (sum of lines 50 thru 199)	3, 922, 496	8, 502, 261				200. 00
201.00 Less Observation Beds	0	0				201.00
202.00 Total (line 200 minus line 201)	3, 922, 496	8, 502, 261				202.00

Health Financial Systems Bloomi	th Financial Systems Bloomington Regional Rehabilitation Hosp					2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C		Period: Worksheet D		
				From 12/17/2021 To 12/31/2022	Part I Date/Time Pre	nared
				10 12/01/2022	5/17/2023 3:1	
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced		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, 597, 564	C	2, 597, 56	6, 433	403.79	30.00
44.00 SKILLED NURSING FACILITY	0			0 0	0.00	44.00
200.00 Total (lines 30 through 199)	2, 597, 564		2, 597, 56	6, 433		200.00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	3, 338	1, 347, 851				30.00
44.00 SKILLED NURSING FACILITY	0	C				44.00
200.00 Total (lines 30 through 199)	3, 338	1, 347, 851				200. 00

Health Financial Systems Bloomi	ngton Regional	Rehabilitation	Hosp	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provider C		Period: From 12/17/2021 To 12/31/2022	Worksheet D Part II Date/Time Pre 5/17/2023 3:1	pared: 8 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges		t Inpatient	Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	r	1	1		-	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 367	447, 494	0. 00528	9 261, 837	1, 385	54.00
57.00 05700 CT SCAN	139	26, 234			54	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.00000		0	58.00
60. 00 06000 LABORATORY	10, 575	765, 771	0. 01381	0 373, 135	5, 153	60.00
65. 00 06500 RESPI RATORY THERAPY	28, 228	1, 109, 013	0. 02545	574, 839	14, 631	65.00
66. 00 06600 PHYSI CAL THERAPY	208, 740	1, 756, 845	0. 11881	5 922, 010	109, 549	66.00
67.00 06700 OCCUPATI ONAL THERAPY	198, 260	1, 680, 820	0. 11795	4 879, 015	103, 683	67.00
68.00 06800 SPEECH PATHOLOGY	31, 388	629, 980	0. 04982	4 309, 205	15, 406	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	59, 379	40, 024	1. 48358	21, 251	31, 528	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	87, 795	2, 046, 080	0. 04290	923, 817	39, 640	73.00
74.00 07400 RENAL DIALYSIS	0	0	0.00000	0 0	0	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	15	0	0.00000	0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS						1
91.00 09100 EMERGENCY	0	0	0.0000	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	•					1
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	626, 886	8, 502, 261		4, 275, 284	321, 029	200.00

	loomington Regional				eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTH	HER PASS THROUGH COST	rs Provider C		Period: From 12/17/2021	Worksheet D Part III	
				To 12/31/2022		epared.
				10 12/01/2022	5/17/2023 3:1	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Healt	h Allied Health	All Other	
	Program	Program	Post-Stepdow	n Cost	Medi cal	
	Post-Stepdown	Ŭ	Adjustments		Education Cost	
	Adjustments					
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0		0 0	0	30.00
44.00 04400 SKILLED NURSING FACILITY	0	0		0 0		44.00
200.00 Total (lines 30 through 199)	0	0		0 0	0	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patien	t Per Diem (col.	Inpatient	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
	instructions)	minus col. 4)				
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	6, 43	0.00	3, 338	30.00
44.00 04400 SKILLED NURSING FACILITY		0		0 0.00	0	44.00
200.00 Total (lines 30 through 199)		0	6, 43	3	3, 338	200.00
Cost Center Description	I npati ent		•			
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
44.00 04400 SKILLED NURSING FACILITY	0					44.00
200.00 Total (lines 30 through 199)	0					200.00

Health Financial Systems Bloomington Regional Rehabilitation Hosp In Lieu of Form CM					au of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Period: From 12/17/2021 To 12/31/2022	Date/Time Pre 5/17/2023 3:1	
			XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments		Post-Stepdown Adjustments	Allied Health	
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS						
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
57.00 05700 CT SCAN	0	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0	)	0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	)	0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	)	0 0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	)	0 0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	)	0 0	0	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	C		0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	0	C		0 0	0	91.00
91. 01 04951 OUTPATI ENT THERAPY	0	0		0 0	0	91.01
93.00 04950 OUTPATIENT WOUND CENTER	0	0		0 0	0	93.00
OTHER REIMBURSABLE COST CENTERS		-				
95. 00 09500 AMBULANCE SERVI CES						95.00
200.00   Total (lines 50 through 199)	0	C		0 0	0	200. 00

Health Financial Systems Bloomi	ngton Regional	Rehabilitation	Hosp	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEA THROUGH COSTS	RVICE OTHER PASS	S Provider C		Period: From 12/17/2021 To 12/31/2022		pared:
					5/17/2023 3:1	
		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	
ANCI LLARY SERVICE COST CENTERS				1		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 447, 494	0.000000	54.00
57.00 05700 CT SCAN	0	0		0 26, 234	0.000000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0.000000	58.00
60. 00 06000 LABORATORY	0	0		0 765, 771	0.000000	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 1, 109, 013	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 1, 756, 845	0.000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 1, 680, 820	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 629, 980	0.000000	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 40, 024	0.000000	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 2, 046, 080	0.000000	73.00
74.00 07400 RENAL DIALYSIS	0	0		0 0	0.000000	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0		o o	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	0	0		0 0	0.00000	91.00
91. 01 04951 OUTPATI ENT THERAPY	0	0		o o	0.000000	91.01
93.00 04950 OUTPATIENT WOUND CENTER	0	0		o o	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS						1
95. 00 09500 AMBULANCE SERVI CES						95.00
200.00 Total (lines 50 through 199)	0	0		0 8, 502, 261		200.00
	•	•	•			•

Health Financial Systems Bloomi	ngton Regional I	Rehabilitation	Hosp	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEE THROUGH COSTS	Provider CO		Period: From 12/17/2021 To 12/31/2022	Worksheet D Part IV Date/Time Pre 5/17/2023 3:1	pared: 8 pm	
		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	Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col.	3	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVICE COST CENTERS						
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	261, 837		0 0	0	54.00
57. 00 05700 CT SCAN	0. 000000	10, 175		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0 0	0	58.00
60. 00 06000 LABORATORY	0. 000000	373, 135		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	574, 839		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	922, 010		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	879, 015		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	309, 205		0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	21, 251		0 0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	923, 817		0 0	0	73.00
74.00 07400 RENAL DI ALYSI S	0. 000000	0		0 0	0	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0		0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS						1
91.00 09100 EMERGENCY	0.000000	0		0 0	0	91.00
91. 01 04951 OUTPATI ENT 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	•		•		•	1
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)		4, 275, 284		0 0	0	200. 00

Health Financial Systems Bloomin	ngton Regional	Rehabilitation	Hosp	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCI NE COST	Provider C		Period: From 12/17/2021 To 12/31/2022	5/17/2023 3:1	
		Title	XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
		Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS		-				
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 111338	0		0 0	0	54.00
57.00 05700 CT SCAN	0. 111420	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0 0	0	58.00
60. 00 06000 LABORATORY	0. 156036	0		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 244266	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 625366	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 587323	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 570829			0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	8. 099166			0 0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 346522			0 0	0	
74. 00 07400 RENAL DI ALYSI S	0. 000000			0 0	0	
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000			0 0	0	
OUTPATIENT SERVICE COST CENTERS		-		-1 -		
91. 00 09100 EMERGENCY	0. 000000	0		0 0	0	91.00
91. 01 04951 OUTPATIENT THERAPY	0. 000000			0 0	0	
93. 00 04950 OUTPATIENT WOUND CENTER	0. 000000			0 0	0	
OTHER REIMBURSABLE COST CENTERS	0.000000	<u> </u>	1	<u> </u>	Ŭ	10100
95. 00 09500 AMBULANCE SERVICES	0.00000			0		95.00
200.00 Subtotal (see instructions)	0.00000	0		0 0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0	0	200.00
Only Charges						201.00
202.00 Net Charges (line 200 - line 201)		о		o o	0	202.00

Health Financial Systems Bloomi	ington Regional	Rehabilitation	Hosp	In Lie	u of Form CMS	-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	ID VACCINE COST	Provider C		Period: From 12/17/2021 To 12/31/2022	5/17/2023 3:	
	_		XVIII	Hospi tal	PPS	
		sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS						
54.00 05400 RADI OLOGY-DI AGNOSTI C	C	0				54.00
57.00 05700 CT SCAN	C	0				57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	C	0				58.00
60. 00 06000 LABORATORY	C	0				60.00
65. 00 06500 RESPI RATORY THERAPY	C	0				65.00
66. 00 06600 PHYSI CAL THERAPY	C	0				66.00
67.00 06700 OCCUPATIONAL THERAPY	C	0				67.00
68.00 06800 SPEECH PATHOLOGY	C	0 0				68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0 0				71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0 0				73.00
74.00 07400 RENAL DIALYSIS	0	0				74.00
76.00 03950 OTHER ANCI LLARY SERVICE COST CENTERS	0	0				76.00
OUTPATIENT SERVICE COST CENTERS	-	· · · ·	1			_
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					93.00
OTHER REIMBURSABLE COST CENTERS		-	1			
95. 00 09500 AMBULANCE SERVICES	(					95.00
200.00 Subtotal (see instructions)		ol o				200.00
201.00 Less PBP Clinic Lab. Services-Program	(					201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	0	o o				202.00
			1			

Health Financial Systems Bloor	i ngton Regi onal	Rehabilitation	Hosp	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITA	L COSTS	Provider C		Period:	Worksheet D	
				From 12/17/2021 To 12/31/2022	Part I Date/Time Pre 5/17/2023 3:1	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1	-	1		
30.00 ADULTS & PEDIATRICS	2, 597, 564	C	2, 597, 56	4 6, 433	403.79	30.00
44.00 SKILLED NURSING FACILITY	0			0 0	0.00	44.00
200.00 Total (lines 30 through 199)	2, 597, 564		2, 597, 56	4 6, 433		200.00
Cost Center Description	I npati ent	Inpati 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	92	37, 149				30.00
44.00 SKILLED NURSING FACILITY	0	C				44.00
200.00 Total (lines 30 through 199)	92	37, 149				200. 00

Health Financial Systems Bloomin	ngton Regional	Rehabilitation	Hosp	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provider C	CN: 15-3049	Period: From 12/17/2021 To 12/31/2022	Worksheet D Part II Date/Time Pre 5/17/2023 3:1	pared: 8 pm
			e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS	r	-	-			
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 367				7	54.00
57.00 05700 CT SCAN	139	26, 234			0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.0000		0	58.00
60. 00 06000 LABORATORY	10, 575		0. 01381			60.00
65. 00 06500 RESPI RATORY THERAPY	28, 228	1, 109, 013	0. 02545	53 21, 378	544	65.00
66. 00 06600 PHYSI CAL THERAPY	208, 740	1, 756, 845	0. 11881			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	198, 260		0. 11795			67.00
68.00 06800 SPEECH PATHOLOGY	31, 388	629, 980	0. 04982	24 5, 915	295	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	59, 379	40, 024	1. 48358	35 859	1, 274	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	87, 795	2, 046, 080	0.04290	32, 738	1, 405	73.00
74.00 07400 RENAL DIALYSIS	0	0	0.0000	0 0	0	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	15	0	0.0000	0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS			_			
91.00 09100 EMERGENCY	0	0	0.0000	0 0	0	91.00
91. 01 04951 OUTPATI ENT THERAPY	0	0	0.0000	0 0	0	91.01
93.00 04950 OUTPATIENT WOUND CENTER	0	0	0.0000	0 0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES						95.00
200.00 Total (lines 50 through 199)	626, 886	8, 502, 261		118, 626	9, 539	200. 00

	oomington Regional				eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHE	R PASS THROUGH COST	rs Provider C		Period: From 12/17/2021	Worksheet D Part III	
				To 12/31/2022		narod
				10 12/31/2022	5/17/2023 3:1	
		Titl	e XIX	Hospi tal	PPS	0 pm
Cost Center Description	Nursi ng	Nursi ng	Allied Healt	h Allied Health	All Other	
•	Program	Program	Post-Stepdow	n Cost	Medi cal	
	Post-Stepdown	Ŭ	Adjustments		Education Cost	
	Adjustments					
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0		0 0	0	30.00
44.00 04400 SKILLED NURSING FACILITY	0	0		0 0		44.00
200.00 Total (lines 30 through 199)	0	0		0 0	0	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patien	t Per Diem (col.	Inpatient	
·	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
	instructions)	minus col. 4)				
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	6, 43	0.00	92	30.00
44.00 04400 SKILLED NURSING FACILITY		0		0 0.00	0	44.00
200.00 Total (lines 30 through 199)		0	6, 43	3	92	200.00
Cost Center Description	I npati ent		•			
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
44.00 04400 SKILLED NURSING FACILITY	0					44.00
200.00 Total (lines 30 through 199)	0					200.00

Health Financial Systems Bloomin	ngton Regional	Rehabilitation	Hosp	In Li	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	RVICE OTHER PAS	S Provider C	CN: 15-3049	Period: From 12/17/2021 To 12/31/2022		pared: 8 pm
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng		Allied Health	
	Anesthetist	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS						
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0 0	
57.00 05700 CT SCAN	0	C		0 (	0 0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0 0	58.00
60. 00 06000 LABORATORY	0	C		0 (	0 0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0	)	0 0	0 0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	)	0 0	0 0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0	)	0 0	0 0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	o o	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0 0	o o	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0 0	o o	73.00
74.00 07400 RENAL DIALYSIS	0	C	)	0 0	o o	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	C	)	0 0	o o	76.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	0	C	)	0 (	0 0	91.00
91. 01 04951 OUTPATI ENT THERAPY	0	C	)	0 0	o o	91.01
93.00 04950 OUTPATIENT WOUND CENTER	0	C	)	0 0	o o	93.00
OTHER REIMBURSABLE COST CENTERS	•				·	1
95. 00 09500 AMBULANCE SERVI CES						95.00
200.00 Total (lines 50 through 199)	0	C		0 0	o o	200.00
	,					

Health Financial Systems Bloomi	ngton Regional	Rehabilitation	Hosp	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	6 Provider C		Period: From 12/17/2021	Worksheet D Part IV	
THROUGH COSTS				To 12/31/2022		pared:
					5/17/2023 3:1	8 pm
· · · · · · · · · · · · · · · · · · ·			e XIX	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost		Cost (sum of		(col. 5 ÷ col.	
		4)	cols. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS	-	-				
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 447, 494		
57.00 05700 CT SCAN	0	0		0 26, 234		
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0. 000000	
60. 00 06000 LABORATORY	0	0		0 765, 771	0. 000000	
65. 00 06500 RESPI RATORY THERAPY	0	0		0 1, 109, 013		
66. 00 06600 PHYSI CAL THERAPY	0	0		0 1, 756, 845	0. 000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 1, 680, 820	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 629, 980	0.000000	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 40, 024	0.000000	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 2, 046, 080	0.000000	73.00
74.00 07400 RENAL DIALYSIS	0	0		0 0	0.000000	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0 0	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	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS	·		•		•	
95.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	0		0 8, 502, 261		200. 00
			•			-

Health Financial Systems Bloomin	ngton Regional F	Rehabilitation	Hosp	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PASS	Provider CO		Period: From 12/17/2021 To 12/31/2022		
		Ti tl	e XIX	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.	3	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS						
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	1, 347		0 0	0	54.00
57.00 05700 CT SCAN	0. 000000	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0 0	0	58.00
60. 00 06000 LABORATORY	0. 000000	6, 339		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	21, 378		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	25, 870		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	24, 180		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	5, 915		0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	859		0 0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	32, 738		0 0	0	73.00
74.00 07400 RENAL DIALYSIS	0. 000000	0		0 0	0	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0		0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	0.000000	0		0 0	0	91.00
91. 01 04951 OUTPATI ENT 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						1
95. 00 09500 AMBULANCE SERVICES						95.00
200.00   Total (lines 50 through 199)		118, 626		0 0	0	200. 00

Bloomington Regional	Reh	nabilitation Hosp		In Lieu	ı
		Provider CCN: 15-3049	Peri od:		N

Lieu of Form CMS-2552-10

	TI NANCI AL SYSTEMS BI OOMI NG TON REGIONAL RE ATI ON OF INPATIENT OPERATING COST	Provider CCN: 15-3049	Peri od:	Worksheet D-1	
			From 12/17/2021 To 12/31/2022	Date/Time Pre 5/17/2023 3:1	
		Title XVIII	Hospi tal	PPS	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS	· · · · · ·			
1.00 2.00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			6, 433	1.00
3.00	Private room days (excluding swing-bed and observation bed da		rivate room days,	6, 433 0	2.00 3.00
4 00	do not complete this line.			( 100	4 00
4.00 5.00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro reporting period		er 31 of the cost	6, 433 0	4.00 5.00
6.00	Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	oom days) after December	31 of the cost	0	6.00
7.00	Total swing-bed NF type inpatient days (including private roo reporting period	om days) through December	31 of the cost	0	7.00
8.00	Total swing-bed NF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	om days) after December 3	31 of the cost	0	8. 00
9.00	Total inpatient days including private room days applicable t newborn days) (see instructions)	to the Program (excluding	g swing-bed and	3, 338	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instruc		room days)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII of December 31 of the cost reporting period (if calendar year, e	only (including private i	room days) after	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period		te room days)	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar )			0	13.00
14.00	Medically necessary private room days applicable to the Progr			0	14.00
15.00	Total nursery days (title V or XIX only)			0	
16.00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16.00
17.00	Medicare rate for swing-bed SNF services applicable to servic	ces through December 31 (	of the cost	0.00	17.00
18.00	reporting period Medicare rate for swing-bed SNF services applicable to servic	ces after December 31 of	the cost	0.00	18.00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	f the cost	0.00	19.00
20.00	reporting period Medicaid rate for swing-bed NF services applicable to service	es after December 31 of t	the cost	0.00	20. 00
21.00	reporting period Total general inpatient routine service cost (see instruction	าร)		10, 069, 153	21.00
22.00	Swing-bed cost applicable to SNF type services through Decemb 5 x line 17)		ting period (line	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reportin	ng period (line 6	0	23. 00
24.00	Swing-bed cost applicable to NF type services through December 7 x line 19)	er 31 of the cost reporti	ng period (line	0	24.00
25.00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	g period (line 8	0	25. 00
26.00	Total swing-bed cost (see instructions)			0	
27.00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		10, 069, 153	27.00
28.00	General inpatient routine service charges (excluding swing-be	ed and observation bed ch	narges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)		-	0	
30.00	Semi-private room charges (excluding swing-bed charges)	Line 20		0	
31.00 32.00	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	- IIIIe 28)		0.000000	
32.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34.00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instruc	ctions)	0.00	
35.00	Average per diem private room cost differential (line 34 x li			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 di	fferential (line	0 10, 069, 153	
57.00	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY			10,007,103	37.00
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	IUSTMENTS			1
38.00	Adjusted general inpatient routine service cost per diem (see	e instructions)		1, 565. 23	
39.00	Program general inpatient routine service cost (line 9 x line			5, 224, 738	
40.00	Medically necessary private room cost applicable to the Progr	, , ,		0 5 224 729	
41.00	Total Program general inpatient routine service cost (line 39	7 + TTHE 40)		5, 224, 738	41.00

To         11/21/202         District The Program Days District Total         District Total         Nerrage Part         Program Days Program Days         District Total         Nerrage Part         Program Days         District Cot           42.00         MURSTPY (11 to V A XIX orly)         10.00         4.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00		Financial Systems Bloomir ATION OF INPATIENT OPERATING COST	ngton Regional	Rehabilitation Provider C		Period:	u of Form CMS- Worksheet D-1	
Cost Center Description         Total Impattief Cost (cost)         Total (cost)							5/17/2023 3:1	
Image: the start of the sta		Cost Center Description		Total	Average Per	Program Days	Program Cost	
24.00         MARSLEY (Title V & XIX Only)         42.00           Interserve Care Toys [Deprication Heapital Units]         43.00           43.00         INTERSIVE CARE UNIT         45.00           43.00         INTERSIVE CARE UNIT         45.00           45.00         SURPLACE AND ALL AT EXEMPTION         45.00           45.00         SURPLACE AND ALL AT EXEMPTION         45.00           45.00         FORTER EXEMPTION         45.00           45.00         FORTER EXEMPTION         45.00           46.00         Program Ingatient and Lings Scare of Times 41 Anrough AS 03 (scale informatiling)         7.752.21           47.00         Times Exemption         48.00           47.00         Times Exemption         1.00           48.01         Times 41 Anrough AS 03 (scale informatiling)         7.752.21           47.00         Times 41 Anrough AS 03 (scale informatiling)         7.752.21           47.00         Times 41 Anrough AS 03 (scale informatiling)         7.752.21           47.00         Times 41 Anrough AS 03 (scale informatiling)         7.752.21           47.00         Times 50 and 51         7.752.21         7.00           47.00         Times 50 and 51         7.752.21         7.00           47.00         Times 51					col 2)		4)	
Interactive Care type Inpact int Hospital Units         43           0.0         INTERNAY CARE UNIT         44           4.00         Consumer Care Units         44           6.00         Program Inpatient Care Scient Units         40           6.00         Program Units         Consumer Care Units         53           6.00         Program On Care Units         53         53           6.00         Total Program Care Units         54         54           6.00         Total Program Care Units         54 </td <td>42.00</td> <td>NURSERY (title V &amp; XIX only)</td> <td>1.00</td> <td>2.00</td> <td>3.00</td> <td>4.00</td> <td>5.00</td> <td>42.00</td>	42.00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42.00
44.00       CORPONEY CARE UNIT       44.00         45.00       DORMARY CARE UNIT       45.00         45.00       DARG DAL INTERIVE CARE UNIT       45.00         45.00       DARG DAL INTERIVE CARE UNIT       45.00         45.00       DARG DAL LANGE STORE CARE UNIT       45.00         45.00       DARG DAL LANGE STORE CARE UNIT       1.00         45.00       DARG DAL LANGE STORE CARE UNIT       1.00         45.00       DARG DAL LANGE STORE CARE UNIT       1.00         45.00       Program Inpattent cell Ling * service ocst (Wart. D-S., col. 3. Line 200)       1.01         45.00       Instant Program Servicability for the S of metal 10.1 (See Transactions)       3.01.00         55.00       Program Inpattent operating cost excluding capital related, non-physician anesthetist, and medical decalcion costs (Inne 40 minos)       5.00         56.00       Program Inpattent poperating cost excluding capital related, non-physician anesthetist, and medical decalcion costs (Inne 40 minos)       0.00         56.00       Program Inpattent Innes 5.00       0.00       56.00         56.00       Program Inpattent poperating cost ackluding and target amount (Inne 56 minos line 53)       0.00       55.00         56.00       Program Inpattent poperating cost ackluding and target amount (Inne 56 minos line 53)       0.00       55.00		Intensive Care Type Inpatient Hospital Units		1	1			
45.00       BURK INTERSIVE CARE UNIT       45.00         47.00       OTHER SPECIAL CARE UNIT       1.00         48.00       Program Inpatient and Hary service cost (Mkst. D.S. col. 3, The 200)       1.00         48.00       Program Inpatient costs (age of the program inpatient and Harvagh 48, 01) (see instructions)       7.135, 201         50.00       Pass Through costs applicable to Program inpatient and Harvagh 48, 01) (see instructions)       1.04, 813       5.00         50.00       Total Program Inpatient present operating cost and S1)       3.04, 313       5.04, 313       5.04         50.00       Total Program Inpatient operating cost and S10       5.04, 310       5.04, 310       5.04         50.00       Total Program Inpatient operating cost and S10       5.04, 310       5.04       5.00         50.00       Trapet anount per discharge       0.00       5.00       6.00       5.00       6.00       5.00       6.00       5.00       6.00       5.00       6.00       5.00       6.00       5.00       6.00       5.00       6.00								
17.00       DTHER SPECIAL CARE (SPECIPY)       1.00         42.00       Forgame inputient ancillary service cost (Met. D.4. col. 5. line 200)       1.00         42.00       Program inputient ancillary service cost (Met. D.4. col. 5. line 200)       1.00         43.00       Program inputient costs (sum of lines 41 through 48.01) (see instructions)       7.215.261         49.00       Posts through costs applicable to Program inputient ancillary services (from Mest. 0. sum of Parts I and 1.347,861       50.00         50.00       Pess through costs applicable to Program inputient ancillary services (from Mest. 0. sum of Parts I and 1.347,861       50.00         50.00       Total Program excludeble cost (sum of lines 50 and 51)       1.666,880       52.00         50.00       Total Program inputient operating cost excluding capital related, non-physician anesthetist, and nediculin costs (line 40 minus line 55)       0.00       55.00         50.00       Torget amount per discharge       0.00       55.00         50.01       Torget amount per discharge (cortractor us only)       0.00       55.00         50.01       Torget amount per discharge (cortractor us only)       0.00       55.00         50.01       Torget amount per discharge (cortractor us only)       0.00       55.00         50.01       Torget amount per discharge (cortractor us only)       0.00       55.00	44.00							45.00
Cost Center Description         1.00           48.00         Program Inpatient cell (art therapy sequal sition cost (R0r Kahest D-6, Part III, Time 10, column 1)         1.90% b73         48.00           60.01         Program Inpatient cell (art therapy sequal sition cost (R0r Kahest D-6, Part III, Time 10, column 1)         7.215,224         48.00           60.01         Program Inpatient cell (art therapy sequal sition cost (R0r Kahest D-6, Part III, Time 10, column 1)         7.215,224         48.00           60.01         Program Inpatient cell (art therapy sequal sition cost (R0r Kahest D-6, Part III, Time 10, column 1)         7.215,224         48.00           60.01         Program Inpatient cell (art therapy sequal sition cost (R0r Kahest D-6, Part III, Time 10, column 1)         7.215,224         48.00           61.01         Program Inpatient cell (art therapy sequal sition cost (R0r Kahest D-6, Part III, Part B-7, Part B	46.00							46.00
Accord         1:00         1:00           00         Program inpatient cellular therapy acquisition cost (Workshort D-6, Part III, Line To, column 1)         1:990.523         48.00           48:00         Program inpatient cellular therapy acquisition cost (Workshort D-6, Part III, Line To, column 1)         7:215.24         49.00           50:00         Test Hrough costs applicable to Program inputient routine services (from 0kst. D, sum of Parts I and 1.347.851         50.00           51:00         Pass through costs applicable to Program inputient routine services (from 0kst. D, sum of Parts I and 1.347.851         50.00           51:00         Pass through costs applicable cost (sum of 1 ines 50 and 51)         1.668.885         50.00           52:00         Total Program equatient operating cost case of 10.50         51.00         56.05           60         Program discharges         0.64.00         56.00         55.00           50:00         Target amount per discharge         0.00         55.00         60.00         55.00           50:00         Target amount per discharge         0.00         55.00         60.00         55.00           50:00         Target amount per discharge         0.00         55.00         60.00         55.00           50:00         Target amount per discharge         0.00         55.00         60.00         <	47.00	· · ·						47.00
48. 01       Program Inpatient cellular therapy acquisticution cost (Worksheet D-6, Part III, Line 10, column 1)       D. 64. 07         50. 00       Total Program Inpatient costs (um of lines 41 through 48. 01) (usup 18. 01)		cost center beschiption					1.00	
47:00       Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)       7,215.201       43:00         48:05       HOUGH COST ADJUSTIMUS       7,215.201       43:00         50:00       Pass Through costs applicable to Program inpatient ancillary services (from West. D. sum of Parts II       321,029       51:00         51:00       Total Program excluduable cost (sum of lines 50 and 51)       1.668.82       50:00       53:00       Total Program excluduable cost (sum of lines 50 and 51)       1.668.82       50:00       54:00       1.668.82       50:00       54:00       1.668.82       50:00       50:00       1.668.82       50:00       50:00       1.668.82       50:00       50:00       1.668.82       50:00       50:00       1.668.82       50:00       50:00       1.668.82       50:00       50:00       1.668.82       50:00       50:00       1.668.82       50:00       50:00       1.668.82       50:00       50:00       1.668.82       50:00       50:00       1.668.82       50:00       50:00       1.668.82       50:00       50:00       50:00       50:00       50:00       50:00       50:00       50:00       50:00       50:00       50:00       50:00       50:00       50:00       50:00       50:00       50:00       50:00       50:00       5	48.00							
BASS THROUGH COST ADJUSTMENTS           00         Resk Through Costs applicable to Program inpatient routine services (from Wkst. D. sum of Parts II         321,029           51:00         Pass bitrough costs applicable to Program inpatient ancillary services (from Wkst. D. sum of Parts II         321,029           51:00         Pass bitrough costs applicable to Program inpatient ancillary services (from Wkst. D. sum of Parts II         321,029           51:00         Total Program (nystime to perating cost excluding capital related, non-physician anesthetist, and edical education costs (line 49 minus line 52)         1.668,800         520           60:00         Target anount per discharge         0.04         0.05         50           60:00         Farget anount per discharge         0.04         0.06         50           60:00         Farget anount (line 54 was mof lines 55, 56.01, and 55.02)         0.06         50         0.06           70:00         Difference between adjusted inpatient baskt)         0.06         50         0.05         50           70:00         Difference bask and provide baskt)         0.00         50         0.00         50         0.00         50         0.00         50         0.00         50         0.00         50         0.00         50         0.00         50         0.00         50         0.00         50 <td></td> <td></td> <td></td> <td></td> <td></td> <td>column 1)</td> <td>-</td> <td></td>						column 1)	-	
0.000       Pess through costs applicable to Program inputient routine services (from West. D. sum of Parts I and 1.347,851 50.00       1.347,851 50.00         0.100       Pross through costs applicable to Program inputient ancillary services (from West. D. sum of Parts II and 1.347,851 50.00       321,029 51.00         0.101       Program excludeble cost (sum of lines 50 and 51)       1.668,852 00         0.101       Program excludeble cost (sum of lines 50 and 51)       1.668,633 15.00         0.101       Program excludeble cost (sum of lines 50,350 00, and 55.02)       0.00 55.00         0.101       Program excludeble cost (sum of licebarge corrector us only)       0.00 55.00         0.201       Oldreforme between adjusted inpatient operating cost and target anount (line 54 sum of licebarge correctors)       0.00 55.00         0.001       Differome between adjusted inpatient operating cost and target anount (line 55.00 0, online 50.00 11.005, 00.00 0,	49.00		+1 thi ough 48. C				7,215,201	49.00
51.00       Pass's through costs applicable to Program inpatient ancillary services (from West. D, sum of Parts II and IVy)       2321,229       51.00         52.00       Total Program inpatient coversing capital related, non-physician anesthetist, and bodied education costs (line 49 minus line 52)       55.66,831       53.00         50.01       Total Program inpatient coversing capital related, non-physician anesthetist, and discharges in Country Total State and ascharges in Country Total State and ascharges in Country Contractor use only)       0       0       56.00         50.01       Target amount per discharge Contractor use only in the 55, 05.01, and 55.02       0       0       0       0       56.00         50.01       Target amount (ine 54 sum of lines 55, 50.01, and 55.02       0       0       0       0       0       0       56.00       0       0       56.00       0       0       56.00       0 <td>50.00</td> <td>Pass through costs applicable to Program inpa</td> <td>atient routine</td> <td>services (from</td> <td>Wkst. D, sur</td> <td>n of Parts I and</td> <td>1, 347, 851</td> <td>50.00</td>	50.00	Pass through costs applicable to Program inpa	atient routine	services (from	Wkst. D, sur	n of Parts I and	1, 347, 851	50.00
and iv)       1.668.800       52.00         Total Program excludeble cost (sum of lines 50 and 51)       1.668.800       52.00         Total Program inpatient operating cost excluding capital related. non-physician anesthetist, and medical education costs (line 49 minus line 52)       53.00       54.00         Total Program inpatient converse       0.00       55.01       55.01         Program exclusion       0.00       55.01       0.00       55.01         50.01       Permanent adjusted inpatient operating cost and target amount (line 56 minus line 53)       0.00       55.00         50.01       Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)       0.00       56.00         50.01       Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)       0.80       0.00       56.00         50.01       Difference between adjusted inpatient operating cost s(line 53 is line 54 or line 55 from prior year cost report, updated by the       0.00       66.00         61.00       Continuous ingrovement bours payment (line 53 + line 54 or line 55 from mount by which operating costs (line 55 plus cost plus instructions)       0       62.00         62.00       Difference and pace by line patient routine costs through becember 31 of the cost reporting period (See instructions)       0       63.00         63.00       Differencos ming be 59 with patie	51 00		atient ancillar	rv services (fr	om Wkst D «	sum of Parts II	321 029	51 00
53.00       Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and education costs (line 49 minus line 52)       Addet aducation costs (line 49 minus line 52)         44.00       Program inschinges       0.00         55.00       Target amount per discharge       0.00         56.00       Target amount per discharge       0.00         57.00       Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)       0.50         58.00       Bonus payment (see instructions)       0.00       58.00         50.00       Terdende costs (lesser of line 53 + line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)       0.00       50.00         60.01       Expected costs (lesser of line 53 + line 54, or line 54 is less than the lonest of lines 55 plus of line 53 is line 54, or line 54 is less than the lonest of lines 55 plus of line 53 is relating the payment (see instructions)       0       64.00         61.00       Expected costs (lesser of line 53 + line 54, or line 54 is less than the lonest of lines 55 plus of line 56 is relating the payment (see instructions)       0       62.00         62.00       Relief payment (see instructions)       0       63.00       0       64.00         63.00       Interve to ask line 50 is line 51 is line 54.00, or 1 % of the cost reporting period (See instructions)       0       63.00         <	01.00	, , , , , , , , , , , , , , , , , , ,		y services (11	om more b, c		021,027	01.00
medical education costs (inc 40 <sup>-</sup> minus line 52)         1           TARKET ARXONT AND LINE CONFUTATION         0           54.00         Program discharges         0           55.01         Permanent adjustment amount per discharge (contractor use only)         0.000           55.01         Farget amount of discharge         0.000           55.01         Farget amount (line 54 x sum of lines 55, 50.0, and 55.02)         0.000           50.00         Darget amount (line 54 x sum of lines 55, 50.0, and 55.02)         0.000           50.00         Darget amount (line 54 x sum of lines 55, 50.0, and 55.02)         0.000           50.00         Drended costs (lesser of line 53 + line 54, or line 55 from the cost report, updated by the market basket)         0.000           60.00         Expected costs (lesser of line 53 + line 54, or line 55 from prior year cost report, updated by the market basket)         0.000           61.00         Continuous improvement bous payment (if line 53 - line 54 is less than the lowest of lines 55 lus 53, are lass than expected costs (lines 54 x 60), or 1 k of the carget amount (line 56), otherwise         0.200           62.00         Relief payment (see instructions)         0         6.200           63.00         Howain ped SNF inpatient routine costs through becember 31 of the cost reporting period (See instructions)         0.400           64.00         Trais wing-bed SNF inpatient routine costs	52.00	5	,					
TARGET ANDUMT AND LIMIT COMPUTATION       6         4.00 Program discharge       0         5.00 Target amount per discharge       0.00 E5.00         5.00 Target amount per discharge (contractor use only)       0.00 E5.00         5.00 Target amount (ine F4 xsum of lines 55. 55.01, and 55.02)       0.00 E5.00         6.00 Utforence between adjusted inpatient operating cost and target amount (line 56 minus line 53)       0.00 E5.00         6.00 Deparement (see instructions)       0.00 E5.00         6.00 Expected costs (lesser of line 53, or line 55 from the cost reporting period ending 1996, 0.00 E5.01, or line 50, or line 53 is less than the lowest of lines 55 plus 50.01, or line 50, or line 53, is line 54, or line 53 is less than the lowest of lines 55, on enstructions)       0.00 E5.00 E0.00 E0.0	53.00			erated, non-pny	sician anestr	netist, and	5, 546, 381	53.00
54.00       Program discharges       0       64.00         55.01       Farget amount per discharge       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.000       0.00 <t< td=""><td></td><td>TARGET AMOUNT AND LIMIT COMPUTATION</td><td>- /</td><td></td><td></td><td></td><td>1</td><td>1</td></t<>		TARGET AMOUNT AND LIMIT COMPUTATION	- /				1	1
5.01       Permanent adjustment amount per discharge       0.00       55.00         5.02       Adjustment amount per discharge (contractor use only)       0.00       55.00         5.00       Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)       0.00       55.00         5.00       Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)       0.00       55.00         6.00       Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)       0.00       60.00         6.00       Expected costs (lesser of line 53 + line 54, or line 55 from prior year cost report, updated by the market baskel)       0.00       60.00         6.00       Refield payment (see instructions)       0       61.00       62.00       62.00         7.00       Refield payment (see instructions)       0       62.00       62.00       62.00       63.00         62.00       Relief payment (see instructions)       0       62.00       64.00       64.00       65.00       65.00       64.00       65.00       65.00       65.00       65.00       65.00       65.00       65.00       65.00       65.00       65.00       65.00       65.00       65.00       65.00       65.00       65.00       65.00       65.00 <td< td=""><td>54.00</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>	54.00							
5.02       Adjustment amount per discharge (contractor use only)       0.00       55.00       Forget amount (line 54 x sum of lines 55, 55.01, and 55.02)       0.00       55.00       0.00       55.00       0.00       55.00       0.00       55.00       0.00       55.00       0.00       55.00       0.00       55.00       0.00       55.00       0.00       55.00       0.00       55.00       0.00       55.00       0.00       55.00       0.00       55.00       0.00       55.00       0.00       55.00       0.00       56.00       0.00 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
57.00       Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)       0       57.00       0       0       57.00       0	55.02	, , , , , , , , , , , , , , , , , , , ,	use only)					
58.00       Bonus payment (see instructions)       0       58.00         59.00       Tended costs (lesser of line 53 + line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)       0.00       59.00         60.00       Expected costs (lesser of line 53 + line 54, or line 55 from prior year cost report, updated by the market basket)       0.00 <td< td=""><td>56.00</td><td>8</td><td></td><td></td><td></td><td></td><td>-</td><td></td></td<>	56.00	8					-	
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)       0.00       59.00         60.00       Expected costs (lesser of line 53 + line 54, or line 55 from prior year cost report, updated by the market basket)       0.00       60.00         61.00       Continuous improvement bonus payment (if line 53 + line 54 is less than the lowest of line 55, otherwise enter zero. (see instructions)       0       61.00         62.00       Relief payment (see instructions)       0       62.00       62.00         62.00       Relief payment (see instructions)       0       63.00         64.00       Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)       0       64.00         65.00       Total medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for Cot as swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for Cot as wing-bed NF inpatient routine costs after December 31 of the cost reporting period (See instructions)       0       67.00         67.00       Title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)       0       0       0       67.00         68.00       Total enursing facility/Other MURSING FACILITY, OTHER MURSING FACILITY, AND ICF/LID ONLY       70.00       71.00       72.00       73.00       73.00       74.00			ing cost and ta	arget amount (I	ine 56 minus	line 53)	-	
60.00       Expected costs (lesser of line 53 + line 54, or line 55 from prior year cost report, updated by the narket basket)       0.00       60.00         61.00       Continuous improvement bonus payment (if line 53 + line 54 is less than the lowest of lines 55 plus of 55, 01, or line 59, or line 60, onter the lesser of 500 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       62.00         62.00       Rellef payment (see instructions)       0       62.00         64.00       Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (tite XVIII only)       0         65.00       Madicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (tite XVIII only)       0       66.00         66.00       CAH, see instructions       0       67.00       66.00         67.00       Title V or XIX swing-bed NF inpatient routine costs (line 64 plus line 65) (title XVIII only); for CAH, see instructions       0       66.00         68.00       Title V or XIX swing-bed NF inpatient routine costs (line 67 + line 63)       0       67.00         69.00       Title V or XIX swing-bed NF inpatient routine costs (line 70 + line 21)       70.00       68.00         70.00       Kusted general inpatient routine service costs (line 73 - line 63)       73.00       73.00	59.00		or line 55 from	n the cost repo	orting period	endi ng 1996,	-	
market basket)       market basket)         0.0       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 (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)       0         62.00       Relief payment (see instructions)       0         63.00       Allowable Inpatient cost plus incentive payment (see instructions)       0         70.00       Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (tite XVIII only)       0         64.00       Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only): for CAH, see instructions       0         65.00       Total Medicare swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19)       0         66.00       Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)       0         70.00       Skilled nursing facility/other nursing facility/(IC/IID routine service cost (line 37)       0         70.00       Skilled nursing facility/other mursing facility/(IC/IID routine service cost (line 14 x line 35)       73.00         70.00       Capital-related costs (line 74 + line 31)       74.00         70.00       Forgeram coultal-related costs (line 74 + li								
61.00       Continuous improvement bonus payment (if line 53 + line 54 is less than the lowest of lines 55 plus S5.01. or line 59, or line 60, enter the lessor of 50% of the amount by which operating costs (line S3) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)       0       62.00         62.00       Relief payment (see instructions)       0       63.00         64.00       Medicare swing-bed SMF inpatient routine costs through December 31 of the cost reporting period (See instructions) (tite WIII only)       0         65.00       Total Medicare swing-bed SMF inpatient routine costs (line 64 plus line 65) (title XVIII only); for CAH, see instructions       0       66.00         66.00       Total Medicare swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19)       0       67.00         67.00       Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)       0       69.00         68.00       Title SVILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY       70.00       68.00       71.00         70.00       Skilled nursing facility/other nursing facility/ICF/ID routine service cost (line 37)       71.00       70.00         70.00       Adjusted general inpatient routine service cost (line 72 + line 73)       73.00       73.00       73.00         70.00	60.00		or line 55 fro	om prior year c	ost report, ι	updated by the	0.00	60.00
62:00       Relief payment (see instructions)       0       62:00       Relief payment (see instructions)       0       63:00         63:00       Minwable (npatient cost plus incentive payment (see instructions)       0       63:00       64:00         PROGRAM INPATIENT ROUTINE SWING BED COST       0       64:00       0       64:00         64:00       Medicare swing-bed SWF inpatient routine costs through December 31 of the cost reporting period (See instructions) (tite XVIII only)       0       64:00         65:00       Total Medicare swing-bed SWF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions       0       66:00         67:00       Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)       0       66:00         68:00       Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)       0       69:00         70:00       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/ICF/IID routine service cost (line 37)       70:00       70:00         71:00       Adjusted general inpatient routine service costs (from Yanna Sing Facility)       71:00       72:00         72:00       Program routine service cost (line 75 + line 2)       72:00       73:00	61.00	Continuous improvement bonus payment (if line 55.01, or line 59, or line 60, enter the less	ser of 50% of t	the amount by w	hich operatin	ng costs (İine	0	61.00
63.00       Allowabic Inpatient cost plus incentive payment (see instructions)       0       63.00         PROGRAM INPATIENT ROUTINE SWING BED COST       0       64.00       Medicare swing-bed SWF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)       0       64.00         60.00       Total Medicare swing-bed SWF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)       0       65.00         60.00       Total Medicare swing-bed SWF inpatient routine costs (line 64 plus line 65) (title XVIII only); for CAH, see instructions       0       66.00         61.00       Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19)       0       67.00         68.00       Title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)       0       68.00         69.00       Total title V or XIX swing-bed NF inpatient routine costs (line 70 + line 20)       70.00       68.00         70.00       Skilled nursing facility/Other nursing facility/ICF/IID routine service cost (line 37)       71.00       70.00         71.00       Adjusted general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)       72.00         72.00       Part II - SKILLED NURSING FACILITY, AND ICF/IID ONLY       73.00       74.00         73.00       Capital-related cost (line 9	(0.00	· · · · · · · · · · · · · · · · · · ·						
PROGRAM INPATIENT ROUTINE SWING BED COST         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           66.00         Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only): for (CAH, see instructions)         0           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)         0           68.00         Title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)         0           69.00         Total title V or XIX swing-bed NF inpatient routine costs (line 70 + line 2)         0           70.00         Skilled nursing facility/Other			ent (see instru	uctions)				
instructions)(title XVIII only)       65.00       Modicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only); for CAH, see instructions       0       65.00         66.00       Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions       0       66.00         67.00       Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)       0       67.00         68.00       Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 20)       0       68.00         69.00       Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)       0       69.00         69.00       Total title A ursing facility/CF/IID routine service cost (line 70 + line 2)       70.00       69.00         70.00       Adjusted general inpatient routine service costs (line 70 + line 2)       70.00       70.00         71.00       Program coutine service cost (line 9 x line 71)       71.00       73.00       74.00       75.00         73.00       Inpatient routine service costs (line 75 + line 2)       76.00       77.00       78.00         70.00       Forgram capital -related costs (line 75 + line 2)       78.00       78.00         74.00       Total Program general inpatient routine se		PROGRAM INPATIENT ROUTINE SWING BED COST		,				
65.00       Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)       66.00         66.00       Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only); for CAH, see instructions       0       66.00         67.00       Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)       0       67.00         68.00       Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)       0       68.00         69.00       Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)       0       68.00         69.00       Total title V or XIX swing-bed NF inpatient routine costs per diem (line 7 + line 68)       0       69.00         70.00       Skilled nursing facility/OFT unter service cost (line 9 x line 71)       70.00       71.00       71.00       72.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       74.00       74.00       74.00       74.00       75.00       74.00       74.00       74.00       74.00       74.00       74.00       74.00       74.00       74.00       74.00       74.00       74.00       74.00       74.00       74.00       74.00       74.00       74.00 <td< td=""><td>64.00</td><td></td><td>ts through Dece</td><td>ember 31 of the</td><td>e cost reporti</td><td>ng period (See</td><td>0</td><td>64.00</td></td<>	64.00		ts through Dece	ember 31 of the	e cost reporti	ng period (See	0	64.00
instructions) (it ite XVIII only)66.00Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (it ite XVIII only); for CAH, see instructions66.0066.0067.00Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)66.0067.0068.00Total title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)68.0067.0069.00Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)069.0069.01Total title V or XIX swing-bed NF inpatient routine costs (line 70 + line 2)069.0070.02Skilled nursing facility/other nursing facility/ICF/ID routine service cost (line 70 + line 2)70.0071.00Adjusted general inpatient routine service costs (line 72 + line 73)70.0073.00Medically necessary private room cost applicable to Program (line 14 x line 35)73.0074.00Total Program general inpatient routine service costs (from worksheet B, Part II, column 26, line 45)76.0077.00Program routine service costs (line 75 + line 2)77.0077.00Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)78.0080.00Total Program inpatient routine service costs (from provider records)78.0078.00Reasonable inpatient routine service costs (see instructions)83.0081.00Inpatient routine service costs (see instructions)83.0082.00Inpatient routine service costs (see instructions)83.00 </td <td>65.00</td> <td></td> <td>ts after Decemb</td> <td>per 31 of the c</td> <td>ost reporting</td> <td>period (See</td> <td>0</td> <td>65.00</td>	65.00		ts after Decemb	per 31 of the c	ost reporting	period (See	0	65.00
CAH, see instructionsCAH, see instructionsCAH, see instructions67.00Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period067.00Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period068.00Total title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period069.00Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)069.00Total title V or XIX swing-bed NF inpatient routine service cost (line 37)070.00Skilled nursing facility/IC/TrUP routine service cost (line 37)70.0071.00Adjusted general inpatient routine service cost per diem (line 70 + line 2)70.0072.00Program routine service cost (line 9 x line 71)72.0073.00Medically necessary private room cost applicable to Program (line 14 x line 35)73.0074.00Total Program general inpatient routine service costs (line 72 + line 73)74.0075.00Per diem capital -related costs (line 75 + line 2)76.0077.00Program capital -related costs (line 74 minus line 77)77.0078.00Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79)80.0081.00Inpatient routine service cost (see instructions)82.0084.00Program inpatient ancillary services (see instructions)84.0085.00Hingtient routine service cost (see instructions)84.0086.00Total Program inpatient ancillary services (see instructions)		instructions)(title XVIII only)					_	
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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)       0       68.00         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/ICF/II proutine service cost (line 37)       70.00       70.00         71.00       Adjusted general inpatient routine service cost per diem (line 70 + line 2)       70.00         72.00       Program routine service cost (line 9 x line 71)       73.00         73.00       Medically necessary private room cost applicable to Program (line 14 x line 35)       74.00         74.00       Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)       75.00         75.00       Capital -related costs (line 75 + line 2)       70.00         77.00       Program capital -related costs (line 76 minus line 77)       78.00         79.00       Aggregate charges to beneficiaries for excess costs (from provider records)       78.00         79.00       Inpatient routine service costs (see instructions)       81.00         81.00       Reasonable inpatient routine service costs (see instructions)       81.00         82.00       Inpatient routine service costs (see instructions)       85.00         83.00       Reasonable inpatient oro	67.00		e costs through	n December 31 d	of the cost re	eporting period	0	67.00
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81.00       Inpatient routine service cost per diem limitation       81.00         82.00       Inpatient routine service cost limitation (line 9 x line 81)       82.00         83.00       Reasonable inpatient routine service costs (see instructions)       83.00         84.00       Program inpatient ancillary services (see instructions)       84.00         85.00       Utilization review - physician compensation (see instructions)       84.00         86.00       Total Program inpatient operating costs (sum of lines 83 through 85)       86.00         PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST       87.00         87.00       Total observation bed days (see instructions)       87.00         88.00       Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)       0.00       88.00	79.00		• •		· · ·	1 = 20		79.00
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84.00       Program inpatient ancillary services (see instructions)       84.00         85.00       Utilization review - physician compensation (see instructions)       85.00         86.00       Total Program inpatient operating costs (sum of lines 83 through 85)       86.00         PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST       87.00         88.00       Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)       0.00	82.00	Inpatient routine service cost limitation (li	ine 9 x line 81					82.00
85.00       Utilization review - physician compensation (see instructions)       85.00         86.00       Total Program inpatient operating costs (sum of lines 83 through 85)       86.00         PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST       87.00         87.00       Total observation bed days (see instructions)       0         88.00       Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)       0.00	83.00			ıs)				83.00
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88.00       Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)       0.00       88.00	07.00						-	07.07
	87.00 88.00			line 2)				
	89.00							

Health Financial Systems	Bloomington Regional	Rehabilitation	Hosp	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider C		Period:	Worksheet D-1	
				From 12/17/2021 To 12/31/2022	Date/Time Pre 5/17/2023 3:1	
		Title	e XVIII	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 T	HROUGH COST	·				
90.00 Capital-related cost	2, 597, 56	4 10, 069, 153	0. 25797	2 0	0	90.00
91.00 Nursing Program cost		0 10, 069, 153	0. 00000	0 0	0	91.00
92.00 Allied health cost		0 10, 069, 153	0. 00000	0 0	0	92.00
93.00 AII other Medical Education		0 10, 069, 153	0. 00000	0 0	0	93.00

Bloomington Regional	Rehabilitation Hosp	In Li
	Provider CCN: 15-3049	Period

Lieu of Form CMS-2552-10 Worksheet D-1

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-3049	Peri od:	Worksheet D-1	
		From 12/17/2021 To 12/31/2022		
	Title XIX	Hospi tal	5/17/2023 3: 18 PPS	8 ріп
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS			1.00	
INPATIENT DAYS				
1.00 Inpatient days (including private room days and swing-b 2.00 Inpatient days (including private room days, excluding			6, 433 6, 433	
3.00 Private room days (excluding swing-bed and observation do not complete this line.		rivate room days,	0, 433	
4.00 Semi-private room days (excluding swing-bed and observa 5.00 Total swing-bed SNF type inpatient days (including priv		er 31 of the cost	6, 433 0	
6.00 reporting period Total swing-bed SNF type inpatient days (including priv reporting period (if calendar year, enter 0 on this lir		31 of the cost	0	6.00
7.00 Total swing-bed NF type inpatient days (including priva reporting period		- 31 of the cost	0	7.00
8.00 Total swing-bed NF type inpatient days (including priva reporting period (if calendar year, enter 0 on this lin		31 of the cost	0	8. 00
9.00 Total inpatient days including private room days applic newborn days) (see instructions)	cable to the Program (excluding	, <u> </u>	92	9.00
10.00 Swing-bed SNF type inpatient days applicable to title X through December 31 of the cost reporting period (see i	nstructions)	•	0	
11.00 Swing-bed SNF type inpatient days applicable to title X December 31 of the cost reporting period (if calendar y	vear, enter 0 on this line)	-	0	
<ul> <li>12.00 Swing-bed NF type inpatient days applicable to titles V through December 31 of the cost reporting period</li> <li>13.00 Swing-bed NF type inpatient days applicable to titles V</li> </ul>		•	0	
after December 31 of the cost reporting period (if cale 14.00 Medically necessary private room days applicable to the	endar year, enter 0 on this lir	ne)	0	
15.00 Total nursery days (title V or XIX only)	in ogram (exer daring sinnig bed	uuys)	0	
16.00 Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16.00
17.00 Medicare rate for swing-bed SNF services applicable to reporting period	services through December 31 c	of the cost	0.00	17.00
18.00 Medicare rate for swing-bed SNF services applicable to reporting period	services after December 31 of	the cost	0.00	18.00
19.00 Medicaid rate for swing-bed NF services applicable to s reporting period	services through December 31 of	f the cost	0.00	19.00
20.00 Medicaid rate for swing-bed NF services applicable to s reporting period	services after December 31 of 1	the cost	0.00	20.00
21.00 Total general inpatient routine service cost (see instr 22.00 Swing-bed cost applicable to SNF type services through		ting period (line	10, 069, 153 0	
5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after De x line 18)	ecember 31 of the cost reportin	ng period (line 6	0	23.00
24.00 Swing-bed cost applicable to NF type services through E 7 x line 19)	December 31 of the cost reporti	ng period (line	0	24.00
25.00 Swing-bed cost applicable to NF type services after Dec x line 20)	cember 31 of the cost reporting	g period (line 8	0	25.00
26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed	l cost (line 21 minus line 26)		0 10, 069, 153	26.00 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding sw	ving-bed and observation bed ch	narges)	0	
29.00  Private room charges (excluding swing-bed charges) 30.00  Semi-private room charges (excluding swing-bed charges)			0	
31.00 General inpatient routine service cost/charge ratio (li			0. 000000	
32.00 Average private room per diem charge (line 29 ÷ line 3)			0.00	
33.00 Average semi-private room per diem charge (line 30 ÷ li	ne 4)		0.00	
34.00 Average per diem private room charge differential (line		ctions)	0.00	
35.00 Average per diem private room cost differential (line 3			0.00	
36.00 Private room cost differential adjustment (line 3 x lir		66	0	
37. 00 General inpatient routine service cost net of swing-bec 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY	i cost and private room cost di	TTEPENTIAL (LINE	10, 069, 153	37.00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH CO	ST ADJUSTMENTS			-
38.00 Adjusted general inpatient routine service cost per die			1, 565. 23	38.00
	, ,		144,001	
39.00 Program general inpatient routine service cost (line 9				
40.00 Medically necessary private room cost applicable to the			0	40.00

Title XIX       Cost Center Description     Total       Inpatient CostInpatient Days     Diem (1)	From 12/17/2021 To 12/31/2022		
Cost Center Description Total Total Avera		5/17/2023 3:1	
	Hospital age Per Program Days col. 1 ÷ . 2)	PPS Program Cost (col. 3 x col. 4)	
1.00 2.00 3	. 00 4. 00	5.00	
42.00 NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units			42.00
43. 00 INTENSIVE CARE UNIT			43.00
44. 00 CORONARY CARE UNI T			44.00
45.00 BURN INTENSIVE CARE UNIT 46.00 SURGICAL INTENSIVE CARE UNIT			45.00
47. 00 OTHER SPECIAL CARE (SPECIFY)			40.00
Cost Center Description	·	1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		1.00	48.00
48.01 Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, Ii	ine 10, column 1)	0	1
49.00 Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)		202, 418	49.00
PASS THROUGH COST ADJUSTMENTS 50.00 Pass through costs applicable to Program inpatient routine services (from Wkst.	D sum of Parts L and	37, 149	50.00
		57,147	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wks and IV)	t. D, sum of Parts II	9, 539	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)		46, 688	
53.00 Total Program inpatient operating cost excluding capital related, non-physician medical education costs (line 49 minus line 52)	anesthetist, and	155, 730	53.00
TARGET AMOUNT AND LIMIT COMPUTATION		1	
54.00 Program discharges		0	
55.00 Target amount per discharge 55.01 Permanent adjustment amount per discharge		0.00	1
55.02 Adjustment amount per discharge (contractor use only)		0.00	1
56.00 Target amount (line 54 x sum of lines 55, 55.01, and 55.02)		0	
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 58.00 Bonus payment (see instructions)	minus line 53)	0	
59.00 Trended costs (lesser of line 53 + line 54, or line 55 from the cost reporting )	period ending 1996,	0.00	
updated and compounded by the market basket)	next undeted by the	0.00	40.00
60.00 Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost rep market basket)		0.00	
61.00 Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the low 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which of 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (l enter zero. (see instructions)	perating costs (line	0	61.00
62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions)		0	
PROGRAM I NPATI ENT ROUTI NE SWI NG BED COST			00.00
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost instructions)(title XVIII only)	reporting period (See	0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reprint instructions)(title XVIII only)	porting period (See	0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(tit) CAH, see instructions	le XVIII only); for	0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the ( (line 12 x line 19)	cost reporting period	0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost (line 13 x line 20)	st reporting period	0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (Ii	ine 37)		70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)			71.00
72.00 Program routine service cost (line 9 x line 71)			72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73)			73.00 74.00
75.00 Capital -related cost allocated to inpatient routine service costs (rine 72 + rine 73)	et B, Part II, column		75.00
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)			76.00
78.00 Inpatient routine service cost (line 74 minus line 77)			78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)	70		79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 81.00 Inpatient routine service cost per diem limitation	νσ minus line /9)		80.00 81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)			82.00
83.00 Reasonable inpatient routine service costs (see instructions)			83.00
84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions)			84.00 85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)			86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		1	
87.00 Total observation bed days (see instructions)		0.00	1
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)			89.00

Health Financial Systems	Bloomington Regional	Rehabilitatio	n Hosp	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 12/17/2021 To 12/31/2022	Date/Time Pre 5/17/2023 3:1	
		Ti	le XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 2	) 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 TH	ROUGH COST					
90.00 Capital-related cost	2, 597, 50	10, 069, 15	0. 25797	2 0	0	90.00
91.00 Nursing Program cost		0 10, 069, 15	0. 00000	0 0	0	91.00
92.00 Allied health cost		0 10, 069, 15	0. 00000	0 0	0	92.00
93.00 All other Medical Education		0 10, 069, 15	0. 00000	0 0	0	93.00

Health Financial Systems Bloomington Regional Rel	habilitation	Hosp	In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C		Peri od:	Worksheet D-3	
			From 12/17/2021 To 12/31/2022	Date/Time Pre	narod
			10 12/31/2022	5/17/2023 3:1	
	Title	e XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos	t Inpatient	I npati 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	0.504.000	1	
30. 00 03000 ADULTS & PEDI ATRI CS			3, 504, 900		30.00
ANCI LLARY SERVI CE COST CENTERS		0.44400	0/4 007	00.450	1 54 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 11133			
57.00 05700 CT SCAN		0. 11142			
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0.00000		, o	
60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY		0. 15603 0. 24426			60.00 65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY		0. 62536 0. 58732			
68. 00 06800 SPEECH PATHOLOGY		0. 58732			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		8. 09916			•
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 34652			
74. 00 07400 RENAL DIALYSIS		0. 00000			
76. 00 03950 OTHER ANCI LLARY SERVICE COST CENTERS		0.00000		-	76.00
OUTPATIENT SERVICE COST CENTERS		0.00000			/0.00
91. 00 09100 EMERGENCY		0.0000	0 0	0	91.00
91. 01 04951 OUTPATI ENT THERAPY		0. 00000		0	
93. 00 04950 OUTPATIENT WOUND CENTER		0. 00000		-	•
OTHER REIMBURSABLE COST CENTERS				-	
95. 00 09500 AMBULANCE SERVICES					95.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			4, 275, 284	1, 990, 523	200.00
201.00 Less PBP Clinic Laboratory Services-Program only charges	s (line 61)		0	,	201.00
202.00 Net charges (line 200 minus line 201)	. ,		4, 275, 284		202.00

Health Financial Systems Bloomington Regional Re				u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C		Peri od:	Worksheet D-3	
			From 12/17/2021 To 12/31/2022	Date/Time Pre	narod
			10 12/31/2022	5/17/2023 3:1	
	Titl	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		
30. 00 03000 ADULTS & PEDI ATRI CS			96, 600		30.00
ANCI LLARY SERVI CE COST CENTERS		1		1	-
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 11133			•
57.00 05700 CT SCAN		0. 11142		0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0.00000	-	0	
60. 00 06000 LABORATORY		0. 15603			
65. 00 06500 RESPI RATORY THERAPY		0. 24426			65.00
66. 00 06600 PHYSI CAL THERAPY		0. 62536			
67.00 06700 OCCUPATI ONAL THERAPY		0. 58732			67.00
68.00 06800 SPEECH PATHOLOGY		0. 57082			•
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		8. 09916			•
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 34652			
74. 00 07400 RENAL DI ALYSI S		0.00000		-	
76.00 03950 OTHER ANCI LLARY SERVICE COST CENTERS		0.00000	00 0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
91. 00 09100 EMERGENCY		0.00000			
91. 01 04951 OUTPATI ENT THERAPY		0.00000		0	
93. 00 04950 OUTPATIENT WOUND CENTER		0.00000	00 0	0	93.00
OTHER REI MBURSABLE COST CENTERS		1			05 66
95. 00 09500 AMBULANCE SERVICES					95.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			118, 626	58, 417	•
201.00 Less PBP Clinic Laboratory Services-Program only charge	s (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			118, 626		202.00

	Financial Systems         Bloomington Regional Rehabilitation Ho           ATION OF REIMBURSEMENT SETTLEMENT         Provider CCN:		In Lie Period: From 12/17/2021	u of Form CMS-2 Worksheet E Part B	2552-10
			To 12/31/2022	Date/Time Pre	
	Title X	VIII	Hospi tal	5/17/2023 3: 18 PPS	s pili
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			0	
2.00 3.00	Medical and other services reimbursed under OPPS (see instructions) OPPS payments			0	2.00 3.00
4.00	Outlier payment (see instructions)			0	4.00
4.01	Outlier reconciliation amount (see instructions)			0	4.01
5.00 6.00	Enter the hospital specific payment to cost ratio (see instructions) Line 2 times line 5			0.000	5.00 6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
8.00	Transitional corridor payment (see instructions)			0	
9. 00 10. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, I Organ acquisitions	ine 200		0	9.00 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			0	
	COMPUTATION OF LESSER OF COST OR CHARGES				
12.00	Reasonable charges			0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0	
14.00	Total reasonable charges (sum of lines 12 and 13)			0	14.00
15.00	Customary charges Aggregate amount actually collected from patients liable for payment for se	rvices on	a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for			0	16.00
17.00	had such payment been made in accordance with 42 CFR §413.13(e)			0,000000	17 00
17.00 18.00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			0. 000000 0	
19.00	Excess of customary charges over reasonable cost (complete only if line 18	exceeds li	ne 11) (see	0	
20.00	instructions)	avaaada Li	no 10) (coo	0	20.00
20. 00	Excess of reasonable cost over customary charges (complete only if line 11 instructions)	exceeds II	ne 18) (see	0	20.00
21.00	Lesser of cost or charges (see instructions)			0	
22. 00 23. 00	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see instructions)			0	22.00 23.00
	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00 26.00	Deductibles and coinsurance amounts (for CAH, see instructions) Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH,	see instr	uctions)	0	
27.00				0	
~~~~~	instructions)				
28. 00 29. 00	Direct graduate medical education payments (from Wkst. E-4, line 50) ESRD direct medical education costs (from Wkst. E-4, line 36)			0	28.00 29.00
30.00	Subtotal (sum of lines 27 through 29)			0	30.00
31.00 32.00	Primary payer payments Subtotal (line 30 minus line 31)			0	
32.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			0	32.00
	Composite rate ESRD (from Wkst. I-5, line 11)				33.00
34.00 35.00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			0	
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	36.00
37.00				0	
38.00 39.00	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	38.00 39.00
	Pioneer ACO demonstration payment adjustment (see instructions)			0	39.50
	N95 respirator payment adjustment amount (see instructions)			0	
39. 97 39. 98	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replaced devices (s	oo instruc	tions)	0	39. 97 39. 98
39.90	RECOVERY OF ACCELERATED DEPRECIATION		(1013)	0	
40.00	Subtotal (see instructions)			0	40.00
40. 01 40. 02	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			0	40. 01 40. 02
40.02				0	40.02
41.00	Interim payments			0	
41. 01 42. 00	Interim payments-PARHM or CHART Tentative settlement (for contractors use only)			0	41.01 42.00
42.00	Tentative settlement (IG contractor s use only) Tentative settlement-PARHM or CHART (for contractor use only)			0	42.00
43.00	Balance due provider/program (see instructions)			0	43.00
43.01 44.00	Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accordance with CMS P	ub 15_2	chapter 1	0	43.01 44.00
14.00	§115. 2	. IU-Z,		0	17.00
00.00	TO BE COMPLETED BY CONTRACTOR			_	00.00
90.00 91.00	5			0	90.00 91.00
					92.00
93.00	Time Value of Money (see instructions)			0	
74.00	Total (sum of lines 91 and 93)			U	94.00

Health Financial Systems	Bloomington Regional Ref	nabilitation Hosp	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-3049	Period: From 12/17/2021	Worksheet E	
				Date/Time Pre 5/17/2023 3:1	pared: 8 pm
		Title XVIII	Hospi tal	PPS	
				1.00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				0	200. 00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CC		Period: From 12/17/2021 To 12/31/2022	Date/Time Pre 5/17/2023 3:1	pared:
		Title		Hospi tal	PPS	1
		Inpatient	LPARLA	Par	-t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		5, 528, 10	1 0	0	1.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.00
3.01	ADJUSTMENTS TO PROVIDER			0	0	3. 01
3. 02 3. 03				0	0	3. 02 3. 03
3.03				0	0	3.03
3.05				0	0	
	Provider to Program			1	1	
3.50 3.51	ADJUSTMENTS TO PROGRAM			0	0	3.50 3.51
3.51				0	0	3.52
3.53				0	0	
3.54				0	0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		5, 528, 10	1	0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					5.00
5.01	TENTATI VE TO PROVI DER			0	0	5.01
5.02				0	0	
5.03				0	0	5.03
E EO	Provider to Program	I				
5.50 5.51	TENTATI VE TO PROGRAM			0	0	5.50 5.51
5.52				0	0	
5.99	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6. 01	SETTLEMENT TO PROVIDER		175, 00	9	0	6.01
6.02	SETTLEMENT TO PROGRAM			0	0	
7.00	Total Medicare program liability (see instructions)		5, 703, 11		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-3049	Period: From 12/17/2021 To 12/31/2022	Worksheet E-3 Part III Date/Time Pre 5/17/2023 3:1	pare
		Title XVIII	Hospi tal	PPS	o pin
		· ·		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS				
	Net Federal PPS Payment (see instructions)			5, 731, 817	
	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0000	
	Inpatient Rehabilitation LIP Payments (see instructions)			160, 491	
00 00	Outlier Payments Unweighted intern and resident FTE count in the most recent of	cost reporting pariod or	ding on or prior	0 0.00	
00	to November 15, 2004 (see instructions)	cost reporting period er		0.00	
01	Cap increases for the unweighted intern and resident FTE cour	nt for residents that we	e displaced by	0.00	5
	program or hospital closure, that would not be counted without	ut a temporary cap adjust	tment under 42		
	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)				
	New Teaching program adjustment. (see instructions)			0.00	
00	Current year's unweighted FTE count of I&R excluding FTEs in	the new program growth p	period of a "new	0.00	7
00	teaching program" (see instructions)	the new program growth	ariad of a "now	0.00	8
00	Current year's unweighted I&R FTE count for residents within teaching program" (see instructions)	the new program growth p		0.00	°
00	Intern and resident count for IRF PPS medical education adjus	stment (see instructions)		0.00	9
	Average Daily Census (see instructions)			16. 928947	
	Teaching Adjustment Factor (see instructions)			0.000000	
. 00	Teaching Adjustment (see instructions)			0	12
. 00	Total PPS Payment (see instructions)			5, 892, 308	13
	Nursing and Allied Health Managed Care payments (see instruct	tion)		0	14
	Organ acquisition (DO NOT USE THIS LINE)				15
	Cost of physicians' services in a teaching hospital (see inst	tructions)		0	
	Subtotal (see instructions)			5, 892, 308	
	Primary payer payments			0 E 000 200	
	Subtotal (line 17 less line 18). Deductibles			5, 892, 308 68, 464	
	Subtotal (line 19 minus line 20)			5, 823, 844	
	Coinsurance			52, 904	
	Subtotal (line 21 minus line 22)			5, 770, 940	
. 00	Allowable bad debts (exclude bad debts for professional servi	ces) (see instructions)		3, 112	24
. 00	Adjusted reimbursable bad debts (see instructions)			2, 023	25
	Allowable bad debts for dual eligible beneficiaries (see inst	tructions)		3, 112	
	Subtotal (sum of lines 23 and 25)			5, 772, 963	
	Direct graduate medical education payments (from Wkst. E-4, I	ine 49)		0	
	Other pass through costs (see instructions)			0	
	Outlier payments reconciliation OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
	Pioneer ACO demonstration payment adjustment (see instruction	as)		0	
	Recovery of accel erated depreciation.	13)		0	
	Demonstration payment adjustment amount before sequestration			0	
	Total amount payable to the provider (see instructions)			5, 772, 963	
	Sequestration adjustment (see instructions)			69, 853	32
. 02	Demonstration payment adjustment amount after sequestration			0	32
. 00	Interim payments			5, 528, 101	33
	Tentative settlement (for contractor use only)			0	
	Balance due provider/program (line 32 minus lines 32.01, 32.0	· · · · ·		175, 009	
. 00	Protested amounts (nonallowable cost report items) in accorda §115.2	ance with CMS Pub. 15-2,	chapter 1,	0	36
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount from Wkst. E-3, Pt. III, line 4			0	
	Outlier reconciliation adjustment amount (see instructions)			0	
	The rate used to calculate the Time Value of Money			0.00	
. 00	Time Value of Money (see instructions)			0	53
. 00	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND			0. 000000	99
	Teaching Adjustment Factor for the cost reporting period imme Calculated Teaching Adjustment Factor for the current year.		ai y 27, 2020.	0.000000	

	SHEET (If you are nonproprietary and do not maintain	Provider C		eriod: rom 12/17/2021	Worksheet G	
und-tyj nly)	pe accounting records, complete the General Fund column			o 12/31/2022	Date/Time Pre	
		General Fund	Specific	Endowment Fund	<u>5/17/2023 3:1</u> Plant Fund	8 pm
			Purpose Fund			
С	CURRENT ASSETS	1.00	2.00	3.00	4.00	-
-	Cash on hand in banks	114, 473	0	0	0	1.
. 00 T	Temporary investments	0	0	0	0	2.
	Notes receivable	0	0	0	0	
	Accounts receivable	2, 431, 965	0	0	0	
	Other receivable	0	0	0	0	
	Allowances for uncollectible notes and accounts receivable	-308, 737	0	0	0	
	nventory Prepaid expenses	122, 047 -1, 095, 763		0	0	
	Other current assets	1, 093, 703	0	0	0	
	Due from other funds	0	0	0	0	
	Total current assets (sum of lines 1-10)	1, 263, 985			0	
	I XED ASSETS			· · · · ·		1
. 00 🛛	_and	0	0	0	0	12
	_and improvements	0	0	0	0	
	Accumulated depreciation	0	0	0	0	
	Buildings	17, 045, 633	0	0	0	
	Accumulated depreciation	-669, 253	0	0	0	
	_easehold improvements Accumulated depreciation			0	0	1
	Fixed equipment	-4, 261		0	0	
	Accumul ated depreciation	-28, 083	0	0	0	
	Automobiles and trucks	0	0	0	0	
	Accumulated depreciation	0	0	0	0	
	Major movable equipment	1, 292, 831	0	0	0	23
. 00   A	Accumulated depreciation	-726, 198	0	0	0	24
	Ainor equipment depreciable	0	0	0	0	
	Accumulated depreciation	0	0	0	0	
	HT designated Assets	0	0	0	0	
	Accumulated depreciation	0	0	0	0	
	Minor equipment-nondepreciable Fotal fixed assets (sum of lines 12-29)	16, 910, 669	0	-	0	
	THER ASSETS	10, 910, 009		<u> </u>	0	1 30
	nvestments	0	0	0	0	31
	Deposits on Leases	0	0	0	0	32
. 00 [	Due from owners/officers	0	0	0	0	33
. 00 0	Other assets	75, 933, 904	0	0	0	34
1	Total other assets (sum of lines 31-34)	75, 933, 904	1	-	0	
	Total assets (sum of lines 11, 30, and 35)	94, 108, 558	0	0	0	36
	CURRENT LIABILITIES	1(0.110				1
	Accounts payable	162, 143 367, 749		0	0	
	Salaries, wages, and fees payable Payroll taxes payable	233, 090		0	0	
	Notes and Loans payable (short term)	233,070		0	0	
	Deferred income	0	0	0	0	1
	Accelerated payments	0		_		42
. 00 [	Due to other funds	0	0	0	0	43
. 00 0	Other current liabilities	83, 331, 260	0	0	0	44
	Total current liabilities (sum of lines 37 thru 44)	84, 094, 242	0	0	0	45
	ONG TERM LIABILITIES					4
	Mortgage payable	0	0		0	
	Notes payable Jnsecured Loans		0	0	0	
	Other long term liabilities	14, 832, 130		0	0	1
	Total long term liabilities (sum of lines 46 thru 49)	14, 832, 130		Ő	0	
	Total liabilities (sum of lines 45 and 50)	98, 926, 372		0	0	
	CAPI TAL ACCOUNTS					1
. 00 🤅	General fund balance	-4, 817, 814				52
	Specific purpose fund		0			53
	Donor created - endowment fund balance - restricted			0		54
	Donor created - endowment fund balance - unrestricted			0		55
	Governing body created - endowment fund balance			0	-	56
	Plant fund balance - invested in plant				0	
	Plant fund balance - reserve for plant improvement,				0	58
	replacement, and expansion Fotal fund balances (sum of lines 52 thru 58)	-4, 817, 814	_	0	0	59
	Total liabilities and fund balances (sum of lines 51 and	94, 108, 558		0	0	
		, , , , , , , , , , , , , , , , , , , ,		0	0	

der CCN: 15-3049 Peri From To Special Purpo 0 0 58, 435 58, 435	12/17/2021         Date/Time Prepared:           12/31/2022         Date/Time Prepared:           5/17/2023         3:18 pm           pose Fund         Endowment Fund           4.00         5.00
0 68, 435	4.00 5.00
0 58, 435	
0 58, 435	
68, 435	0 1.00
0 0 58, 435 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0
0 0 0 17, 379 17, 814	0 16.00 0 17.00 18.00 19.00
0.88	1.00
	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
0 0 0	10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00
	0

STATEN	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CCN	l: 15-3049	Period: From 12/17/2021 To 12/31/2022	Worksheet G-2 Parts I & II Date/Time Pre 5/17/2023 3:1	pared:
	Cost Center Description		Inpati ent	Outpati ent	Total	
			1.00	2.00	3.00	
	PART I - PATIENT REVENUES					-
1.00	General Inpatient Routine Services Hospital		6, 753, 60	20	6, 753, 600	1 1.0
2.00	SUBPROVIDER - IPF		0, /53, 00	50	0, 753, 600	2.0
2.00	SUBPROVIDER - IRF					3.0
4.00	SUBPROVIDER					4.0
5.00	Swing bed - SNF			0	0	5.0
5.00	Swing bed - NF			0	0	
7.00	SKILLED NURSING FACILITY			0	0	7.0
3.00	NURSING FACILITY			-		8.0
9.00	OTHER LONG TERM CARE					9.0
10.00	Total general inpatient care services (sum of lines 1-9)		6, 753, 60	00	6, 753, 600	10.0
	Intensive Care Type Inpatient Hospital Services					1
11.00	INTENSIVE CARE UNIT					11.0
12.00	CORONARY CARE UNIT					12.0
13.00	BURN INTENSIVE CARE UNIT					13.0
14.00	SURGI CAL I NTENSI VE CARE UNI T					14.0
15.00	OTHER SPECIAL CARE (SPECIFY)					15.0
16.00	Total intensive care type inpatient hospital services (sum of	lines		0	0	16. C
	11-15)					
17.00	Total inpatient routine care services (sum of lines 10 and 16)		6, 753, 60		6, 753, 600	
18.00	Ancillary services		8, 474, 30		8, 502, 259	
19.00	Outpatient services			0 0	0	19.0
20.00	RURAL HEALTH CLINIC			0 0	0	
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	
22.00 23.00	HOME HEALTH AGENCY AMBULANCE SERVICES			0 0	0	22.0 23.0
23.00	CMHC			0 0	0	23.0
25.00	AMBULATORY SURGICAL CENTER (D. P. )					24.0
26.00	HOSPICE					26.0
27.00	OTHER (SPECIFY)			0 0	0	27.0
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst	15, 227, 90	27, 950		
	G-3. Line 1)					
	PART II - OPERATING EXPENSES					1
29.00	Operating expenses (per Wkst. A, column 3, line 200)			13, 025, 089		29.0
30.00	ADD (SPECIFY)			0		30.0
31.00				0		31.0
32.00				0		32.0
33.00				0		33.0
34.00				0		34.0
35.00				0		35.0
36.00	Total additions (sum of lines 30-35)			0		36.0
37.00	DEDUCT (SPECI FY)			0		37.0
38.00				0		38.0
39.00				0		39.0
0.00				0		40.0
41.00				0		41.0
42.00	Total deductions (sum of lines 37-41)	) (1		12 025 020		42.0
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42 to Wkst. G-3, line 4)	transfer		13, 025, 089		43. C

STATEM	IENT OF REVENUES AND EXPENSES	Provider CCN: 15-3049	Peri od:	Worksheet G-3	
			From 12/17/2021		
			To 12/31/2022	Date/Time Prep 5/17/2023 3:18	
				1.00	
1.00	) Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)				
2.00	Less contractual allowances and discounts on patie	nts' accounts		5, 142, 877	2.00
3.00	Net patient revenues (line 1 minus line 2)			10, 112, 982	3.00
4.00	Less total operating expenses (from Wkst. G-2, Par	t II, line 43)		13, 025, 089	
5.00	Net income from service to patients (line 3 minus	line 4)		-2, 912, 107	5.00
	OTHER INCOME				1
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			3, 044	7.00
8.00	Revenues from telephone and other miscellaneous co	mmunication services		0	
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase di scounts			0	
11.00	Rebates and refunds of expenses			0	
12.00	Parking lot receipts			0	12.00
	Revenue from Laundry and Linen service			0	13.00
	Revenue from meals sold to employees and guests			24, 387	
	Revenue from rental of living quarters			0	15.00
	Revenue from sale of medical and surgical supplies	to other than patients		0	16.00
	Revenue from sale of drugs to other than patients			0	17.00
18.00	Revenue from sale of medical records and abstracts			3	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	
	Revenue from gifts, flowers, coffee shops, and can	teen		0	20.00
	Rental of vending machines			0	
22.00	Rental of hospital space			0	22.00
23.00	Governmental appropriations			0	23.00
	MI SC I NC, TRANSPORT			16, 238	
	COVI D-19 PHE Fundi ng			0	24.50
25.00	Total other income (sum of lines 6-24)			43, 672	
	Total (line 5 plus line 25)			-2, 868, 435	
	OTHER EXPENSES (SPECIFY)			0	27.00
	Total other expenses (sum of line 27 and subscript			0	28.00
29.00	Net income (or loss) for the period (line 26 minus	line 28)		-2, 868, 435	29.00