3 -SETTLED WITH AUDIT

4 -REOPENED

5 -AMENDED

Optimizer Systems, Ir	C.	WinLASI	\mathbf{H}	Micro System
•		In Lieu of Form Period:		Run Date: 05/23/2014
RH OF NORTHWEST INDIA	NA, LLC	CMS-2552-10	From: 02/01/2013	Run Time: 08:11
Provider CCN: 15-2024				Version: 2014.03
HOSPITAL AND HOSPITAL HEAD PART I - COST REPORT STATUS	TH CARE COMPLEX COS	ST REPORT CERTIFICATION AND S	ETTLEMENT SUMMARY	WORKSHEET S PARTS I, II & III
PROVIDER USE ONLY	1. [X] ELECTRON	ICALLY FILED COST REPOR	T DATE: 05/2	3/2014 TIME: 08:11
TROVIDER OBE ONE		SUBMITTED COST REPORT	DAIE: 05/2	5/2011 11ME: 00:11
		IS AN AMENDED REPORT EN	TER THE NUMBER OF TIM	ES THE PROVIDER
		TED THE COST REPORT		
		UTILIZATION. ENTER 'F	'' FOR FULL OR 'L' FOR	LOW.
CONTRACTOR 5. [] COS	T REPORT STATUS	6. DATE RECEIVED:	10. NPR	DATE:
USE ONLY 1 -AS	SUBMITTED	7. CONTRACTOR NO:	11. CON	TRACTOR'S VENDOR CODE:

PART II - CERTIFICATION

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

PROVIDER CCN

PROVIDER CCN

9. [] FINAL REPORT FOR THIS

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

2 -SETTLED WITHOUT AUDIT 8. [] INITIAL REPORT FOR THIS

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY RH OF NORTHWEST INDIANA, LLC (15-2024) {(PROVIDER NAME(S) AND NUMBER(S)} FOR THE COST REPORTING PERIOD BEGINNING 02/01/2013 AND ENDING 01/31/2014, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

(SIGNED)_	
	OFFICER OR ADMINISTRATOR OF PROVIDER(S)
_	
	TITLE
_	
	DATE

12. [] IF LINE 5, COLUMN 1 IS 4: ENTER NUMBER OF TIMES

REOPENED = 0-9.

PART III - SETTLEMENT SUMMARY

1 /1/1/1	III - SETTLEMENT SUMMANT						
			TITLE	XVIII			
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		47,705				1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC						10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		47,705				200

THE ABOVE AMOUNTS REPRESENT 'DUE TO' OR 'DUE FROM' THE APPLICABLE PROGRAM FOR THE ELEMENT OF THE ABOVE COMPLEX INDICATED.

ACCORDING TO THE PAPERWORK REDUCTION ACT OF 1995, NO PERSONS ARE REQUIRED TO RESPOND TO A COLLECTION OF INFORMATION UNLESS IT DISPLAYS A VALID OMD CONTROL NUMBER. THE VALID OMB CONTROL NUMBER FOR THIS INFORMATION COLLECTION IS 0938-0050, THE TIME REQUIRED TO COMPLETE THIS INFORMATION COLLECTION IS ESTIMATED 673 HOURS PER RESPONSE, INCLUDING THE TIME TO REVIEW INSTRUCTIONS, SEARCH EXISTING RESOURCES, GATHER THE DATA NEEDED, AND COMPLETE AND REVIEW THE INFORMATION COLLECTION. IF YOU HAVE ANY COMMENTS CONCERNING THE ACCURACY OF THE TIME ESTIMATE(S) OR SUGGESTIONS FOR IMPROVING THIS FORM, PLEASE WRITE TO: CMS, 7500 SECURITY BOULEVARD, ATTN: PRA REPORT CLEARANCE OFFICER, MAIL STOP C4-26-05, BALTIMORE, MARYLAND 21244-1850.

Optimizer Systems, Inc.

WinLASH

Micro System
Run Date: 05/23/2014

RH OF NORTHWEST INDIANA, LLC Provider CCN: 15-2024 In Lieu of Form CMS-2552-10

Period : From: 02/01/2013 To: 01/31/2014

Run Time: 08:11 Version: 2014.03

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

	STREET: 4321 FIR STREET	P.O. BOX:		D G0D= ::			A 7775				1
CDIT	CITY: EAST CHICAGO	STATE: IL	ZI	P CODE: 4631	2 C	DUNTY: L	AKE				2
SPH	TAL AND HOSPITAL-BASED COMPONENT IDEN	TIFICATION:						ΡΔΥ	MENT SY	STEM	T
									, T, O, OR		
		COMPONENT	r	CCN	CBSA	PROV-	DATE				
	COMPONENT	NAME		NUMBER	NUMBER	IDER	CERTIFIED	V	XVIII	XIX	
	0	1		2	3	TYPE 4	5	6	7	8	+
	HOSPITAL	RH OF NORTHWEST IN	IDIANA.								3
		LLC		15-2024	23844	2	02/01/2004	N	P	P	
	SUBPROVIDER - IPF										4
	SUBPROVIDER - IRF SUBPROVIDER - (OTHER)										5
	SWING BEDS - SNF										7
	SWING BEDS - NF										8
	HOSPITAL-BASED SNF										9
	HOSPITAL BASED OF TO										10
	HOSPITAL-BASED OLTC HOSPITAL-BASED HHA										12
	SEPARATELY CERTIFIED ASC										13
	HOSPITAL-BASED HOSPICE										14
	HOSPITAL-BASED HEALTH CLINIC - RHC										15
	HOSPITAL-BASED HEALTH CLINIC - FQHC HOSPITAL-BASED (CMHC)										10
	RENAL DIALYSIS										18
	OTHER										19
	-										
	COST REPORTING PERIOD (mm/dd/yyyy)	FROM: 02 / 01 / 2013		TO: 01 / 31 /	2014						20
TT	TYPE OF CONTROL (see instructions) ENT PPS INFORMATION	4							1	2	2:
111	DOES THIS FACILITY QUALIFY FOR AND REC	CEIVE DISPROPORTIONAT	TE SHARE I	HOSPITAL PA	YMENT IN A	CCORDA	NCE WITH 42	CFR	1		
	§412.106 IN COLUMN 1, ENTER 'Y' FOR YES AN COLUMN 2, ENTER 'Y', FOR YES OR 'N' FOR NO	ND 'N' FOR NO. IS THIS FA O.	CILTY SUE	BJECT TO 42 C	CFR§412.06(c)	(2)(Pickle	amendment hos	pital)? IN	N	N	22
	DID THIS HOSPITAL RECEIVE INTERIM UNCO	MPENSATED CARE PAY!	MENTS FOI	ם דעוני כי סיבדו		DEDIUD9:	ENTED IN COL	LUMN 1.			
1	'Y' FOR YES OF 'N' FOR NO FOR THE PORTION	OF THE COST REPORTING	G PERIOD (OCCURRING	PRIOR TO OC	TOBER 1	ENTER IN CO	DLUMN 2	N	N	22
1	'Y' FOR YES OR 'N' FOR NO FOR THE PORTION WHICH METHOD IS USED TO DETERMINE ME	OF THE COST REPORTING OF THE COST REPORTINE EDICAID DAYS ON LINES	G PERIOD (NG PERIOD 24 AND/OR	OCCURRING I OCCURRING R 25 BELOW?	PRIOR TO OC ON OR AFTE IN COLUMN	TOBER 1 R OCTOE 1, ENTER	ENTER IN CO ER 1. (see instr 1 IF DATE OF	OLUMN 2 ructions)			22
1	'Y' FOR YES OR 'N' FOR NO FOR THE PORTION WHICH METHOD IS USED TO DETERMINE ME ADMISSION, 2 IF CENSUS DAYS, OR 3 IF DATE	OF THE COST REPORTING OF THE COST REPORTING DICAID DAYS ON LINES E OF DISCHARGE. IS THE	G PERIOD (NG PERIOD 24 AND/OR METHOD (OCCURRING DOCCURRING R 25 BELOW?	PRIOR TO OC ON OR AFTE IN COLUMN ING THE DAY	TOBER 1 ER OCTOE 1, ENTER 'S IN THIS	ENTER IN CO ER 1. (see instr 1 IF DATE OF 5 COST REPOR	OLUMN 2 ructions)	N 3	N N	22
1	'Y' FOR YES OR 'N' FOR NO FOR THE PORTION WHICH METHOD IS USED TO DETERMINE ME	OF THE COST REPORTING OF THE COST REPORTING DICAID DAYS ON LINES E OF DISCHARGE. IS THE	G PERIOD (NG PERIOD 24 AND/OR METHOD (OCCURRING OCCURRING R 25 BELOW? OF IDENTIFYI PERIOD? IN C	PRIOR TO OC ON OR AFTE IN COLUMN ING THE DAY COLUMN 2, EI	TOBER 1 ER OCTOE 1, ENTER 'S IN THIS	ENTER IN CO ER 1. (see instr 1 IF DATE OF 5 COST REPOR FOR YES OR 'N	OLUMN 2 ructions)			
1	'Y' FOR YES OR 'N' FOR NO FOR THE PORTION WHICH METHOD IS USED TO DETERMINE ME ADMISSION, 2 IF CENSUS DAYS, OR 3 IF DATE	OF THE COST REPORTING OF THE COST REPORTING DICAID DAYS ON LINES E OF DISCHARGE. IS THE	G PERIOD (NG PERIOD 24 AND/OR METHOD (EPORTING)	OCCURRING 1 OCCURRING 2 OCCURRING 2 OF IDENTIFYI PERIOD? IN C	PRIOR TO OCO ON OR AFTE IN COLUMN ING THE DAY COLUMN 2, EI ATE OUT	TOBER 1 CR OCTOE 1, ENTER TS IN THIS NTER 'Y' I	ENTER IN CO ER 1. (see instr 1 IF DATE OF 5 COST REPOR	OLUMN 2 ructions)	3	N	
1	'Y' FOR YES OR 'N' FOR NO FOR THE PORTION WHICH METHOD IS USED TO DETERMINE ME ADMISSION, 2 IF CENSUS DAYS, OR 3 IF DATE	OF THE COST REPORTING OF THE COST REPORTING DICAID DAYS ON LINES E OF DISCHARGE. IS THE	G PERIOD (NG PERIOD (24 AND/OR METHOD (EPORTING) IN-STAT	OCCURRING I OCCURRING R 25 BELOW? OF IDENTIFYI PERIOD? IN C IN-STA	PRIOR TO OCO ON OR AFTE IN COLUMN ING THE DAY COLUMN 2, EI ATE AID ST.	TOBER 1 ER OCTOE 1, ENTER TS IN THIS NTER 'Y' I 1-OF- ATE	ENTER IN CO ER 1. (see instr 1 IF DATE OF 5 COST REPOR FOR YES OR 'N OUT-OF- STATE MEDICAID	OLUMN 2 ructions) RTING N' FOR NO. MEDICA	3 ID C	N OTHER	
1	'Y' FOR YES OR 'N' FOR NO FOR THE PORTION WHICH METHOD IS USED TO DETERMINE ME ADMISSION, 2 IF CENSUS DAYS, OR 3 IF DATE	OF THE COST REPORTING OF THE COST REPORTING DICAID DAYS ON LINES E OF DISCHARGE. IS THE	G PERIOD (NG PERIOD 24 AND/OR METHOD (EPORTING)	OCCURRING I OCCURRING R 25 BELOW? DF IDENTIFYI PERIOD? IN C IN-STA TE MEDIC ID ELIGIE	PRIOR TO OCON OR AFTE IN COLUMN ING THE DAY COLUMN 2, EINTE IN ATE	TOBER 1 ER OCTOE 1, ENTER 7 S IN THIS NTER 'Y' I 1-OF- ATE ICAID	ENTER IN CO ER 1. (see instr 1 IF DATE OF 5 COST REPOR FOR YES OR 'N OUT-OF- STATE MEDICAID ELIGIBLE	OLUMN 2 ructions) RTING N' FOR NO.	3 C ME	N	
1	'Y' FOR YES OR 'N' FOR NO FOR THE PORTION WHICH METHOD IS USED TO DETERMINE ME ADMISSION, 2 IF CENSUS DAYS, OR 3 IF DATE	OF THE COST REPORTING OF THE COST REPORTING DICAID DAYS ON LINES E OF DISCHARGE. IS THE	G PERIOD (NG PERIOD (24 AND/OR METHOD (EPORTING) IN-STAT MEDICA	OCCURRING I OCCURRING R 25 BELOW? DF IDENTIFYI PERIOD? IN C IN-STA TE MEDIC ID ELIGIE	PRIOR TO OCO ON OR AFTE IN COLUMN ING THE DAY COLUMN 2, EI ATE AID BLE AID DAID PAID	TOBER 1 ER OCTOE 1, ENTER TS IN THIS NTER 'Y' I 1-OF- ATE	ENTER IN CO ER 1. (see instr 1 IF DATE OF S COST REPOR FOR YES OR 'N OUT-OF- STATE MEDICAID ELIGIBLE UNPAID	OLUMN 2 ructions) RTING N' FOR NO. MEDICA	3 C ME	N OTHER EDICAID	
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1	Y' FOR YES OR 'N' FOR NO FOR THE PORTION WHICH METHOD IS USED TO DETERMINE ME ADMISSION, 2 IF CENSUS DAYS, OR 3 IF DATE PERIOD DIFFERENT FROM THE METHOD USE IF THIS PROVIDER IS AN IPPS HOSPITAL, ENT MEDICAID PAID DAYS IN COL. 1, IN-STATE M	OF THE COST REPORTING OF THE COST REPORTING THE COST REPORTING THE COST REPORTING THE PRIOR COST	G PERIOD (NG PERIOD (24 AND/OR METHOD (EPORTING IN-STAT MEDICA PAID DA	OCCURRING DOCCURRING DOCCURRING SELOW? SELOW? IN COMMENTE MEDICAL DELIGION OF THE MEDICAL DOCCURRING DELIGION OF THE MEDICAL DOCCURRING DOCCURR	PRIOR TO OCON ON OR AFTE IN COLUMN 2. EIN CO	TOBER 1 ER OCTOE 1, ENTER 'S IN THIS NTER 'Y' I T-OF- ATE ICAID DAYS	ENTER IN CO ER 1. (see instr 1 IF DATE OF 5 COST REPOR FOR YES OR 'N OUT-OF- STATE MEDICAID ELIGIBLE UNPAID DAYS	DLUMN 2 ructions) RTING N FOR NO. MEDICA HMO DA	3 C ME	N OTHER EDICAID DAYS	
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	'Y' FOR YES OR 'N' FOR NO FOR THE PORTION WHICH METHOD IS USED TO DETERMINE ME ADMISSION, 2 IF CENSUS DAYS, OR 3 IF DATE PERIOD DIFFERENT FROM THE METHOD USE IF THIS PROVIDER IS AN IPPS HOSPITAL, ENT MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICALD PAID DAYS IN COL. 2, OUT-OF-STATE MEDICOL. 3, OUT-OF-STATE MEDICALD ELIGIBLE UMEDICAID HIGH PAID AND ELIGIBLE BUT UN	OF THE COST REPORTING OF THE COST REPORTING OF THE COST REPORTING DISCHARGE. IS THE LOT IN THE PRIOR COST REPORT OF THE IN-STATE DEDICATE PAID DAYS IN UNPAID DAYS IN COL. 4,	G PERIOD (G PERIOD (24 AND/OB METHOD (EPORTING) IN-STAT MEDICA PAID DA	OCCURRING DOCCURRING DOCCURRING SELOW? SELOW? IN COMMENTE MEDICAL DELIGION OF THE MEDICAL DOCCURRING DELIGION OF THE MEDICAL DOCCURRING DOCCURR	PRIOR TO OCON ON OR AFTE IN COLUMN 2. EIN CO	TOBER 1 ER OCTOE 1, ENTER 'S IN THIS NTER 'Y' I T-OF- ATE ICAID DAYS	ENTER IN CO ER 1. (see instr 1 IF DATE OF 5 COST REPOR FOR YES OR 'N OUT-OF- STATE MEDICAID ELIGIBLE UNPAID DAYS	DLUMN 2 ructions) RTING N FOR NO. MEDICA HMO DA	3 C ME	N OTHER EDICAID DAYS	2:
1	Y' FOR YES OR 'N' FOR NO FOR THE PORTION WHICH METHOD IS USED TO DETERMINE ME ADMISSION, 2 IF CENSUS DAYS, OR 3 IF DATE PERIOD DIFFERENT FROM THE METHOD USE. IF THIS PROVIDER IS AN IPPS HOSPITAL, ENT MEDICAID PAID DAYS IN COL. 1, IN-STATE M UNPAID DAYS IN COL. 2, OUT-OF-STATE MEDICAID. 3, OUT-OF-STATE MEDICAID HMO PAID AND ELIGIBLE BUT UN AND OTHER MEDICAID DAYS IN COL. 6.	OF THE COST REPORTING OF THE COST REPORTING OF THE COST REPORTING OF THE COST REPORTING OF THE PRIOR COST REPORT OF THE P	G PERIOD (G PERIOD (24 AND/OB METHOD (EPORTING) IN-STAT MEDICA PAID DA	OCCURRING DOCCURRING DOCCURRING SELOW? SELOW? IN COMMENTE MEDICAL DELIGION OF THE MEDICAL DOCCURRING DELIGION OF THE MEDICAL DOCCURRING DOCCURR	PRIOR TO OCON ON OR AFTE IN COLUMN 2. EIN CO	TOBER 1 ER OCTOE 1, ENTER 'S IN THIS NTER 'Y' I T-OF- ATE ICAID DAYS	ENTER IN CO ER 1. (see instr 1 IF DATE OF 5 COST REPOR FOR YES OR 'N OUT-OF- STATE MEDICAID ELIGIBLE UNPAID DAYS	DLUMN 2 ructions) RTING N FOR NO. MEDICA HMO DA	3 C ME	N OTHER EDICAID DAYS	2:
1	Y' FOR YES OR 'N' FOR NO FOR THE PORTION WHICH METHOD IS USED TO DETERMINE ME ADMISSION, 2 IF CENSUS DAYS, OR 3 IF DATE PERIOD DIFFERENT FROM THE METHOD USE IF THIS PROVIDER IS AN IPPS HOSPITAL, ENT MEDICAID PAID DAYS IN COL. 1, IN-STATE M UNPAID DAYS IN COL. 2, OUT-OF-STATE MEDICALD ELIGIBLE UMEDICAID HMO PAID AND ELIGIBLE BUT UN AND OTHER MEDICAID DAYS IN COL. 6. IF THIS PROVIDER IS AN IRF, ENTER THE IN-S	OF THE COST REPORTING OF THE COST REPORTING OF THE COST REPORTING EDICAID DAYS ON LINES E OF DISCHARGE. IS THE EDICAID FROM COST RE ET THE IN-STATE EDICAID FAID DAYS IN UNPAID DAYS IN COL. 4, IPAID DAYS IN COL. 5, ETATE MEDICAID PAID	G PERIOD (G PERIOD (24 AND/OB METHOD (EPORTING) IN-STAT MEDICA PAID DA	OCCURRING DOCCURRING DOCCURRING SELOW? SELOW? IN COMMENTE MEDICAL DELIGION OF THE MEDICAL DOCCURRING DELIGION OF THE MEDICAL DOCCURRING DOCCURR	PRIOR TO OCON ON OR AFTE IN COLUMN 2. EIN CO	TOBER 1 ER OCTOE 1, ENTER 'S IN THIS NTER 'Y' I T-OF- ATE ICAID DAYS	ENTER IN CO ER 1. (see instr 1 IF DATE OF 5 COST REPOR FOR YES OR 'N OUT-OF- STATE MEDICAID ELIGIBLE UNPAID DAYS	DLUMN 2 ructions) RTING N FOR NO. MEDICA HMO DA	3 C ME	N OTHER EDICAID DAYS	2:
1	Y' FOR YES OR 'N' FOR NO FOR THE PORTION WHICH METHOD IS USED TO DETERMINE ME ADMISSION, 2 IF CENSUS DAYS, OR 3 IF DATE PERIOD DIFFERENT FROM THE METHOD USE. IF THIS PROVIDER IS AN IPPS HOSPITAL, ENT MEDICAID PAID DAYS IN COL. 1, IN-STATE M UNPAID DAYS IN COL. 2, OUT-OF-STATE MEDICAID. 3, OUT-OF-STATE MEDICAID HMO PAID AND ELIGIBLE BUT UN AND OTHER MEDICAID DAYS IN COL. 6.	OF THE COST REPORTING OF THE COST REPORTING OF THE COST REPORTING DICAID DAYS ON LINES OF DISCHARGE. IS THE DICAID FAIR DAYS IN COL. 4, IPAID DAYS IN COL. 5, STATE MEDICAID PAID LE UNPAID DAYS IN LIPAID DAYS IN COL. 5, STATE MEDICAID PAID LE UNPAID DAYS IN COL. 5	G PERIOD (G PERIOD (24 AND/OB METHOD (EPORTING) IN-STAT MEDICA PAID DA	OCCURRING DOCCURRING DOCCURRING SELOW? SELOW? IN COMMENTE MEDICAL DELIGION OF THE MEDICAL DOCCURRING DELIGION OF THE MEDICAL DOCCURRING DOCCURR	PRIOR TO OCON ON OR AFTE IN COLUMN 2. EIN CO	TOBER 1 ER OCTOE 1, ENTER 'S IN THIS NTER 'Y' I T-OF- ATE ICAID DAYS	ENTER IN CO ER 1. (see instr 1 IF DATE OF 5 COST REPOR FOR YES OR 'N OUT-OF- STATE MEDICAID ELIGIBLE UNPAID DAYS	DLUMN 2 ructions) RTING N FOR NO. MEDICA HMO DA	3 C ME	N OTHER EDICAID DAYS	2:
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	Y' FOR YES OR 'N' FOR NO FOR THE PORTION WHICH METHOD IS USED TO DETERMINE ME ADMISSION, 2 IF CENSUS DAYS, OR 3 IF DATE PERIOD DIFFERENT FROM THE METHOD USE IF THIS PROVIDER IS AN IPPS HOSPITAL, ENT MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE BUT WHEN PAID OF THE MEDICAID BELIGIBLE BUT UNAND OTHER MEDICAID DAYS IN COL. 6. IF THIS PROVIDER IS AN IRF, ENTER THE IN-SDAYS IN COL. 1, IN-STATE MEDICAID DAYS IN COL. 2, OUT-OF STATE MEDICAID DAYS IN COL. 4. MEDICAID BLIGIBLE UNPAID DAYS IN COL. 4. AND ELIGIBLE BUT UNPAID DAYS IN COL. 5,	OF THE COST REPORTING OF THE COST REPORTING OF THE COST REPORTING OF THE COST REPORTING OF THE COST RESERVED IN THE PRIOR COST RESERVED IN COL. 4, IPAID DAYS IN COL. 5, STATE MEDICAID PAID LE UNPAID DAYS IN COL. 3, OUT-OF STATE IS, MEDICAID HMO PAID IN COL. 3, OUT-OF STATE IS, MEDICAID HMO PAID IN COL. 3, OUT-OF STATE IS, MEDICAID HMO PAID IN COL. 3, OUT-OF STATE IS, MEDICAID HMO PAID IN COL. 3, OUT-OF STATE IS, MEDICAID HMO PAID IN COL. 3, OUT-OF STATE IS, MEDICAID HMO PAID IN COL. 3, OUT-OF STATE IS, MEDICAID HMO PAID	G PERIOD (G PERIOD (24 AND/OB METHOD (EPORTING) IN-STAT MEDICA PAID DA	OCCURRING DOCCURRING DOCCURRING SELOW? SELOW? IN COMMENTE MEDICAL DELIGION OF THE MEDICAL DOCCURRING DELIGION OF THE MEDICAL DOCCURRING DOCCURR	PRIOR TO OCON ON OR AFTE IN COLUMN 2. EIN CO	TOBER 1 ER OCTOE 1, ENTER 'S IN THIS NTER 'Y' I T-OF- ATE ICAID DAYS	ENTER IN CO ER 1. (see instr 1 IF DATE OF 5 COST REPOR FOR YES OR 'N OUT-OF- STATE MEDICAID ELIGIBLE UNPAID DAYS	DLUMN 2 ructions) RTING N FOR NO. MEDICA HMO DA	3 C ME	N OTHER EDICAID DAYS	2
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	Y' FOR YES OR 'N' FOR NO FOR THE PORTION WHICH METHOD IS USED TO DETERMINE ME ADMISSION, 2 IF CENSUS DAYS, OR 3 IF DATE PERIOD DIFFERENT FROM THE METHOD USE IF THIS PROVIDER IS AN IPPS HOSPITAL, ENT MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID DAYS IN COL. 2, OUT-OF-STATE MEDICAID ELIGIBLE UMEDICAID HOM PAID AND ELIGIBLE BUT UN AND OTHER MEDICAID DAYS IN COL. 6. IF THIS PROVIDER IS AN IRF, ENTER THE IN-SDAYS IN COL. 1, IN-STATE MEDICAID DAYS IN COL. 4, IN-STATE MEDICAID DAYS IN COL. 4 AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, DAYS IN COL. 6. ENTER YOUR STANDARD GEOGRAPHIC CLASSOF THE COST REPORTING PERIOD. ENTER IN COLUM APPLICABLE, ENTER THE EFFECTIVE DATE COLUMN 2. IF THIS IS A SOLE COMMUNITY HOSPITAL (SO IN EFFECT IN THE COST REPORTING PERIOD. ENTER IN COLUMN 2. IF THIS IS A SOLE COMMUNITY HOSPITAL (SO IN EFFECT IN THE COST REPORTING PERIOD. ENTER APPLICABLE BEGINNING AND ENDIN NUMBER OF PERIODS IN EXCESS OF ONE AN IF THIS IS A MEDICARE DEPENDENT HOSPITAL SO IN EXCESS OF ONE AN IF THIS IS A MEDICARE DEPENDENT HOSPITAL SO IN EXCESS OF ONE AN IF THIS IS A MEDICARE DEPENDENT HOSPITAL SO IN EXCESS OF ONE AN IF THIS IS A MEDICARE DEPENDENT HOSPITAL	OF THE COST REPORTING OF THE INSTATE OF THE PRIOR COST REPORTING OF THE PRIOR COST REPORT OF THE PORT OF THE PRIOR COST REPORT OF THE PRIOR COST RE	G PERIOD O G PERIOD O G PERIOD 24 AND/OB METHOD O EPORTING IN-STAT MEDICA PAID DA 1 TATUS AT RURAL FATUS AT FOR RURAL CLASSIFIC R OF PERIO S. SUBSCRI DATES.	OCCURRING OCCURRING OCCURRING ACTOR OCCURRING OCCURRING ACTOR OCCURRING OCCU	PRIOR TO OC ON OR AFTE IN COLUMN ING THE DAY COLUMN 2, EI ATE AID ST MED PAID ING ITHE TUS DR BEGII	TOBER 1 R OCTOE 1, ENTER S IN THIS NTER 'Y' I G-OF- ATE ICAID DAYS 3	ENTER IN CO ER 1. (see instr 1 IF DATE OF 5 COST REPOR FOR YES OR 'N OUT-OF- STATE MEDICAID ELIGIBLE UNPAID DAYS	DLUMN 2 vuctions) RTING RTING WFOR NO. MEDICA HMO DA 5	3 C ME	N OTHER EDICAID DAYS	2:
	Y' FOR YES OR 'N' FOR NO FOR THE PORTION WHICH METHOD IS USED TO DETERMINE ME ADMISSION, 2 IF CENSUS DAYS, OR 3 IF DATE PERIOD DIFFERENT FROM THE METHOD USE PERIOD DIFFERENT FROM THE METHOD USE OF THE WORLD WAS IN COL. 1, IN-STATE MEDICAL DAYS IN COL. 2, OUT-OF-STATE MEDICAL DELIGIBLE BUT UN AND OTHER MEDICALD DAYS IN COL. 6. IF THIS PROVIDER IS AN IRF, ENTER THE IN-SDAYS IN COL. 1, IN-STATE MEDICALD DAYS IN COL. 6. IF THIS PROVIDER IS AN IRF, ENTER THE IN-SDAYS IN COL. 1, IN-STATE MEDICALD DAYS IN COL. 4 AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, DAYS IN COL. 6. ENTER YOUR STANDARD GEOGRAPHIC CLASOF THE COST REPORTING PERIOD. ENTER IT COLUMN 2. IF THIS IS A SOLE COMMUNITY HOSPITAL (SCIL) IN EFFECT IN THE COST REPORTING PERIOD. ENTER IN COLUMN 2. IF THIS IS A SOLE COMMUNITY HOSPITAL (SCIL) IN EFFECT IN THE COST REPORTING PERIOD. ENTER APPLICABLE BEGINNING AND ENDIN UNBER OF PERIODS IN EXCESS OF ONE ANIF THIS IS A MEDICARD DEPENDENT HOSPITAL STATUS IN EFFECT IN THE COST REPORTING PERIOD. ENTER APPLICABLE BEGINNING AND ENDIN UNBER OF PERIODS IN EXCESS OF ONE ANIF THIS IS A MEDICARD DEPENDENT HOSPITAL STATUS IN EFFECT IN THE COST REPORTING ENTER APPLICABLE BEGINNING AND ENDIN UNBER OF PERIODS IN EXCESS OF ONE ANIF THAT IS IS A MEDICARD DEPENDENT HOSPITAL STATUS IN EFFECT IN THE COST REPORTING ENTER APPLICABLE BEGINNING AND ENDIN UNBER OF PERIODS IN EXCESS OF ONE ANIF THE COST REPORTING ENTER APPLICABLE BEGINNING AND ENDIN	OF THE COST REPORTING OF THE PRIOR COST OF THE PRIOR COS	G PERIOD OF GREEN OF PERIOD OF THE PERIOD OF	OCCURRING OCCURRING OCCURRING & OCCURRING & OCCURRING & OCCURRING & OCCURRING & ELGIP	PRIOR TO OC ON OR AFTE IN COLUMN OR AFTE IN COLUMN 2, EI ATE AID ST. MED PAID IN COLUMN 2, EI ATE AID ST. M	TOBER 1 R OCTOE 1, ENTER S'S IN THIS NTER 'Y' I G-OF- ATE ICAID DAYS 3	ENTER IN CO ER 1. (see instr 1 IF DATE OF 5 COST REPOR FOR YES OR 'N OUT-OF- STATE MEDICAID ELIGIBLE UNPAID DAYS	ENDING:	3 C ME	N OTHER EDICAID DAYS	2:
	Y' FOR YES OR 'N' FOR NO FOR THE PORTION WHICH METHOD IS USED TO DETERMINE ME ADMISSION, 2 IF CENSUS DAYS, OR 3 IF DATE PERIOD DIFFERENT FROM THE METHOD USE IF THIS PROVIDER IS AN IPPS HOSPITAL, ENT MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID DAYS IN COL. 2, OUT-OF-STATE MEDICAID ELIGIBLE BUT UN AND OTHER MEDICAID DAYS IN COL. 6. IF THIS PROVIDER IS AN IRF, ENTER THE IN-SDAYS IN COL. 1, IN-STATE MEDICAID DAYS IN COL. 6. IF THIS PROVIDER IS AN IRF, ENTER THE IN-SDAYS IN COL. 1, IN-STATE MEDICAID DAYS IN COL. 4 AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, DAYS IN COL. 5. ENTER YOUR STANDARD GEOGRAPHIC CLASOF THE COST REPORTING PERIOD. ENTER 'I' ENTER YOUR STANDARD GEOGRAPHIC CLASOF THE COST REPORTING PERIOD. ENTER IN COLUMN APPLICABLE, ENTER THE EFFECTIVE DATE COLUMN 2. IF THIS IS A SOLE COMMUNITY HOSPITAL (SUN EFFECT IN THE COST REPORTING PERIOD. ENTER IN COLUMN 1. IF THIS IS A SOLE COMMUNITY HOSPITAL (SUN EFFECT IN THE COST REPORTING PERIOD. ENTER IN COLUMN 1. IF THIS IS A MEDICARE DEPENDENT HOSPITAL (SUN EFFECT IN THE COST REPORTING PERIOD. ENTER APPLICABLE BEGINNING AND ENDIN UMBER OF PERIODS IN EXCESS OF ONE AND IT THIS IS A MEDICARE DEPENDENT HOSPITAL STATUS IN EFFECT IN THE COST REPORTING	OF THE COST REPORTING OF THE PRIOR COST OF THE PRIOR COS	G PERIOD OF GREEN OF PERIOD OF THE PERIOD OF	OCCURRING OCCURRING OCCURRING & OCCURRING & OCCURRING & OCCURRING & OCCURRING & ELGIP	PRIOR TO OC ON OR AFTE IN COLUMN OR AFTE IN COLUMN 2, EI ATE AID ST. MED PAID IN COLUMN 2, EI ATE AID ST. M	TOBER 1 R OCTOE 1, ENTER S IN THIS NTER 'Y' I G-OF- ATE ICAID DAYS 3	ENTER IN CO ER 1. (see instr 1 IF DATE OF 5 COST REPOR FOR YES OR 'N OUT-OF- STATE MEDICAID ELIGIBLE UNPAID DAYS	DLUMN 2 vuctions) RTING RTING WFOR NO. MEDICA HMO DA 5	3 C ME	N OTHER EDICAID DAYS 6	22 24 25 26 27 35 36 37 36 37 37 37 37 37 37 37 37 37 37 37 37 37
	Y' FOR YES OR 'N' FOR NO FOR THE PORTION WHICH METHOD IS USED TO DETERMINE ME ADMISSION, 2 IF CENSUS DAYS, OR 3 IF DATE PERIOD DIFFERENT FROM THE METHOD USE PERIOD DIFFERENT FROM THE METHOD USE OF THE WORLD WAS IN COL. 1, IN-STATE MEDICAL DAYS IN COL. 2, OUT-OF-STATE MEDICAL DELIGIBLE BUT UN AND OTHER MEDICALD DAYS IN COL. 6. IF THIS PROVIDER IS AN IRF, ENTER THE IN-SDAYS IN COL. 1, IN-STATE MEDICALD DAYS IN COL. 6. IF THIS PROVIDER IS AN IRF, ENTER THE IN-SDAYS IN COL. 1, IN-STATE MEDICALD DAYS IN COL. 4 AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, DAYS IN COL. 6. ENTER YOUR STANDARD GEOGRAPHIC CLASOF THE COST REPORTING PERIOD. ENTER IT COLUMN 2. IF THIS IS A SOLE COMMUNITY HOSPITAL (SCIL) IN EFFECT IN THE COST REPORTING PERIOD. ENTER IN COLUMN 2. IF THIS IS A SOLE COMMUNITY HOSPITAL (SCIL) IN EFFECT IN THE COST REPORTING PERIOD. ENTER APPLICABLE BEGINNING AND ENDIN UNBER OF PERIODS IN EXCESS OF ONE ANIF THIS IS A MEDICARD DEPENDENT HOSPITAL STATUS IN EFFECT IN THE COST REPORTING PERIOD. ENTER APPLICABLE BEGINNING AND ENDIN UNBER OF PERIODS IN EXCESS OF ONE ANIF THIS IS A MEDICARD DEPENDENT HOSPITAL STATUS IN EFFECT IN THE COST REPORTING ENTER APPLICABLE BEGINNING AND ENDIN UNBER OF PERIODS IN EXCESS OF ONE ANIF THAT IS IS A MEDICARD DEPENDENT HOSPITAL STATUS IN EFFECT IN THE COST REPORTING ENTER APPLICABLE BEGINNING AND ENDIN UNBER OF PERIODS IN EXCESS OF ONE ANIF THE COST REPORTING ENTER APPLICABLE BEGINNING AND ENDIN	OF THE COST REPORTING OF THE STATE OF THE IN-STATE OF THE PRIOR COST REPORTING OF THE PRIOR COST OF THE GEOGRAPHIC REPORTING OF THE PRIOR COST OF THE SUBSEQUENT ENTER SUBSEQUENT ENTER SUBSEQUENT DAT	G PERIOD OF GREEN OF THE PERIOD OF THE PERIO	OCCURRING I OCCURRING I OCCURRING I OCCURRING I S 25 BELOW? I 25 BELOW? IN-STA MEDIC ID ELIGII YS UNPA DAY 2 THE BEGINNI THE END OF TALL IF ATION IN ODS SCH STAT IPT LINE 36 FO PERIODS MD RIPT LINE 38 F	PRIOR TO OCONO OR AFTE IN COLUMN 2, EINTE IN COLUMN	TOBER 1 R OCTOE 1, ENTER S IN THIS NTER 'Y' I F-OF- ATE ICAID DAYS 3	ENTER IN CO ER 1. (see instr 1 IF DATE OF 5 COST REPOR FOR YES OR 'N OUT-OF- STATE MEDICAID ELIGIBLE UNPAID DAYS 4	ENDING:	3 C ME	N OTHER EDICAID DAYS	

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Page: 3

Micro System
Run Date: 05/23/2014

RH OF NORTHWEST INDIANA, LLC
Provider CCN: 15-2024

In Lieu of Form
CMS-2552-10

Period: From: 02/01/2013 To: 01/31/2014

Run Time: 08:11 Version: 2014.03

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

			V	XVIII	XIX	
PROSE	PECTIVE PAYMENT SYSTEM (PPS)-CAPITAL		1	2	3	
45	IN ACCORDANCE WITH 42 CFR §412.320?	PITAL PAYMENT FOR DISPROPORTIONATE SHARE	N	N	N	45
46	IS THIS FACILITY ELIGIBLE FOR ADDITIONAL PA' CIRCUMSTANCES PURSUANT TO 42 CFR §412.348(L-1, PARTS I THROUGH III.	YMENT EXCEPTION FOR EXTRAORDINARY f)? IF YES, COMPLETE WORKSHEET L, PART III AND	N	N	N	46
47	IS THIS A NEW HOSPITAL UNDER 42 CFR §412.300		N	N	N	47
48	IS THE FACILITY ELECTING FULL FEDERAL CAPIT	TAL PAYMENT? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N	48
TEACI	HING HOSPITALS		1	2	3	
56		IDENTS IN APPROVED GME PROGRAMS? ENTER 'Y'	N			56
57		ACILITY? ENTER 'Y' FOR YES OR 'N' FOR NO IN ART TRAINING IN THE FIRST MONTH OF THIS COST OR NO IN COLUMN 2. IF COLUMN 2 IS 'Y', COMPLETE	N	N		57
58		REIMBURSEMENT FOR PHYSICIANS' SERVICES AS	N			58
	DEFINED IN CMS PUB 15-1, SECTION 2148? IF YES,		N			59
59	ARE COSTS CLAIMED ON LINE 100 OF WORKSHEE ARE YOU CLAIMING NURSING SCHOOL AND/OR A		1N			39
60		DER §413.85? ENTER 'Y' FOR YES OR 'N' FOR NO. (see	N			60
	DID VOLID HOGDITAL DECEME ETE (LOTG LINDED	A CLA SECTION 55000 ENTED IN EOD VES OD IN EOD	Y/N	IME	DIRECT GME	+
61	NO IN COLUMN 1.)(see instructions)	ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR	N			61
C1 01	ENTER THE AVERAGE NUMBER OF UNWEIGHTED	PRIMARY CARE FTEs FROM THE HOSPITAL'S 3				61.01
61.01	MOST RECENT COST REPORTS ENDING AND SUB!					61.01
61.02	ENTER THE CURRENT YEAR TOTAL UNWEIGHTEI general surgery FTEs, and primary care FTEs added under	section 5503) of ACA). (see instructions)				61.02
61.03	ENTER THE BASE LINE FTE COUNT FOR PRIMARY WHICH IS USED FOR DETERMINING COMPLIANCE	WITH THE 75% TEST. (see instructions)				61.03
61.04	ENTER THE NUMBER OF UNWEIGHTED PRIMARY OSTEOPATHIC FTES IN THE CURRENT COST REPO					61.04
61.05		E PRIMARY AND/OR GENERAL SURGERY FTES AND ENERAL SURGERY FTE COUNTS (line 61.04 minus line				61.05
61.06	ENTER THE AMOUNT OF ACA §5503 AWARD THAT THAT ARE NONPRIMARY CARE OR GENERAL SUR					61.06
		ROGRAM SPECIALTY, IF ANY, AND THE NUMBER OF I NAME, ENTER IN COLUMN 2 THE PROGRAM CODE, EN FE LINWEIGHTED COLINT				
	COUNTING ENTER IN COLUMN Y BIRDET GIMET	PROGRAM NAME	PROGRAM CODE	UNWEIGHTED IME FTE COUNT	UNWEIGHTED DIRECT GME FTE COUNT	
		1	2	3	4	
		DED PROGRAM SPECIALTY, IF ANY, AND THE NUMB HE PROGRAM NAME, ENTER IN COLUMN 2 THE PROC DIRECT GME FTE UNWEIGHTED COUNT.				
ACA P	ROVISIONS AFFECTING THE HEALTH RESOURCES A					
62	PERIOD FOR WHICH YOUR HOSPITAL RECEIVED I					62
62.01	ENTER THE NUMBER OF FTE RESIDENTS THAT RO INTO YOUR HOSPITAL IN THIS COST REPORTING	OTATED FROM A TEACHING HEALTH CENTER (THC) PERIOD OF HRSA THC PROGRAM. (see instructions)				62.01
TFACI	HING HOSPITALS THAT CLAIM RESIDENTS IN NON-F	PROVIDER SETTINGS				+-
63	HAS YOUR FACILITY TRAINED RESIDENTS IN NON-F REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FO instructions)	N-PROVIDER SETTINGS DURING THIS COST	N			63
	,					

Page: 4

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Micro System
Run Date: 05/23/2014

RH OF NORTHWEST INDIANA, LLC Provider CCN: 15-2024 In Lieu of Form CMS-2552-10

Period : From: 02/01/2013 To: 01/31/2014

Run Time: 08:11 Version: 2014.03

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

		FTE RESIDENTS IN NON-PROVIDER SETTINGS-THIS I BEGINS ON OR AFTER JULY 1, 2009 AND BEFORE JUN		UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (col. 1/ col. 1 +	
64	PERIOD, THE NUMBER OF UNW ROTATIONS OCCURRING IN AL UNWEIGHTED NON-PRIMARY O	B IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN EIGHTED NON-PRIMARY CARE RESIDENT FTES ATTI L NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 T ARE RESIDENT FTES THAT TRAINED IN YOUR HOSP on 1 divided by (column 1 + column 2)). (see instructions)	RIBUTABLE TO HE NUMBER OF	SHE		col. 2))	64
	ENTER IN COLUMN 2 THE PROC ROTATIONS OCCURRING IN AL	UMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAIN IRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF I L NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 T ENTER IN COLUMN 5 THE RATIO OF (column 3 divided I	UNWEIGHTED PRIN HE NUMBER OF UN	MARY CARE FTE RI WEIGHTED PRIMA	ESIDENTS ATTRIBU ARY CARE RESIDEN	TABLE TO	
		PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
	REPORTING PERIODS BEGINNING			UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTES IN HOSPITAL	RATIO (col. 1/ col. 1 + col. 2))	65
66	ATTRIBUTABLE TO ROTATIONS THE NUMBER OF UNWEIGHTED	BER OF UNWEIGHTED NON-PRIMARY CARE RESIDE GOCCURRING IN ALL NON-PROVIDER SETTINGS. EN NON-PRIMARY CARE RESIDENT FTES THAT TRAINE 3 THE RATIO OF (column 1 divided by (column 1 + column	TER IN COLUMN 2 ED IN YOUR				66
	UNWEIGHTED PRIMARY CARE	MN 1 THE PROGRAM NAME. ENTER IN COLUMN 2 TE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCC MARY CARE RESIDENT FTES THAT TRAINED IN YOU ions)	CURRING IN ALL N	ON-PROVIDER SET	TINGS. ENTER IN C	COLUMN 4 THE	
		PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	67
67							07
INPATI	IENT PSYCHIATRIC FACILITY PPS			1	2	3	
70	SUBPROVIDER? ENTER 'Y' FOR	T PSYCHIATRIC FACILITY (IPF), OR DOES IT CONTAI YES OR 'N' FOR NO.	N AN IPF	N			70
71	FILED ON OR BEFORE NOVEMB COLUMN 2: DID THIS FACILITY WITH 42 CFR §412.424(d)(1)(iii)(D COLUMN 3: IF COLUMN 2 IS Y, I REPORTING PERIOD COVERS TI	HAVE A TEACHING PROGRAM IN THE MOST RECENT ER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. TRAIN RESIDENTS IN A NEW TEACHING PROGRAM I)? ENTER 'Y' FOR YES AND 'N' FOR NO. ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF TH HE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN C YEARS OF THE NEW TEACHING PROGRAM IN EXISTI	IN ACCORDANCE IS COST OLUMN 3, OR IF				71
	+ TIE SUBSEQUENT TIE BENNE		3.102, 2.112.0				
INPATI	IENT REHABILITATION FACILITY	PPS T REHABILITATION FACILITY (IRF), OR DOES IT CON	JTAIN AN IDE	1	2	3	
75	SUBPROVIDER? ENTER 'Y' FOR 'IF LINE 75 YES:		VIAIN AN IKF	N			75
	COLUMN 1: DID THE FACILITY REPORTING PERIOD ENDING OF COLUMN 2: DID THIS FACILITY	HAVE A TEACHING PROGRAM IN THE MOST RECENT NOR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YI TRAIN RESIDENTS IN A NEW TEACHING PROGRAM	ES OR 'N' FOR NO.				76
76	COLUMN 3: IF COLUMN 2 IS Y, I REPORTING PERIOD COVERS TI)? ENTER 'Y' FOR YES AND 'N' FOR NO. ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF TH HE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN C YEARS OF THE NEW TEACHING PROGRAM IN EXISTI	OLUMN 3, OR IF				
	COLUMN 3: IF COLUMN 2 IS Y, I REPORTING PERIOD COVERS TI THE SUBSEQUENT ACADEMIC	NTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THE HE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN C	OLUMN 3, OR IF				
LONG	COLUMN 3: IF COLUMN 2 IS Y, I REPORTING PERIOD COVERS TI THE SUBSEQUENT ACADEMIC TERM CARE HOSPITAL PPS IS THIS A LONG TERM CARE HO	NTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THE HE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN C	OLUMN 3, OR IF		Y		80
LONG	COLUMN 3: IF COLUMN 2 IS Y, I REPORTING PERIOD COVERS TI THE SUBSEQUENT ACADEMIC TERM CARE HOSPITAL PPS IS THIS A LONG TERM CARE HO PROVIDERS	ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THE HE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN C YEARS OF THE NEW TEACHING PROGRAM IN EXISTE	OLUMN 3, OR IF ENCE, ENTER 5.		Y		80

Optimizer Systems, Inc.

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Page: 5

Micro System
Run Date: 05/23/2014

Run Time: 08:11 Version: 2014.03

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

				V	XIX	
	AND XIX SERVICES DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICE	ES? ENTER 'Y' FOR	YES. OR 'N' FOR NO	1	2	
90	IN APPLICABLE COLUMN.			N	N	90
91	IS THIS HOSPITAL REIMBURSED FOR TITLE V AND/OR XIX THROUGH THE COST PART? ENTER 'Y' FOR YES, OR 'N' FOR NO IN THE APPLICABLE COLUMN.	REPORT EITHER IN	N FULL OR IN	N	N	91
92	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (dual certification IN THE APPLICABLE COLUMN.)? ENTER 'Y' FOR Y	ES OR 'N' FOR NO		N	92
93	DOES THIS FACILITY OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE V FOR NO IN THE APPLICABLE COLUMN.	AND XIX? ENTER	Y' FOR YES OR 'N'	N	N	93
94	DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N'		PLICABLE COLUMN	N	N	94
95	IF LINE 94 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COL DOES TITLE V OR TITLE XIX REDUCE OPERATING COST? ENTER 'Y' FOR YES OR		ADDI ICARI E			95
96	COLUMN.		ATTLICABLE	N	N	96
97	IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COL	LUMN.				97
RURAL	PROVIDERS			1	2	
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?	METHOD OF DAVIAN	INT FOR	N		105
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE MOUTPATIENT SERVICES.	TETHOD OF PAYME	ENTFOR			106
	COLUMN 1: IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST RE					
107	PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, THE GME WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIM					107
	WORKSHEET D-2, PART II, COLUMN 2: IF THIS FACILITY IS A CAH, DO I&Rs IN AN	N APPROVED MEDI	CAL EDUCATION			
	PROGRAM TRAIN IN THE CAH'S EXCLUDED IPF AND/OR IRF UNIT? ENTER 'Y' FOI IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEI					
108	ENTER 'Y' FOR YES OR 'N' FOR NO.			N		108
	TE THIC HOCDITAL OHALIETES AS A CAHOD A COST DROWIDED, ARE THER ADV	PHYSICAL N	OCCUPATIONAL N	SPEECH N	RESPIRATORY N	
109	IF THIS HOSPITAL QUALIFIES AS A CAH OR A COST PROVIDER, ARE THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIER? ENTER 'Y' FOR YES OR 'N' FOR	IN .	IN .	IN .	IN .	109
	EACH THERAPY.					
MISCEL	LANEOUS COST REPORTING INFORMATION					
	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO					
115	YES, ENTER THE METHOD USED (A, B, or E only) IN COLUMN 2. IF COLUMN 2 IS 'E COLUMN 3 EITHER '93' PERCENT FOR SHORT TERM HOSPITAL OR '98'	C, ENTER IN	N			115
116	IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR			N		116
117	IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? IS THE MALPRACTICE INSURANCE A CLAIMS-MADE OR OCCURRENCE POLICY?			Y		117
118	MADE. ENTER 2 IF THE POLICY IS OCCURRENCE.	ENTER I IF THE FC	DEICT IS CLAIM-	1		118
			PREMIUMS	PAID LOSSES	SELF INSURANCE	
118.01	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES:		30,000,000	30,000,000	INSURANCE	118.01
440.02	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN A COST CENTE					
118.02	ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SAND AMOUNTS CONTAINED THEREIN.			N		118.02
	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLE APPLICABLE AMENDMENTS? (see instructions). ENTER IN COLUMN 1 'Y' FOR YES C					
120	HOSPITAL WITH < 100 BEDS THAT QUALIFIES FOR THE OUTPATIENT HOLD HAR			N	N	120
	APPLICABLE AMENDMENTS? (see instructions). ENTER IN COLUMN 2 'Y' FOR YES ODID THIS FACILITY INCUR AND REPORT COSTS FOR HIGH COST IMPLANTABLE		O TO DATIENTES			
121	ENTER 'Y' FOR YES OR 'N' FOR NO.	DEVICES CHARGE	D TO PATIENTS?	N		121
TDANCE	A ANTE CENTEED INFORMATION					
	LANT CENTER INFORMATION DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? ENTER 'Y' FOR YES OR	'N' FOR NO. IF YES	, ENTER	N		125
125	CERTIFICATION DATE(S)(mm/dd/yyyy) BELOW.	CEDITIEIC ATION D	TE IN COLUMN 1	N		123
126	IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CAND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.	CERTIFICATION DA	TE IN COLUMN 1			126
127	IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE C AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.	ERTIFICATION DA	TE IN COLUMN 1			127
128	IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CE AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.	ERTIFICATION DAT	E IN COLUMN 1			128
129	IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CE AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.	RTIFICATION DAT	E IN COLUMN 1			129
130	IF THIS IS A MEDICARE CERTIFIED PANCREAS TRANSPLANT CENTER, ENTER THE	HE CERTIFICATION	DATE IN COLUMN			130
131	1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2. IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER TO COLUMN 1. AND TERMINATION DATE. IF APPLICABLE IN COLUMN 2.	THE CERTIFICATIO	N DATE IN			131
132	COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2. IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CE	RTIFICATION DAT	E IN COLUMN 1			132
133	AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2. IF THIS IS A MEDICARE CERTIFIED OTHER TRANSPLANT CENTER, ENTER THE C	ERTIFICATION DA	ΓΕ IN COLUMN 1			133
	AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2. IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO N	UMBER IN COLUM	N 1 AND			
134	TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.		•			134

Win-LASH 2552-10

Optimizer Systems, Inc.



Page: 6

Micro System

Run Date: 05/23/2014

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Version: 2014.03 In Lieu of Form Period: RH OF NORTHWEST INDIANA, LLC From: 02/01/2013 To: 01/31/2014 CMS-2552-10 Provider CCN: 15-2024

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

ALL PROVIDERS ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-1, CHAPTER 107 BATTER Y FOR YES, OR Y FOR NO BY COLLINN I. IF YES, AND HOME OFFICE COSTS ARE CLAIMED, ENTER IN COLUMN Y H06312 2 THE HOMEOMORPHIC CHANN NUMBER. IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER ON LINES 141 THROUGH 143 THE NAME AND ADDRESS OF THE HOME OFFICE AND ENTER THE HOMEONTRACTOR NAME AND CONTRACTOR THE HOMEONTRACTOR IN THE CONTRACTOR NAME AND CONTRACTOR THE HOMEONTRACTOR IN THE HOM									
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IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER ON LINES 141 THROUGH 143 THE NAME AND ADDRESS OF THE HOME OFFICE AND ENTER THE HOME CONTRACTOR NAME AND CONTRACTOR NUMBER. 141	140	ENTER 'Y' FOR YES, OR 'N' FOR NO IN COLUMN 1. II					Y	HB0312	140
CONTRACTOR NAME AND CONTRACTOR NUMBER.		2 THE HOME OFFICE CHAIN NUMBER.							
CONTRACTOR NAME AND CONTRACTOR NUMBER.	IF THIS	FACILITY IS PART OF A CHAIN ORGANIZATION EN	TER ON LINES 141 TH	ROUGH 143 TH	E NAME AND	ADDRESS OF THE H	OME OFFICE AN	D ENTER THE HOM	IE OFFIC
141 NAME: NAME: SELECT MEDICAL CONTRACTOR'S NAME: NOVITAS SOLUTIONS INC. CONTRACTOR'S NUMBER: 12001			I DIT OIT DITTED ITT III			TIDDICED OF THE I	onie orrice in	D LIVILIN IIIL IION	01110
132 STREET. STREET: 3714 GETTYSBURG ROAD P.O. BOX: 132 CITY. CITY. MECHANICSBURG STATE: PA ZIP CODE: 17055 143 CITY. CITY. MECHANICSBURG STATE: PA ZIP CODE: 17055 144 ARE PROVIDER BASED PHYSICIANS COSTS INCLUDED IN WORKSHIET A? Y 145 IF COSTS FOR RENAL SERVICES ARE CLAIMED ON WORKSHIET A, LINE 74 ARE THEY COSTS FOR INPATIENT Y 146 FOR STS FOR RENAL SERVICES ARE CLAIMED ON WORKSHIET A, LINE 74 ARE THEY COSTS FOR INPATIENT Y 146 FOR YES AND N'F FOR NO IN COLUMN 1. (see CMS Pub. 15-2, section 4020). IF YES, ENTER THE APPROVAL DATE N 146 FOR YES AND N'F FOR NO IN COLUMN 1. (see CMS Pub. 15-2, section 4020). IF YES, ENTER THE APPROVAL DATE N 147 WAS THERE A CHANGE IN THE STATISTICAL BASIS? ENTER: Y'FOR YES OR N'FOR NO. N 148 WAS THERE A CHANGE IN THE STATISTICAL BASIS? ENTER: Y'FOR YES OR N'FOR NO. N 149 WAS THERE A CHANGE IN THE STATISTICAL BASIS? ENTER: Y'FOR YES OR N'FOR NO. N 149 WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? ENTER: Y'FOR YES OR N'FOR NO. N 140 WAS THERE A CHANGE IN THE ORDER OF AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COSTS OR CHARGES? ENTER: Y'FOR YES OR N'FOR NO. N 140 WAS THERE A CHANGE IN THE ORDER OF AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COSTS OR CHARGES? ENTER: Y'FOR YES OR N'FOR NO. N 150 SUBPROVIDER: A PART B TITLE V TITLE XIX 151 PART A PART B TITLE V TITLE XIX 152 N N N N N 153 SUBPROVIDER: A PART B TITLE V TITLE XIX 154 SUBPROVIDER: A PART B TITLE V TITLE XIX 155 SUBPROVIDER: A PART B TITLE V TITLE XIX 156 SUBPROVIDER: A PART B TITLE V TITLE XIX 157 SUBPROVIDER: A PART B N N N 157 SUBPROVIDER: A PART B N N N 158 SUBPROVIDER: A PART B TITLE V TITLE XIX 159 SNF N N N 151 SUBPROVIDER IN SUB			CONTRACTOR'S	NAME: NOVITA	S SOLUTION:	S INC. CONTRAC	TOR'S NUMBER	: 12001	141
143 CITY: CITY: MECHANICSBURG									142
144 ARE PROVIDER BASED PHYSICIANS COSTS INCLUDED IN WORKSHEET A? Y				ZIP CODE	17055				143
IF COSTS FOR RENAL SERVICES ARE CLAIMED ON WORKSHEET A, LINE 74 ARE THEY COSTS FOR INPATIENT SERVICES ONLY? ENTER Y' FOR YES, OR 'N FOR NO. Y							Y		144
SERVICES ONLY ENTER Y' FOR YES, OR N' FOR NO.					COSTS FOR I	NPATIENT			
HAS THE COST ALLOCATION METHODOLOGY CHANGED FROM THE PREVIOUSLY FILED COST REPORT? ENTER Y FOR NO IN COLUMN 1. (see CMS Pub. 15-2, section 4020). IF YES, ENTER THE APPROVAL DATE N	145			_ ,	000101011		Y		145
146 FOR YES AND 'N FOR NO IN COLUMN 1, (see CMS Pub. 15-2, section 4020). IF YES, ENTER THE APPROVAL DATE N				REVIOUSLY FIL	ED COST REP	ORT? ENTER 'Y'			
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DOES THIS FACILITY CONTAIN A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COSTS OR CHARGES? ENTER 'Y' FOI NO FOR EACH COMPONENT FOR PART A AND PART B. SEE 42 CFR §413.13) TITLE XVIII PART A PART B TITLE V TITLE XIX 1 2 3 155 HOSPITAL N N N SUBPROVIDER - IPF SUBPROVIDER - IPF SUBPROVIDER - ION SUBPROVIDER - ION N N N N N N N N N N N N N									148
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155 HOSPITAL N N N N N N N N N N N					PART A				
156 SUBPROVIDER - IPF N N N N 157 SUBPROVIDER - IRF N N N N N 158 SUBPROVIDER - (OTHER) 159 SNF N N N N 160 HHA N N N N 161 CMFC N N N N 161 CMFC N N N N 161 CMFC N N N N 161 CMFC N N N N 162 IS THIS HOSPITAL PART OF A MULTICAMPUS HOSPITAL THAT HAS ONE OR NOW N 165 IS THIS HOSPITAL PART OF A MULTICAMPUS HOSPITAL THAT HAS ONE OR NOW N 166 IF LINE 165 IS YES, FOR EACH CAMPUS, ENTER THE NAME IN COLUMN 0, COUNTY IN COLUMN 1, STATE IN COLUMN 2, ZIP IN COLUMN 3, CBSA IN COLUMN 4, FTE/CAMPUS IN COLUMN 5. NAME	155	HOCDITAL			NT.	-			155
157 SUBPROVIDER - IRF N N N N 158 SUBPROVIDER - (OTHER) N N N N N N N N N N								N	155
158 SUBPROVIDER - (OTHER) N N N N 160									156
159 SNF					N	N			157
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	107								109
DESPECTIVELY (mm/dd/yayay)	170		DATE AND ENDING	DATE FOR THE	REPORTING	PERIOD			170
RESI ECTIVEET (IIIII/dd/yyyy)	1/0	RESPECTIVELY (mm/dd/yyyy)							170

Optimizer Systems, Inc.

WinLASH

Micro System
Run Date: 05/23/2014 In Lieu of Form Period: RH OF NORTHWEST INDIANA, LLC CMS-2552-10 From: 02/01/2013 Run Time: 08:11 To: 01/31/2014 Version: 2014.03 Provider CCN: 15-2024

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2 PART II

GENERAL INSTRUCTION: ENTER Y FOR ALL YES RESPONSES. ENTER N FOR ALL NO RESPONSES. ENTER ALL DATES IN THE MM/DD/YYYY FORMAT.

COMPLETED BY ALL HOSPITALS

	Y/N	DATE		
PROVIDER ORGANIZATION AND OPERATION	1	2		
HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COS REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (see instructions)	N N			1
	Y/N 1	DATE 2	V/I 3	
HAS THE PROVIDER TERMINATED PARTICIPATION IN THE MEDICARE PROGRAM? IF YES, ENTER IN COLUMN 2 THE DATE OF TERMINATION AND IN COLUMN 3, 'V' FOR VOLUNTARY OR 'I' FOR INVOLUNTARY.	N			2
IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACT WITH INDIVIDUALS OR ENTITIES (e.g., chain home offices, drug or medical supply companies) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (see instructions)	TS,			3
	Y/N	TYPE	DATE	
FINANCIAL DATA AND REPORTS	1	2	3	
4 COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTAN COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (see instructions). IF NO, SEE INSTRUCTIONS.	Y	С		4
ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	IE N			5
		V/NI	VAI	
APPROVED EDUCATIONAL ACTIVITIES		Y/N 1	Y/N 2	
6 COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?		N		6
7 ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.		N		7
8 WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DUR REPORTING PERIOD?	RING THE COST	N		8
9 ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPOI INSTRUCTIONS.	RT? IF YES, SEE	N		9
10 WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTIN SEE INSTRUCTIONS.	G PERIOD? IF YES,	N		10
11 ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEA ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	ACHING PROGRAM	N		11
BAD DEBTS 12 IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.			Y/N Y	12
13 IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS CO SUBMIT COPY.	ST REPORTING PERIC	DD? IF YES,	Y	13
SUBMIT COPY. 14 IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INS.	TRUCTIONS.		N	14
BED COMPLEMENT				
15 DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE IN	ISTRUCTIONS.		N	15
	PART A	PAI	RT B	
Y/N	DATE	Y/N	DATE	
PS&R REPORT DATA 1 WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER	2	3	4	
16 COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT N USED IN COLUMNS 2 AND 4. (see instructions)		N		16
WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (see instructions)		N		17
IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.		N		18
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 N INSTRUCTIONS.		N		19
20 IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:		N		20

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Page: 8



Micro System
Run Date: 05/23/2014 In Lieu of Form Period: RH OF NORTHWEST INDIANA, LLC CMS-2552-10 From: 02/01/2013 Run Time: 08:11 Version: 2014.03 Provider CCN: 15-2024 To: 01/31/2014

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2 PART II

GENERAL INSTRUCTION: ENTER Y FOR ALL YES RESPONSES. ENTER N FOR ALL NO RESPONSES. ENTER ALL DATES IN THE MM/DD/YYYY FORMAT.

COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)

CADIT	ALDELATED CORTS			
22	AL RELATED COSTS			22
22	HAVE ASSETS BEEN RELIFED FOR MEDICARE PURPOSES? IF YES, SEE INSTRUCTIONS.	T DEDODTING		22
23	HAVE CHANGES OCCURRED IN THE MEDICARE DEPRECIATION EXPENSE DUE TO APPRAISALS MADE DURING THE COS' PERIOD? IF YES, SEE INSTRUCTIONS.			23
24	WERE NEW LEASES AND/OR AMENDMENTS TO EXISTING LEASES ENTERED INTO DURING THIS COST REPORTING PERIC INSTRUCTIONS.	DD? IF YES, SEE		24
25	HAVE THERE BEEN NEW CAPITALIZED LEASES ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INS	TRUCTIONS.		25
26	WERE ASSETS SUBJECT TO SEC. 2314 OF DEFRA ACQUIRED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRU	CTIONS.		26
27	HAS THE PROVIDER'S CAPITALIZED POLICY CHANGED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTION	ONS.		27
INTED	EST EXPENSE			_
	WERE NEW LOANS. MORTGAGE AGREEMENTS OR LETTERS OF CREDIT ENTERED INTO DURING THE COST REPORTING I	DEDIOD3 IE VES		
28	SEE INSTRUCTIONS.	ERIOD: II TES,		28
29	DID THE PROVIDER HAVE A FUNDED DEPRECIATION ACCOUNT AND/OR BOND FUNDS (debt service reserve fund) TREATED	AS A FUNDED		29
30	DEPRECIATION ACCOUNT? IF YES, SEE INSTRUCTIONS. HAS EXISTING DEBT BEEN REPLACED PRIOR TO ITS SCHEDULED MATURITY WITH NEW DEBT? IF YES, SEE INSTRUCTION	NIC		30
31	has bebt been recalled before scheduled maturity with out issuance of new debt; if ies, see instruction			31
31	HAS DEBT BEEN RECALLED BEFORE SCHEDULED MATURITY WITHOUT ISSUANCE OF NEW DEBT; IF TES, SEE INSTRUC	HONS.		31
PURC	HASED SERVICES			
32	HAVE CHANGES OR NEW AGREEMENTS OCCURRED IN PATIENT CARE SERVICES FURNISHED THROUGH CONTRACTUAL	_		32
32	ARRANGEMENTS WITH SUPPLIERS OF SERVICES? IF YES, SEE INSTRUCTIONS.			-
33	IF LINE 32 IS YES, WERE THE REQUIREMENTS OF SEC. 2135.2 APPLIED PERTAINING TO COMPETITIVE BIDDING? IF NO, SI	EE INSTRUCTIONS.		33
DDOM	IDED DAGED DIVIGICIANG			
PROV	IDER-BASED PHYSICIANS ARE SERVICES FURNISHED AT THE PROVIDER FACILITY UNDER AN ARRANGEMENT WITH PROVIDER-BASED PHYSICIA	MCO IE VEC CEE		
34	INSTRUCTIONS.	N5: IF 1E5, 5EE		34
35	IF LINE 34 IS YES, WERE THERE NEW AGREEMENTS OR AMENDED EXISTING AGREEMENTS WITH THE PROVIDER-BASEI	PHYSICIANS		35
33	DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.			33
		37.37	D.A.TE	
HOME	OFFICE COSTS	Y/N 1	DATE 2	
36	WERE HOME OFFICE COSTS CLAIMED ON THE COST REPORT?	1	<u>Z</u>	36
30	WERE HOME OFFICE COSTS CLAIMED ON THE COST REPORT? IF LINE 36 IS YES, HAS A HOME OFFICE COST STATEMENT BEEN PREPARED BY THE HOME OFFICE? IF YES, SEE			
37	INSTRUCTIONS.			37
38	IF LINE 36 IS YES, WAS THE FISCAL YEAR END OF THE HOME OFFICE DIFFERENT FROM THAT OF THE PROVIDER? IF			38
	YES, ENTER IN COLUMN 2 THE FISCAL YEAR END OF THE HOME OFFICE.			
39	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO OTHER CHAIN COMPONENTS? IF YES, SEE INSTRUCTIONS.			39
40	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.			40
COST	REORT PREPARER INFORMATION			
41		MBURSEMENT AN	ALYST	41
42	EMPLOYER: SELECT MEDICAL	MIDOROLMENT AN	ILIDI	42
43	PHONE NUMBER: 717-920-4012 E-MAIL ADDRESS: HELJONES@SELECTMEDICA	AL.COM		43

Win-LASH 2552-10

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Page: 9

In Lieu of Form Period: RH OF NORTHWEST INDIANA, LLC From: 02/01/2013 To: 01/31/2014 CMS-2552-10 Provider CCN: 15-2024

Micro System
Run Date: 05/23/2014
Run Time: 08:11
Version: 2014.03

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

						INPATIE	NT DAYS/OUTP	ATIENT VISI	TS/TRIPS	
	COMPONENT	WKST A LINE NO.	NO. OF BEDS	BED DAYS AVAILABLE	CAH HOURS	TITLE V	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		1	2	3	4	5	6	7	8	
1	HOSPITAL ADULTS & PEDS. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	61	22,265			10,095		13,381	1
2	HMO AND OTHER (see instructions)						1,187			2
3	HMO IPF SUBPROVIDER									3
4	HMO IRF SUBPROVIDER									4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF									5
6	HOSPITAL ADULTS & PEDS. SWING BED NF									6
7	TOTAL ADULTS & PEDS. (exclude observation beds)(see instructions)		61	22,265			10,095		13,381	7
8	INTENSIVE CARE UNIT	31								8
9	CORONARY CARE UNIT	32								9
10	BURN INTENSIVE CARE UNIT	33								10
11	SURGICAL INTENSIVE CARE UNIT	34								11
12	OTHER SPECIAL CARE (SPECIFY)	35								12
13	NURSERY	43								13
14	TOTAL (see instructions)		61	22,265			10,095		13,381	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40								16
17	SUBPROVIDER - IRF	41								17
18	SUBPROVIDER I	42								18
19	SKILLED NURSING FACILITY	44								19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101								22
23	ASC (Distinct Part)	115								23
24	HOSPICE (Distinct Part)	116								24
24.10	HOSPICE (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88								26
27	TOTAL (sum of lines 14-26)		61							27
28	OBSERVATION BED DAYS									28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (see instructions)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (see instructions)								1	32
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)									32.01
33	LTCH NON-COVERED DAYS						177		T .	33
							1//			

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Micro System
Run Date: 05/23/2014

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

		FULL	TIME EQUIVAL	LENTS		DISCH	ARGES		
	COMPONENT	TOTAL INTERNS & RESIDENTS	EMPLOYEES ON PAYROLL	NONPAID WORKERS	TITLE V	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		9	10	11	12	13	14	15	
1	HOSPITAL ADULTS & PEDS. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					403		535	1
2	HMO AND OTHER (see instructions)					50			2
3	HMO IPF SUBPROVIDER								3
4	HMO IRF SUBPROVIDER								4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF								5
6	HOSPITAL ADULTS & PEDS. SWING BED NF								6
7	TOTAL ADULTS & PEDS. (exclude observation beds)(see instructions)								7
8	INTENSIVE CARE UNIT								8
9	CORONARY CARE UNIT								9
10	BURN INTENSIVE CARE UNIT								10
11	SURGICAL INTENSIVE CARE UNIT								11
12	OTHER SPECIAL CARE (SPECIFY)								12
13	NURSERY								13
14	TOTAL (see instructions)		128.04			403		535	14
15	CAH VISITS								15
16	SUBPROVIDER - IPF								16
17	SUBPROVIDER - IRF								17
18	SUBPROVIDER I								18
19	SKILLED NURSING FACILITY								19
20	NURSING FACILITY								20
21	OTHER LONG TERM CARE								21
22	HOME HEALTH AGENCY								22
23	ASC (Distinct Part)								23
24	HOSPICE (Distinct Part)								24
24.10	HOSPICE (non-distinct part)								24.10
25	CMHC								25
26	RHC								26
27	TOTAL (sum of lines 14-26)		128.04						27
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)								32

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Micro System
Run Date: 05/23/2014
Run Time: 08:11
Version: 2014.03 In Lieu of Form Period: RH OF NORTHWEST INDIANA, LLC From: 02/01/2013 To: 01/31/2014 CMS-2552-10 Provider CCN: 15-2024

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3 PARTS II-III

PART	II - WAGE DATA						1	
		WKST A LINE NO.	AMOUNT REPORTED	RECLASSIF- ICATION OF SALARIES (from Worksheet A-6)	ADJUSTED SALARIES (column 2 ± column 3)	PAID HOURS RELATED TO SALARIES IN COLUMN 4	AVERAGE HOURLY WAGE (column 4 ± column 5)	
		1	2	3	4	5	6	
	SALARIES							
1	TOTAL SALARIES (see instructions)	200	7,733,667			266,329.70		1
2	NON-PHYSICIAN ANESTHETIST PART A							2
3	NON-PHYSICIAN ANESTHETIST PART B							3
4	PHYSICIAN-PART A - ADMINISTRATIVE							4
4.01	PHYSICIAN-PART A - TEACHING							4.01
5	PHYSICIAN-PART B							5
6	NON-PHYSICIAN-PART B	2.1						6
7	INTERNS & RESIDENTS (in an approved program)	21						7
7.01	CONTRACTED INTERNS & RESIDENTS (in an approved							7.01
	program)							
8	HOME OFFICE PERSONNEL							8
9	SNF	44				2 22 4 1-		9
10	EXCLUDED AREA SALARIES (see instructions)			56,569		2,224.49		10
1.1	OTHER WAGES & RELATED COSTS		444.271			0.210.00		
11	CONTRACT LABOR (see instructions)		444,371			9,219.00		11
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE							12
	SERVICES							
13	CONTRACT LABOR: PHYSICIAN-PART A		137,354			1,030.00		13
	ADMINISTRATIVE		,			-,,,,,,,,,,		
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS							14
15	HOME OFFICE: PHYSICIAN PART A - ADMINISTRATIVE							15
16	HOME OFFICE & CONTRACT PHYSICIANS PART A -							16
	TEACHING							
	WAGE-RELATED COSTS							
17	WAGE-RELATED COSTS (core)(see instructions)							17
18	WAGE-RELATED COSTS (other)(see instructions)							18
19	EXCLUDED AREAS							19
20	NON-PHYSICIAN ANESTHETIST PART A							20
21	NON-PHYSICIAN ANESTHETIST PART B							21
22	PHYSICIAN PART A - ADMINISTRATIVE							22
22.01	PHYSICIAN PART A - TEACHING							22.01
23	PHYSICIAN PART B							23
24 25	WAGE-RELATED COSTS (RHC/FQHC) INTERNS & RESIDENTS (in an approved program)							24
25								25
26	OVERHEAD COSTS - DIRECT SALARIES EMDLOYEE DENEETS DEDARTMENT		5.050			122.20		26
26 27	EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL		5,050 1,061,409	-56,569		123.28 28,519.70		26
21	ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL UNDER CONTRACT (see		1,061,409	-50,569		28,519.70		27
28	instructions)							28
29								29
30	MAINTENANCE & REPAIRS OPERATION OF PLANT							30
	LAUNDRY & LINEN SERVICE							
31	HOUSEKEEPING							31
33	HOUSEKEEPING HOUSEKEEPING UNDER CONTRACT (see instructions)							33
34	DIETARY		42,190			1,640.00		34
35	DIETARY UNDER CONTRACT (see instructions)		42,190			1,040.00		35
36	CAFETERIA CAPETERIA							36
37	MAINTENANCE OF PERSONNEL							37
38	NURSING ADMINISTRATION		193,708			4.002.64		38
39	CENTRAL SERVICES AND SUPPLY		173,708			4,002.04		39
40	PHARMACY							40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		106,027			5,975.15		40
42	SOCIAL SERVICE		100,027			3,975.15		42
43	OTHER GENERAL SERVICE							43
+3	OTTIER GENERAL SERVICE					1	1	40

PART	III -	HOSPITAL	WAGE	INDEX	SUMMARY

1	NET SALARIES (see instructions)	7,733,667		7,733,667	266,329.70	29.04	1
2	EXCLUDED AREA SALARIES (see instructions)		56,569	56,569	2,224.49	25.43	2
3	SUBTOTAL SALARIES (line 1 minus line 2)	7,733,667	-56,569	7,677,098	264,105.21	29.07	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (see	581.725		581,725	10,249.00	56.76	4
7	instructions)	361,723		301,723	10,247.00	30.70	7
5	SUBTOTAL WAGE-RELATED COSTS (see instructions)						5
6	TOTAL (sum of lines 3 through 5)	8,315,392	-56,569	8,258,823	274,354.21	30.10	6
7	TOTAL OVERHEAD COST (see instructions)	1,408,384	-56,569	1,351,815	40,260.77	33.58	7

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Micro System
Run Date: 05/23/2014

RH OF NORTHWEST INDIANA, LLC Provider CCN: 15-2024 In Lieu of Form CMS-2552-10

Period : Run Do From: 02/01/2013 Run Ti To: 01/31/2014 Version

Run Time: 08:11 Version: 2014.03

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3 PART IV

PART IV - WAGE RELATED COST

PART	Δ.	COR	FI	ICT

		AMOUNT	
		REPORTED	
	RETIREMENT COST		
1	401K EMPLOYER CONTRIBUTIONS		1
2	TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION		2
3	NONQUALIFIED DEFINED BENEFIT PLAN COST (see instructions)		3
4	QUALIFIED DEFINED BENEFIT PLAN COST (see instructions)		4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA PLAN ADMINISTRATION FEES		5
6	LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN		6
7	EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES		7
	HEALTH AND INSURANCE COST		
8	HEALTH INSURANCE (Purchased or Self Funded)		8
9	PRESCRIPTION DRUG PLAN		9
10	DENTAL, HEARING AND VISION PLAN		10
11	LIFE INSURANCE (If employee is owner or beneficiary)		11
12	ACCIDENTAL INSURANCE (If employee is owner or beneficiary)		12
13	DISABILITY INSURANCE (If employee is owner or beneficiary)		13
14	LONG-TERM CARE INSURANCE (If employee is owner or beneficiary)		14
15	WORKERS' COMPENSATION INSURANCE		15
16	RETIREMENT HEALTH CARE COST (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	TAXES		
17	FICA-EMPLOYERS PORTION ONLY		17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19	UNEMPLOYMENT INSURANCE		19
20	STATE OR FEDERAL UNEMPLOYMENT TAXES		20
	OTHER		
21	EXECUTIVE DEFERRED COMPENSATION (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)		21
22	DAY CARE COSTS AND ALLOWANCES		22
23	TUITION REIMBURSEMENT		23
24	TOTAL WAGE RELATED COST (Sum of lines 1-23)		24

	PART	B - OTHER THAN CORE RELATED COST	
ſ	25	OTHER WAGE RELATED (OTHER WAGE REL	25

Optimizer Systems, Inc.

Provider CCN: 15-2024

WinLASH

Micro System
Run Date: 05/23/2014

RH OF NORTHWEST INDIANA, LLC

Supporting Exhibit for Form
CMS-2552-10

for Form Period : From: 02/01/2013 To: 01/31/2014

Run Time: 08:11 Version: 2014.03

WAGE INDEX PENSION COST SCHEDULE (For Worksheet S-3, Part IV, Line 4)

EXHIBIT 3

	STEP 2: DETERMINE THE 3-YEAR AVERAGING PERIOD		
1	WAGE INDEX FISCAL YEAR ENDING DATE		1
2	PROVIDER'S COST REPORTING PERIOD USED FOR WAGE INDEX YEAR ON LINE 1 (FYB in Col. 1, FYE in Col. 2)		2
3	MIDPOINT OF PROVIDER'S COST REPORTING PERIOD SHOWN ON LINE 2, ADJUSTED TO FIRST OF MONTH		3
4	DATE BEGINNING THE 3-YEAR AVERAGING PERIOD (subtract 18 months from midpoint shown on Line 3)		4
5	DATE ENDING THE 3-YEAR AVERAGING PERIOD (add 18 months to midpoint shown on Line 3)		5
	STEP 2 (OPTIONAL): ADJUST AVERAGING PERIOD FOR A NEW PLAN (see instructions)		
6	EFFECTIVE DATE OF PENSION PLAN		6
7	FIRST DAY OF THE PROVIDER COST REPORTING PERIOD CONTAINING THE PENSION PLAN EFFECTIVE DATE		7
8	STARTING DATE OF THE ADJUSTED AVERAGING PERIOD (date on Line 7, adjusted to first of month)		8

IF THIS DATE OCCURS AFTER THE PERIOD SHOWN ON LINE 2, STOP HERE AND SEE INSTRUCTIONS

	STEP 3: AVERAGE PENSION CONTRIBUTIONS DURING THE AVERAGING PERIOD			
9	BEGINNING DATE OF AVERAGING PERIOD FROM LINE 4 OR LINE 8, AS APPLICABLE			9
10	ENDING DATE OF AVERAGING PERIOD FROM LINE 5			10
11	ENTER PROVIDER CONTRIBUTIONS MADE DURING AVERAGING PERIOD ON LINES 9 & 10	DEPOSIT DATE(S)	CONTRIB- UTION(S)	11
12	TOTAL CALENDAR MONTHS INCLUDED IN AVERAGING PERIOD (36 unless Step 2 completed)			12
13	TOTAL CONTRIBUTIONS MADE DURING AVERAGING PERIOD			13
14	AVERAGE MONTHLY CONTRIBUTION (Line 13 divided by Line 12)			14
15	NUMBER OF MONTHS IN PROVIDER COST REPORTING PERIOD ON LINE 2			15
16	AVERAGE PENSION CONTRIBUTIONS (Line 14 times Line 15)			16
	STEP 4: TOTAL PENSION COST FOR WAGE INDEX			
17	ANNUAL PREFUNDING INSTALLMENT (see instructions)			17
18	REPORTABLE PREFUNDING INSTALLMENT ((Line 17 times Line 15) divided by 12)			18
19	TOTAL PENSION COST FOR WAGE INDEX (Line 16 plus Line 18 - transfers to S-3 Part IV Line 4)			19

Optimizer Systems, Inc.

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Micro System
Run Date: 05/23/2014

Run Time: 08:11 Version: 2014.03

HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3 PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPIAL-BASED COMPONENT IDENTIFICATION:

11001	THAE AND HOOF FALSED COME ONEM IDENTIFICATION.			
	COMPONENT	CONTRACT LABOR	BENEFIT COST	
	0	1	2	
1	TOTAL FACILITY CONTRACT LABOR AND BENEFIT COST			1
2	HOSPITAL			2
3	SUBPROVIDER - IPF			3
4	SUBPROVIDER - IRF			4
5	SUBPROVIDER - (OTHER)			5
6	SWING BEDS - SNF			6
7	SWING BEDS - NF			7
8	HOSPITAL-BASED SNF			8
9	HOSPITAL-BASED NF			9
10	HOSPITAL-BASED OLTC			10
11	HOSPITAL-BASED HHA			11
12	SEPARATELY CERTIFIED ASC			12
13	HOSPITAL-BASED HOSPICE			13
14	HOSPITAL-BASED HEALTH CLINIC - RHC			14
15	HOSPITAL-BASED HEALTH CLINIC - FQHC			15
16	HOSPITAL-BASED (CMHC)			16
17	RENAL DIALYSIS			17
18	OTHER			18

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RH OF NORTHWEST INDIANA, LLC Provider CCN: 15-2024

In Lieu of Form CMS-2552-10

Period: From: 02/01/2013 To: 01/31/2014 Micro System

Run Date: 05/23/2014

Run Time: 08:11

Version: 2014.03

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	CAP REL COSTS-BLDG & FIXT				923,509	923,509		923,509	1
2	00200	CAP REL COSTS-MVBLE EQUIP		1,335,564	1,335,564	-1,091,495	244,069	52,488	296,557	2
3	00300	OTHER CAP REL COSTS							-0-	3
4	00400	EMPLOYEE BENEFITS DEPARTMENT	5,050	733	5,783	11,415	17,198		17,198	4
5	00500	ADMINISTRATIVE & GENERAL	1,061,409	1,514,072	2,575,481	62,014	2,637,495	153,276	2,790,771	5
6	00600	MAINTENANCE & REPAIRS								6
7	00700	OPERATION OF PLANT								7
8	00800	LAUNDRY & LINEN SERVICE		80,606	80,606		80,606		80,606	8
9	00900	HOUSEKEEPING		7,720	7,720		7,720		7,720	9
10	01000	DIETARY	42,190	229,100	271,290		271,290		271,290	10
11	01100	CAFETERIA								11
12	01200	MAINTENANCE OF PERSONNEL								12
13	01300	NURSING ADMINISTRATION	193,708	71,685	265,393		265,393		265,393	13
14	01400	CENTRAL SERVICES & SUPPLY								14
15	01500	PHARMACY								15
16	01600	MEDICAL RECORDS & LIBRARY	106,027	45,461	151,488		151,488	-1,705	149,783	16
17	01700	SOCIAL SERVICE								17
19	01900	NONPHYSICIAN ANESTHETISTS								19
20	02000	NURSING SCHOOL								20
21	02100	I&R SERVICES-SALARY & FRINGES APPRVD								21
22	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD								22
23	02300	PARAMED ED PRGM-(SPECIFY)								23
		INPATIENT ROUTINE SERV COST CENTERS								
30	03000	ADULTS & PEDIATRICS	4,378,388	1,283,470	5,661,858		5,661,858	-34,814	5,627,044	30
		ANCILLARY SERVICE COST CENTERS								
50	05000	OPERATING ROOM		438,001	438,001		438,001		438,001	50
54	05400	RADIOLOGY-DIAGNOSTIC		171,225	171,225		171,225		171,225	54
60	06000	LABORATORY		949,302	949,302		949,302		949,302	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	RESPIRATORY THERAPY	882,680	214,460	1,097,140		1,097,140		1,097,140	65
66	06600	PHYSICAL THERAPY	108,470	154,743	263,213		263,213		263,213	66
67	06700	OCCUPATIONAL THERAPY	229,595	57,142	286,737		286,737		286,737	67
68	06800	SPEECH PATHOLOGY	42,798	55,217	98,015		98,015		98,015	
69	06900	ELECTROCARDIOLOGY		23,831	23,831		23,831		23,831	69
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	85,271	1,530,603	1,615,874		1,615,874		1,615,874	71
73	07300	DRUGS CHARGED TO PATIENTS	598,081	1,417,923	2,016,004		2,016,004		2,016,004	73
74	07400	RENAL DIALYSIS		337,191	337,191		337,191		337,191	74
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								_
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)								92
		OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF								99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY								99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY								99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY								99.40
		SPECIAL PURPOSE COST CENTERS								
194	07950	PROVIDER RELATIONS NRCC				94,557	94,557		94,557	194
194.01	07951	NRCC SUBLEASED SPACE		0.04==::			4-2			194.01
200	1	TOTAL (sum of lines 118-199)	7,733,667	9,918,049	17,651,716	1	17,651,716	169,245	17,820,961	200

Optimizer Systems, Inc.

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Micro System
Run Date: 05/23/2014 In Lieu of Form Period: RH OF NORTHWEST INDIANA, LLC CMS-2552-10 From: 02/01/2013 Run Time: 08:11 Provider CCN: 15-2024 To: 01/31/2014 Version: 2014.03

RECLASSIFICATIONS WORKSHEET A-6

	INCREASES						
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE#	SALARY	OTHER	
		1	2	3	4	5	
1	FACILITY RENT	A	CAP REL COSTS-BLDG & FIXT	1		923,509	1
500	TOTAL RECLASSIFICATIONS					923,509	500
	CODE LETTER - A						
1	EMPLOYEE BENEFITS	В	EMPLOYEE BENEFITS DEPARTMENT	4		11,415	
500	TOTAL RECLASSIFICATIONS					11,415	500
	CODE LETTER - B					, -	
1	CAPITAL RECONCILIATION	C	ADMINISTRATIVE & GENERAL	5		167,813	
500	TOTAL RECLASSIFICATIONS					167,813	500
	CODE LETTER - C						
1	OPERATING PORTION OF INTEREST	D	ADMINISTRATIVE & GENERAL	5		173	1
500	TOTAL RECLASSIFICATIONS					173	500
	CODE LETTER - D						
1	PROVIDER RELATIONS	E	PROVIDER RELATIONS NRCC	194	56,569	37,988	1
500	TOTAL RECLASSIFICATIONS	L	THO THE PROPERTY OF THE PARTY O	127	56,569	37,988	500
	CODE LETTER - E						
	GRAND TOTAL (INCREASES)				56,569	1.140.898	

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

Optimizer Systems, Inc.

Provider CCN: 15-2024

RH OF NORTHWEST INDIANA, LLC

WinLASH

Micro System
Run Date: 05/23/2014
Run Time: 08:11 In Lieu of Form Period: From: 02/01/2013 To: 01/31/2014 CMS-2552-10 Version: 2014.03

RECLASSIFICATIONS WORKSHEET A-6

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
1	FACILITY RENT	A	CAP REL COSTS-MVBLE EQUIP	2		923,509	10	1
500	TOTAL RECLASSIFICATIONS					923,509		500
	CODE LETTER - A							
1	EMPLOYEE BENEFITS	В	ADMINISTRATIVE & GENERAL	5		11,415		1
500	TOTAL RECLASSIFICATIONS					11,415		500
	CODE LETTER - B							
1	CAPITAL RECONCILIATION	С	CAP REL COSTS-MVBLE EQUIP	2		167,813	12	1
500	TOTAL RECLASSIFICATIONS					167,813		500
	CODE LETTER - C							
1	OPERATING PORTION OF INTEREST	D	CAP REL COSTS-MVBLE EQUIP	2		173	11	1
500	TOTAL RECLASSIFICATIONS					173		500
	CODE LETTER - D							
1	PROVIDER RELATIONS	Е	ADMINISTRATIVE & GENERAL	5	56,569	37,988		1
500	TOTAL RECLASSIFICATIONS				56,569	37,988		500
	CODE LETTER - E				·	,		
	GRAND TOTAL (DECREASES)				56,569	1,140,898		

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

Optimizer Systems, Inc.

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Run Date: 05/23/2014

RH OF NORTHWEST INDIANA, LLC Provider CCN: 15-2024 In Lieu of Form CMS-2552-10

From: 02/01/2013 To: 01/31/2014

Period:

Run Time: 08:11 Version: 2014.03

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7 PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

				ACQUISITIONS					
	DESCRIPTION	BEGINNING BALANCES	PURCHASES	DONATION	TOTAL	DISPOSALS AND RETIRE- MENTS	ENDING BALANCE	FULLY DEPREC- IATED ASSETS	
		1	2	3	4	5	6	7	
1	LAND								1
2	LAND IMPROVEMENTS								2
3	BUILDINGS AND FIXTURES								3
4	BUILDING IMPROVEMENTS	241,274					241,274		4
5	FIXED EQUIPMENT								5
6	MOVABLE EQUIPMENT	877,016				39,315	837,701		6
7	HIT DESIGNATED ASSETS								7
8	SUBTOTAL (sum of lines 1-7)	1,118,290				39,315	1,078,975		8
9	RECONCILING ITEMS								9
10	TOTAL (line 7 minus line 9)	1,118,290				39,315	1,078,975		10

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

			•	SUN	MARY OF CAPI	TAL			
	DESCRIPTION	DEPREC- IATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL- RELATED COSTS (see instr.)	TOTAL(1) (Sum of (cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	CAP REL COSTS-BLDG & FIXT								1
2	CAP REL COSTS-MVBLE EQUIP	220,404	923,509	•	167,813	20,074	3,764	1,335,564	2
3	TOTAL (sum of lines 1-2)	220,404	923,509		167,813	20,074	3,764	1,335,564	3

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

PART III - RECONCILIATION OF CAPITAL COST CENTERS

FAN	I III - RECONCILIATION OF CAF	TIAL COST CEN	ILKS							
			COMPUTATION	ON OF RATIOS		A	LLOCATION OF	OTHER CAPITA	L	
	DESCRIPTION	GROSS ASSETS	CAPITAL- IZED LEASES	GROSS ASSETS FOR RATIO (col. 1 - col. 2)	RATIO (see instr.)	INSURANCE	TAXES	OTHER CAPITAL- RELATED COSTS	TOTAL (sum of (cols. 5 through 7)	
*		9	10	11	12	13	14	15	16	
1	CAP REL COSTS-BLDG & FI	241,274		241,274	0.223614					1
2	CAP REL COSTS-MVBLE EQU	837,701		837,701	0.776386					2
3	TOTAL (sum of lines 1-2)	1.078.975		1,078,975	1.000000					3

				SUN	MMARY OF CAPI	TAL			
	DESCRIPTION	DEPREC- IATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL- RELATED COSTS (see instr.)	TOTAL(2) (sum of (cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	CAP REL COSTS-BLDG & FIXT		923,509					923,509	1
2	CAP REL COSTS-MVBLE EQUIP	272,892		-173		20,074	3,764	296,557	2
3	TOTAL (sum of lines 1-2)	272,892	923,509	-173		20,074	3,764	1.220.066	3

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

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

Optimizer Systems, Inc.

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Micro System
Run Date: 05/23/2014

RH OF NORTHWEST INDIANA, LLC Provider CCN: 15-2024

In Lieu of Form CMS-2552-10

Period: From: 02/01/2013 To: 01/31/2014

Run Time: 08:11 Version: 2014.03

ADJUSTMENTS TO EXPENSES WORKSHEET A-8

				EXPENSE CLASSIFICATION ON			
				WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
		BASIS/		THE AMOUNT IS TO BE ADJUSTED		WKST	
	DESCRIPTION(1)	CODE (2)	AMOUNT	COST CENTER	LINE#	A-7 REF.	
		1	2	3	4	5 5	
1	INVESTMENT INCOME-BUILDINGS & FIXTURES (chapter 2)			CAP REL COSTS-BLDG & FIXT	1		1
2	INVESTMENT INCOME-MOVABLE EQUIPMENT (chapter 2)			CAP REL COSTS-MVBLE EQUIP	2		2
3	INVESTMENT INCOME-OTHER (chapter 2)						3
4	TRADE, QUANTITY, AND TIME DISCOUNTS (chapter 8)						4
5	REFUNDS AND REBATES OF EXPENSES (chapter 8)						5
6	RENTAL OF PROVIDER SPACE BY SUPPLIERS (chapter 8)						6
7 8	TELEPHONE SERVICES (PAY STATIONS EXCL) (chapter 21) TELEVISION AND RADIO SERVICE (chapter 21)						7 8
9	PARKING LOT (chapter 21)						9
		WKST					
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	A-8-2	-34,814				10
11	SALE OF SCRAP, WASTE, ETC. (chapter 23)	NAME OF THE OWNER					11
12	RELATED ORGANIZATION TRANSACTIONS (chapter 10)	WKST A-8-1	449,092				12
13	LAUNDRY AND LINEN SERVICE						13
14	CAFETERIA - EMPLOYEES AND GUESTS						14
15	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS						15
16	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS						16
17	SALE OF DRUGS TO OTHER THAN PATIENTS						17
18	SALE OF MEDICAL RECORDS AND ABSTRACTS						18
19	NURSING SCHOOL (TUITION, FEES, BOOKS, ETC.)						19
20	VENDING MACHINES						20
21	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (chapter 21)						21
22	INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS						22
22	TO REPAY MEDICARE OVERPAYMENTS						22
23	ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		RESPIRATORY THERAPY	65		23
24	ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION	WKST		PHYSICAL THERAPY	66		24
	(chapter 14)	A-8-3					
25	UTIL REVIEW-PHYSICIANS' COMPENSATION (chapter 21)			UTILIZATION REVIEW-SNF	114		25
26	DEPRECIATION-BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1		26
27 28	DEPRECIATIONMOVABLE EQUIPMENT NON-PHYSICIAN ANESTHETIST			CAP REL COSTS-MVBLE EQUIP NONPHYSICIAN ANESTHETISTS	19		27 28
29	PHYSICIANS' ASSISTANT			NONFH I SICIAN ANESTHETISTS	19		29
	ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF	WKST					
30	LIMITATION (chapter 14)	A-8-3		OCCUPATIONAL THERAPY	67		30
31	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION	WKST		SPEECH PATHOLOGY	68		31
31	(chapter 14)	A-8-3		SPEECH PATHOLOGI	08		31
32	CAH HIT ADJ FOR DEPRECIATION AND						32
33	BAD DEBT REMOVAL	A		ADMINISTRATIVE & GENERAL	5		33
34	GIFTS-PROVIDER RELATIONS	A		ADMINISTRATIVE & GENERAL	5		34
35	OTHER PERSONNAL EXPENSE	A		ADMINISTRATIVE & GENERAL	5		35 36
36 37	AHA DUES MEDICAL RECORDS INCOME	A B		ADMINISTRATIVE & GENERAL MEDICAL RECORDS & LIBRARY	16		37
38	WILDICAL RECORDS INCOME	ы	-1,/03	WILDICAL RECORDS & LIDRAR I	10		38
39							39
40							40
41							41
42							42
43							43
44							44
45 46							45 46
46 47							47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49)		169,245				50
50	(Transfer to worksheet A, column 6, line 200)		109,243				100

Description - all chapter references in this column pertain to CMS Pub. 15-1
 Basis for adjustment (see instructions)
 A. Costs - if cost, including applicable overhead, can be determined
 B. Amount Received - if cost cannot be determined

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

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

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

WORKSHEET A-8-1

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

AMOUNT NET ADJUST AMOUNT OF INCLUDED WKST. LINE MENTS COST CENTER EXPENSE ITEMS ALLOWABLE IN A-7 NO (col 4 minus COST WKST. A REF. col. 5)* COLUMN 5 CAP REL COSTS-MVBLE EQUIP HOME OFFICE CAPITAL 52,488 52,488 9 ADMINISTRATIVE & GENERAL HOME OFFICE ADMIN 735,444 338,840 396,604 TOTALS (SUM OF LINES 1-4) TRANSFER COLUMN 6, LINE 5 TO WORKSHEET A-8, COLUMN 2, LINE 12 787,932 338,840 449,092

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

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

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

				RELATED ORGAN	IIZATION(S) AND	O/OR HOME OFFICE	
	SYMBOL (1)	NAME	PERCENTAGE OF OWNERSHIP	NAME	PERCENTAGE OF OWNERSHIP	TYPE OF BUSINESS	
	1	2	3	4	5	6	
6	В			SELECT MEDICAL	100.00	HEALTHCARE	6
7							7
8							8
9							9
10							10

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

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

Optimizer Systems, Inc.

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In Lieu of Form RH OF NORTHWEST INDIANA, LLC CMS-2552-10 Provider CCN: 15-2024

Period: From: 02/01/2013 To: 01/31/2014 Micro System

Run Date: 05/23/2014

Run Time: 08:11

Version: 2014.03

PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	WKST A LINE#	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN- ERATION	PROFESS- IONAL COMPON- ENT	PROVIDER COMPON- ENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPON- ENT HOURS	UNADJ- USTED RCE LIMIT	5 PERCENT OF UNADJ- USTED RCE LIMIT	
	1	2	3	4	5	6	7	8	9	
1	30	ADULTS & PEDIATRICS A	12,525		12,525	171,400	84	6,922	346	1
2	30	ADULTS & PEDIATRICS B	11,021		11,021	171,400	88	7,252	363	2
3	30	ADULTS & PEDIATRICS C	2,406		2,406	171,400	19	1,566	78	3
4	30	ADULTS & PEDIATRICS D	813		813	171,400	7	577	29	4
5	30	ADULTS & PEDIATRICS E	1,250		1,250	171,400	10	824	41	5
6	30	ADULTS & PEDIATRICS F	2,500		2,500	171,400	20	1,648	82	6
7	30	ADULTS & PEDIATRICS G	12,500		12,500	171,400	100	8,240	412	7
8	30	ADULTS & PEDIATRICS H	13,000		13,000	171,400	104	8,570	429	8
9	30	ADULTS & PEDIATRICS I	13,750		13,750	171,400	110	9,064	453	9
10	30	ADULTS & PEDIATRICS J	13,500		13,500	171,400	108	8,900	445	10
11	30	ADULTS & PEDIATRICS K	15,000		15,000	171,400	120	9,888	494	11
12	30	ADULTS & PEDIATRICS L	22,210		22,210	171,400	5,326	438,883	21,944	12
200		TOTAL	120,475		120,475		6,096	502,334	25,116	200

Optimizer Systems, Inc.

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RH OF NORTHWEST INDIANA, LLC Provider CCN: 15-2024

In Lieu of Form CMS-2552-10

Period: From: 02/01/2013 To: 01/31/2014 Micro System

Run Date: 05/23/2014

Run Time: 08:11

Version: 2014.03

PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	WKST A LINE#	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBER- SHIPS & CONTIN- UING EDUCATION	PROVIDER COMPON- ENT SHARE OF COL. 12	PHYSICIAN COST OF MALPRACT- ICE INSURANCE	PROVIDER COMPON- ENT SHARE OF COL. 14	ADJUSTED RCE LIMIT	RCE DISALLOW- ANCE	ADJUST- MENT	
	10	11	12	13	14	15	16	17	18	
1	30	ADULTS & PEDIATRICS A					6,922	5,603	5,603	1
2	30	ADULTS & PEDIATRICS B					7,252	3,769	3,769	2
3	30	ADULTS & PEDIATRICS C					1,566	840	840	3
4	30	ADULTS & PEDIATRICS D					577	236	236	4
5	30	ADULTS & PEDIATRICS E					824	426	426	5
6	30	ADULTS & PEDIATRICS F					1,648	852	852	6
7	30	ADULTS & PEDIATRICS G					8,240	4,260	4,260	7
8	30	ADULTS & PEDIATRICS H					8,570	4,430	4,430	8
9	30	ADULTS & PEDIATRICS I					9,064	4,686	4,686	9
10	30	ADULTS & PEDIATRICS J					8,900	4,600	4,600	10
11	30	ADULTS & PEDIATRICS K					9,888	5,112	5,112	11
12	30	ADULTS & PEDIATRICS L					438,883			12
200		TOTAL					502,334	34,814	34,814	200

Win-LASH 2552-10 Page: 23 WinLASH Micro System
Run Date: 05/23/2014 Optimizer Systems, Inc. In Lieu of Form Period: RH OF NORTHWEST INDIANA, LLC CMS-2552-10 Run Time: 08:11 From: 02/01/2013 Provider CCN: 15-2024 To: 01/31/2014 Version: 2014.03 REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS WORKSHEET A-8-3 PARTS I-IV CHECK APPLICABLE BOX: [XX] OCCUPATIONAL [] PHYSICAL [] RESPIRATORY [] SPEECH PATHOLOGY PART I - GENERAL INFORMATION TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (see instructions) LINE 1 MULTIPLIED BY 15 HOURS PER WEEK NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (see instructions) 3 NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST 4 4 WAS ON PROVIDER SITE (see instructions) NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (see instructions) NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON 6 WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISITS(S)) (see instructions) STANDARD TRAVEL EXPENSE RATE 7 OPTIONAL TRAVEL EXPENSE RATE 8 8 SUPERVISORS THERAPISTS ASSISTANTS AIDES TRAINEES 4 TOTAL HOURS WORKED 9 10 AHSEA (see instructions) 10 STANDARD TRAVEL ALLOWANCE (columns 1 and 2, one-half of column 2, line 11 11 10; column 3, one half of column 3, line 10) 12 NUMBER OF TRAVEL HOURS (PROVIDER SITE) (see instructions) 12 NUMBER OF TRAVEL HOURS (OFFSITE) (see instructions) 12.01 12.01 NUMBER OF MILES DRIVEN (PROVIDER SITE) (see instructions) 13 13 NUMBER OF MILES DRIVEN (OFFSITE) (see instructions) 13.01 PART II - SALARY EQUIVALENCY COMPUTATION SUPERVISORS (column 1, line 9 times column 1, line 10) 14 15 THERAPISTS (column 2, line 9 times column 2, line 10) 15 ASSISTANTS (column 3, line 9 times column 3, line 10) 16 16 SUBTOTAL ALLOWANCE AMOUNT (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others) 17 17 AIDES (column 4, line 9 times column 4, line 10) 18 18 TRAINEES (column 5, line 9 times column 5, line 10) 19 19 20 TOTAL ALLOWANCE AMOUNT (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others) 20 IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1 THROUGH 3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9 IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21 THROUGH 23. WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 21 21 through 3, line 9 for all others) 22 WEIGHTED ALLOWANCE EXCUDING AIDES AND TRAINEES (line 2 times line 21) 22 TOTAL SALARY EQUIVALENCY (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE STANDARD TRAVEL ALLOWANCE

THERAPISTS (line 3 times column 2, line 11) 24 ASSISTANTS (line 4 times column 3, line 11) 25 25 SUBTOTAL (line 24 for respiratory therapy or sum of lines 24 and 25 for all others) 26 26 27 STANDARD TRAVEL EXPENSE (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others) 27 TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (sum of lines 26 and 27) 28 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE THERAPISTS (column 2, line 10 times the sum of columns 1 and 2, line 12) 29 30 ASSISTANTS (column 3, line 10 times column 3, line 12) 30 SUBTOTAL (line 29 for respiratory therapy or sum of lines 29 and 30 for all others) 31 OPTIONAL TRAVEL EXPENSE (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others) 32 32 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (line 28) 33 33 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 27 and 31) 34 34 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 31 and 32) 35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE STANDARD TRAVEL EXPENSE 36 THERAPISTS (line 5 times column 2, line 11) 36 37 ASSISTANTS (line 6 times column 3, line 11) 37 SUBTOTAL (sum of lines 36 and 37) 38 38 39 STANDARD TRAVEL EXPENSE (line 7 times the sum of lines 5 and 6) 39 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE 40 THERAPISTS (sum of columns 1 and 2, line 9 times column 2, line 10) 40 ASSISTANTS (column 3, line 9 times column 3, line 10) 41 41 SUBTOTAL (sum of lines 40 and 41) 42 42 OPTIONAL TRAVEL EXPENSE (line 8 times the sum of columns 1-3, line 13) 43 TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES: COMPLETE ONE OF THE FOLLOWING THREE LINES 44, 45, OR 46, AS APPROPRIATE. 44 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 38 and 39) (see instructions) 44 45 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 39 and 42) (see instructions) 45 46 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 42 and 43) (see instructions) 46

through 3 for all others.)

 Optimizer Systems, Inc.
 Win LASH
 Micro System

 RH OF NORTHWEST INDIANA, LLC
 In Lieu of Form CMS-2552-10
 Period: From: 02/01/2013
 Run Date: 05/23/2014

 Period: From: 02/01/2013
 Run Time: 08:11

 To: 01/31/2014
 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3 PARTS V-VI

CHECK APPLICABLE BOX:	[XX] OCCUPATIONAL	[] PHYSICAL	[] RESPIRATORY	[]	SPEECH PATHOLOGY

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line						
17	47 is zero or equal to or greater thn 2,080, do not complete lines 48-55 and enter zero						47
	in each column of line 56						
18	OVERTIME RATE (see instructions)						48
19	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE)						49
+9	(multiply line 47 times line 48)						49
CALC	CULATION OF LIMIT						
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each						50
,0	column on line 47 by the total overtime worked incolumn 5, line 47)						30
51	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-						51
) 1	TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)						31
DETE	ERMINATION OF OVERTIME ALLOWANCE						
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION) (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION						55
טנ	AT THE AHSEA (multiply line 47 times line 52)						J 33
	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in						
56	column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1						56

PART	VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT	
57	SALARY EQUIVALENCY AMOUNT (from line 23)	57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)	58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)	59
60	OVERTIME ALLOWANCE (from column 5, line 56)	60
61	EQUIPMENT COST (see instructions)	61
62	SUPPLIES (see instructions)	62
63	TOTAL ALLOWANCE (sum of lines 57-62)	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)	64
65	EXCESS OVER LIMITATION (line 64 minus line 63: if negative enter zero)	65

Win-LASH 2552-10 Page: 25 WinLASH Micro System
Run Date: 05/23/2014 Optimizer Systems, Inc. In Lieu of Form Period: RH OF NORTHWEST INDIANA, LLC CMS-2552-10 Run Time: 08:11 From: 02/01/2013 Provider CCN: 15-2024 To: 01/31/2014 Version: 2014.03 REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS WORKSHEET A-8-3 PARTS V-VI CHECK APPLICABLE BOX: [] OCCUPATIONAL [XX] PHYSTCAL [] RESPIRATORY [] SPEECH PATHOLOGY PART I - GENERAL INFORMATION TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (see instructions) LINE 1 MULTIPLIED BY 15 HOURS PER WEEK NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (see instructions) 3 NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST 4 4 WAS ON PROVIDER SITE (see instructions) NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (see instructions) NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON 6 WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISITS(S)) (see instructions) STANDARD TRAVEL EXPENSE RATE 7 OPTIONAL TRAVEL EXPENSE RATE 8 8 SUPERVISORS THERAPISTS ASSISTANTS AIDES TRAINEES 4 TOTAL HOURS WORKED 9 10 AHSEA (see instructions) 10 STANDARD TRAVEL ALLOWANCE (columns 1 and 2, one-half of column 2, line 11 11 10; column 3, one half of column 3, line 10) 12 NUMBER OF TRAVEL HOURS (PROVIDER SITE) (see instructions) 12 NUMBER OF TRAVEL HOURS (OFFSITE) (see instructions) 12.01 12.01 NUMBER OF MILES DRIVEN (PROVIDER SITE) (see instructions) 13 13 NUMBER OF MILES DRIVEN (OFFSITE) (see instructions) 13.01 PART II - SALARY EQUIVALENCY COMPUTATION SUPERVISORS (column 1, line 9 times column 1, line 10) 14 15 THERAPISTS (column 2, line 9 times column 2, line 10) 15 ASSISTANTS (column 3, line 9 times column 3, line 10) 16 16 SUBTOTAL ALLOWANCE AMOUNT (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others) 17 17 AIDES (column 4, line 9 times column 4, line 10) 18 18 TRAINEES (column 5, line 9 times column 5, line 10) 19 19 20 TOTAL ALLOWANCE AMOUNT (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others) 20 IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1 THROUGH 3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9 IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21 THROUGH 23. WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 21 21 through 3, line 9 for all others) 22 WEIGHTED ALLOWANCE EXCUDING AIDES AND TRAINEES (line 2 times line 21) 22 TOTAL SALARY EQUIVALENCY (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE STANDARD TRAVEL ALLOWANCE THERAPISTS (line 3 times column 2, line 11) 24 ASSISTANTS (line 4 times column 3, line 11) 25 25 SUBTOTAL (line 24 for respiratory therapy or sum of lines 24 and 25 for all others) 26 26 27 STANDARD TRAVEL EXPENSE (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others) 27 TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (sum of lines 26 and 27) 28 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE THERAPISTS (column 2, line 10 times the sum of columns 1 and 2, line 12) 29 30 ASSISTANTS (column 3, line 10 times column 3, line 12) 30 SUBTOTAL (line 29 for respiratory therapy or sum of lines 29 and 30 for all others) 31 OPTIONAL TRAVEL EXPENSE (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others) 32 32 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (line 28) 33 33 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 27 and 31) 34 34 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 31 and 32) 35 PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE STANDARD TRAVEL EXPENSE 36 THERAPISTS (line 5 times column 2, line 11) 36 37 ASSISTANTS (line 6 times column 3, line 11) 37 SUBTOTAL (sum of lines 36 and 37) 38 38 39 STANDARD TRAVEL EXPENSE (line 7 times the sum of lines 5 and 6) 39

TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES: COMPLETE ONE OF THE FOLLOWING THREE LINES 44, 45, OR 46, AS APPROPRIATE.

STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 38 and 39) (see instructions)

OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 39 and 42) (see instructions)

OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 42 and 43) (see instructions)

40

41

42

43

44

45

46

OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE

ASSISTANTS (column 3, line 9 times column 3, line 10)

SUBTOTAL (sum of lines 40 and 41)

THERAPISTS (sum of columns 1 and 2, line 9 times column 2, line 10)

OPTIONAL TRAVEL EXPENSE (line 8 times the sum of columns 1-3, line 13)

40

41

42

44

45

46

Optimizer Systems, Inc.

Win LASH

Micro System

In Lieu of Form

RH OF NORTHWEST INDIANA, LLC

CMS-2552-10

Period:
From: 02/01/2013

Run Date: 05/23/2014

Run Time: 08:11

To: 01/31/2014

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3 PARTS V-VI

Version: 2014.03

CHECK APPLICABLE BOX: [] OCCUPATIONAL [XX] PHYSICAL [] RESPIRATORY [] SPEECH PATHOLOGY

PART V - OVERTIME	COMPUTATION
-------------------	-------------

Provider CCN: 15-2024

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line						
47	47 is zero or equal to or greater thn 2,080, do not complete lines 48-55 and enter zero						47
	in each column of line 56						
48	OVERTIME RATE (see instructions)						48
40	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE)						40
49	(multiply line 47 times line 48)						49
CALC	CULATION OF LIMIT						
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each						50
30	column on line 47 by the total overtime worked incolumn 5, line 47)						30
<i>5</i> 1	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-						5.1
51	TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)						51
DETE	ERMINATION OF OVERTIME ALLOWANCE						
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION) (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION						55
33	AT THE AHSEA (multiply line 47 times line 52)						33
	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in						
56	column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1						56
	through 3 for all others.)						

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (from line 23)	57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)	58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)	59
60	OVERTIME ALLOWANCE (from column 5, line 56)	60
61	EQUIPMENT COST (see instructions)	61
62	SUPPLIES (see instructions)	62
63	TOTAL ALLOWANCE (sum of lines 57-62)	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)	64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)	65

WinLASH Optimizer Systems, Inc.

Micro System
Run Date: 05/23/2014 In Lieu of Form Period: RH OF NORTHWEST INDIANA, LLC CMS-2552-10 Run Time: 08:11 From: 02/01/2013 Provider CCN: 15-2024 To: 01/31/2014 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS WORKSHEET A-8-3 PARTS V-VI CHECK APPLICABLE BOX: [] OCCUPATIONAL [] SPEECH PATHOLOGY [] PHYSICAL [XX] RESPIRATORY PART I - GENERAL INFORMATION TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (see instructions) LINE 1 MULTIPLIED BY 15 HOURS PER WEEK NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (see instructions) 3 NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST 4 4 WAS ON PROVIDER SITE (see instructions) NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (see instructions) NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON 6 WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISITS(S)) (see instructions) STANDARD TRAVEL EXPENSE RATE 7 OPTIONAL TRAVEL EXPENSE RATE 8 8 SUPERVISORS THERAPISTS ASSISTANTS AIDES TRAINEES 4 TOTAL HOURS WORKED 9 10 AHSEA (see instructions) 10 STANDARD TRAVEL ALLOWANCE (columns 1 and 2, one-half of column 2, line 11 11 10; column 3, one half of column 3, line 10) 12 NUMBER OF TRAVEL HOURS (PROVIDER SITE) (see instructions) 12 NUMBER OF TRAVEL HOURS (OFFSITE) (see instructions) 12.01 12.01 NUMBER OF MILES DRIVEN (PROVIDER SITE) (see instructions) 13 13 NUMBER OF MILES DRIVEN (OFFSITE) (see instructions) 13.01 PART II - SALARY EQUIVALENCY COMPUTATION SUPERVISORS (column 1, line 9 times column 1, line 10) 14 15 THERAPISTS (column 2, line 9 times column 2, line 10) 15 ASSISTANTS (column 3, line 9 times column 3, line 10) 16 16 SUBTOTAL ALLOWANCE AMOUNT (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others) 17 17 AIDES (column 4, line 9 times column 4, line 10) 18 18 TRAINEES (column 5, line 9 times column 5, line 10) 19 19 20 TOTAL ALLOWANCE AMOUNT (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others) 20 IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1 THROUGH 3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9 IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21 THROUGH 23. WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 21 21 through 3, line 9 for all others) 22 WEIGHTED ALLOWANCE EXCUDING AIDES AND TRAINEES (line 2 times line 21) 22 TOTAL SALARY EQUIVALENCY (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE STANDARD TRAVEL ALLOWANCE THERAPISTS (line 3 times column 2, line 11) 24 ASSISTANTS (line 4 times column 3, line 11) 25 25 SUBTOTAL (line 24 for respiratory therapy or sum of lines 24 and 25 for all others) 26 26 27 STANDARD TRAVEL EXPENSE (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others) 27 TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (sum of lines 26 and 27) 28 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE THERAPISTS (column 2, line 10 times the sum of columns 1 and 2, line 12) 29 30 ASSISTANTS (column 3, line 10 times column 3, line 12) 30 SUBTOTAL (line 29 for respiratory therapy or sum of lines 29 and 30 for all others) 31 OPTIONAL TRAVEL EXPENSE (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others) 32 32 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (line 28) 33 33 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 27 and 31) 34 34 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 31 and 32) 35 PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE STANDARD TRAVEL EXPENSE 36 THERAPISTS (line 5 times column 2, line 11) 36 37 ASSISTANTS (line 6 times column 3, line 11) 37 SUBTOTAL (sum of lines 36 and 37) 38 38 39 STANDARD TRAVEL EXPENSE (line 7 times the sum of lines 5 and 6) 39 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE 40 THERAPISTS (sum of columns 1 and 2, line 9 times column 2, line 10) 40 ASSISTANTS (column 3, line 9 times column 3, line 10) 41 41 SUBTOTAL (sum of lines 40 and 41) 42 42 OPTIONAL TRAVEL EXPENSE (line 8 times the sum of columns 1-3, line 13) 43 TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES: COMPLETE ONE OF THE FOLLOWING THREE LINES 44, 45, OR 46, AS APPROPRIATE. 44 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 38 and 39) (see instructions) 44 45 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 39 and 42) (see instructions) 45 46 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 42 and 43) (see instructions) 46

Optimizer Systems, Inc.

WinLASH

Micro System
Run Date: 05/23/2014 In Lieu of Form Period: RH OF NORTHWEST INDIANA, LLC CMS-2552-10 From: 02/01/2013 Run Time: 08:11 Provider CCN: 15-2024 To: 01/31/2014 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3 PARTS V-VI

[] SPEECH PATHOLOGY CHECK APPLICABLE BOX: [] OCCUPATIONAL [] PHYSICAL [XX] RESPIRATORY

PART V -	OVEDTIA	TE CON	IDITA	TION

IANI	V - O VERTIME COMI CTATION						
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line						
47	47 is zero or equal to or greater thn 2,080, do not complete lines 48-55 and enter zero						47
	in each column of line 56						
18	OVERTIME RATE (see instructions)						48
10	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE)						40
19	(multiply line 47 times line 48)						49
CALC	CULATION OF LIMIT						
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each						50
50	column on line 47 by the total overtime worked incolumn 5, line 47)						30
	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-						
51	TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)						51
DETE	RMINATION OF OVERTIME ALLOWANCE						
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION) (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION						55
5	AT THE AHSEA (multiply line 47 times line 52)						33
	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in						
56	column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1						56
	through 3 for all others.)						

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

1 / 11 / 1	VI COM CINITON OF THERM I EMITTION AND EXCESS COST ADJUSTMENT	
57	SALARY EQUIVALENCY AMOUNT (from line 23)	57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)	58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)	59
60	OVERTIME ALLOWANCE (from column 5, line 56)	60
61	EQUIPMENT COST (see instructions)	61
62	SUPPLIES (see instructions)	62
63	TOTAL ALLOWANCE (sum of lines 57-62)	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)	64
65	EXCESS OVER LIMITATION (line 64 minus line 63: if negative enter zero)	65

Optimizer Systems, Inc.

WinLASH

Micro System
Run Date: 05/23/2014
Run Time: 08:11 In Lieu of Form CMS-2552-10 Period: RH OF NORTHWEST INDIANA, LLC From: 02/01/2013

Provide	er CCN: 15-2024	T	o: 01/31/2014		Version: 2014.	03	
REASO	NABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY	OUTSIDE SUPP	LIERS			WORKSHE PARTS	
CHECK	APPLICABLE BOX: [] OCCUPATIONAL [] PH	YSICAL	[] RESI	PIRATORY	[XX] SPI	EECH PATHO	LOGY
	- GENERAL INFORMATION						
	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (see instructions)						1
	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	WAS ON BROWN	NED CITE (2
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS O				D THED A DIST	 	3
4	WAS ON PROVIDER SITE (see instructions)	DIVI KO VIDEK SI	IE BUT NEITHER	C SOI ER VISOR IN	JK THEKAHST		4
	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPIS	STS (see instruction	s)				5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INC			IERAPY ASSISTA	NT AND ON		6
	WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE	VISITS(S)) (see in:	structions)				
	STANDARD TRAVEL EXPENSE RATE OPTIONAL TRAVEL EXPENSE RATE						7 8
8	OF HONAL TRAVEL EATENDE RATE	SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	0
		1	2	3	4	5	
	TOTAL HOURS WORKED						9
	AHSEA (see instructions)						10
	STANDARD TRAVEL ALLOWANCE (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)						11
	NUMBER OF TRAVEL HOURS (PROVIDER SITE) (see instructions)						12
12.01	NUMBER OF TRAVEL HOURS (OFFSITE) (see instructions)						12.01
	NUMBER OF MILES DRIVEN (PROVIDER SITE) (see instructions)						13
13.01	NUMBER OF MILES DRIVEN (OFFSITE) (see instructions)						13.01
PART II	- SALARY EQUIVALENCY COMPUTATION						
14	SUPERVISORS (column 1, line 9 times column 1, line 10)						14
	THERAPISTS (column 2, line 9 times column 2, line 10)						15
16	ASSISTANTS (column 3, line 9 times column 3, line 10)	lin 14 16 for .	II athana)				16
	SUBTOTAL ALLOWANCE AMOUNT (sum of lines 14 and 15 for respiratory therapy AIDES (column 4, line 9 times column 4, line 10)	or lines 14-16 for a	iii otners)				17
	TRAINEES (column 5, line 9 times column 5, line 10)						19
20	TOTAL ALLOWANCE AMOUNT (sum of lines 17-19 for respiratory therapy or lines						20
	IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUM						
	PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9 IS GREATER THAN LINE 23 THE AMOUNT FROM LINE 20 OTHERWISE COMPLETE LINES 21 THROUGH		TRIES ON LINES	S 21 AND 22 AND	ENTER ON LINE		
	23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21 THROUG WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (line 17 divid		nns 1 and 2. line 9	for respiratory thera	inv or columns 1		
21	through 3, line 9 for all others)	aca of sam of colar	1 unu 2, iiie >	Tor respiratory there	apy or corumns r		21
	WEIGHTED ALLOWANCE EXCUDING AIDES AND TRAINEES (line 2 times line	21)					22
23	TOTAL SALARY EQUIVALENCY (see instructions)						23
	I - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXP	ENSE COMPUTA	TION - PROVID	ER SITE			
	ARD TRAVEL ALLOWANCE						1
	THERAPISTS (line 3 times column 2, line 11)						24
	ASSISTANTS (line 4 times column 3, line 11) SUBTOTAL (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)						25 26
	STANDARD TRAVEL EXPENSE (line 7 times line 3 for respiratory therapy or sum of	lines 3 and 4 for al	l others)				27
	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPEN			of lines 26 and 27)			28
	NAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE						
	THERAPISTS (column 2, line 10 times the sum of columns 1 and 2, line 12) ASSISTANTS (column 3, line 10 times column 3, line 12)						29
30 31	ASSISTANTS (column 3, line 10 times column 3, line 12) SUBTOTAL (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					+	30
	OPTIONAL TRAVEL EXPENSE (line 8 times columns 1 and 2, line 13 for respiratory	therapy or sum of c	columns 1-3, line 1	3 for all others)			32
	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (line		,				33
	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum						34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum o	f lines 31 and 32)					35
PART I	V - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPI	ENSE COMPUTA	TION - SERVICE	ES OUTSIDE PRO	VIDER SITE		
	OARD TRAVEL EXPENSE						
	THERAPISTS (line 5 times column 2, line 11)						36
	ASSISTANTS (line 6 times column 3, line 11)					 	37
	SUBTOTAL (sum of lines 36 and 37) STANDARD TRAVEL EXPENSE (line 7 times the sum of lines 5 and 6)					 	38
	NAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE					1	1 37
	THERAPISTS (sum of columns 1 and 2, line 9 times column 2, line 10)						40
41	ASSISTANTS (column 3, line 9 times column 3, line 10)						41
12	SUBTOTAL (sum of lines 40 and 41)						42
	OPTIONAL TRAVEL EXPENSE (line 8 times the sum of columns 1-3, line 13) TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES: COMPI	ETE ONE OF THE	E EOL I OWING T	LIDEE LINES 44 4	5 OD 46 AC ADE	DDODIATE	43
	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum			TINEE LINES 44, 4	J, OK 40, A3 APF	NOFNIATE.	44
	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum						45
16	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum o						46

Page: 30 Win-LASH 2552-10

Optimizer Systems, Inc.

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Micro System
Run Date: 05/23/2014 In Lieu of Form Period: RH OF NORTHWEST INDIANA, LLC CMS-2552-10 From: 02/01/2013 Run Time: 08:11 Provider CCN: 15-2024 To: 01/31/2014 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3 PARTS V-VI

CHECK	APPLICABLE	BOX:	[]	OCCUPATIONAL	[]	PHYSICAL	[]	RESPIRATORY	[XX]	SPEECH	PATHOLOG	Y

PART V	- OVERTIME	COMPUTATION
--------	------------	-------------

IANI	V - O VERTIME COMI CTATION						
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line						
47	47 is zero or equal to or greater thn 2,080, do not complete lines 48-55 and enter zero						47
	in each column of line 56						
18	OVERTIME RATE (see instructions)						48
10	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE)						40
19	(multiply line 47 times line 48)						49
CALC	CULATION OF LIMIT						
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each						50
50	column on line 47 by the total overtime worked incolumn 5, line 47)						30
	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-						
51	TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)						51
DETE	RMINATION OF OVERTIME ALLOWANCE						
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION) (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION						55
5	AT THE AHSEA (multiply line 47 times line 52)						33
	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in						
56	column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1						56
	through 3 for all others.)						

57	SALARY EQUIVALENCY AMOUNT (from line 23)	57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)	58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)	59
60	OVERTIME ALLOWANCE (from column 5, line 56)	60
61	EQUIPMENT COST (see instructions)	61
62	SUPPLIES (see instructions)	62
63	TOTAL ALLOWANCE (sum of lines 57-62)	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)	64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)	65

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In Lieu of Form RH OF NORTHWEST INDIANA, LLC Provider CCN: 15-2024

Period: From: 02/01/2013 To: 01/31/2014 CMS-2552-10

Micro System

Run Date: 05/23/2014

Run Time: 08:11

Version: 2014.03

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B PART I

	T	NET EXP						
		FOR COST	CAP	CAP	EMPLOYEE		ADMINIS-	
	COST CENTER DESCRIPTIONS	ALLOCATION	BLDGS &	MOVABLE	BENEFITS	SUBTOTAL	TRATIVE &	
	COST CENTER DESCRIPTIONS	(from Wkst	FIXTURES	EQUIPMENT	DEPARTMENT	(cols.0-4)	GENERAL	
		,	FIATURES	EQUIFMENT	DEFARTMENT	(0018.0-4)	GENERAL	
		A, col.7)	1	2	4	4A	5	
	GENERAL SERVICE COST CENTERS	0	1		4	4A	3	
1	CAP REL COSTS-BLDG & FIXT	923,509	923,509					1
2	CAP REL COSTS-MVBLE EQUIP	296,557	923,309	296,557				2
4	EMPLOYEE BENEFITS DEPARTMENT	17,198	4,717	1,515	23,430			4
5	ADMINISTRATIVE & GENERAL	2,790,771	126,395	40,588	3,047	2,960,801	2,960,801	5
6	MAINTENANCE & REPAIRS	2,770,771	120,373	40,300	3,047	2,700,001	2,700,001	6
7	OPERATION OF PLANT		266,501	85,579		352,080	70,150	7
8	LAUNDRY & LINEN SERVICE	80,606	14,781	4.747		100,134	19,951	8
9	HOUSEKEEPING	7,720	8,586	2,757		19,063	3,798	9
10	DIETARY	271,290	7,328	2,353	128	281,099	56.007	10
11	CAFETERIA	271,230	7,320	2,333	120	201,077	30,007	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	265,393	8,082	2,595	587	276,657	55,122	13
14	CENTRAL SERVICES & SUPPLY	203,393	0,002	2,373	367	270,037	33,122	14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY	149,783	5,063	1,626	321	156,793	31.240	16
17	SOCIAL SERVICE	149,703	5,005	1,020	321	150,775	31,240	17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	5,627,044	402,992	129,408	13,272	6,172,716	1,229,881	30
	ANCILLARY SERVICE COST CENTERS	5,02.,011	,,,,_	,,	3,2,2		-,,	
50	OPERATING ROOM	438,001				438,001	87,269	50
54	RADIOLOGY-DIAGNOSTIC	171,225				171,225	34,116	54
60	LABORATORY	949,302	5,504	1,767		956,573	190,591	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS		ĺ	,		ŕ	,	62.3
65	RESPIRATORY THERAPY	1,097,140	11,793	3,787	2,676	1,115,396	222,236	65
66	PHYSICAL THERAPY	263,213	6,573	2,111	329	272,226	54,239	66
67	OCCUPATIONAL THERAPY	286,737	6,573	2,111	696	296,117	59,000	67
68	SPEECH PATHOLOGY	98,015	2,988	959	130	102,092	20,341	68
69	ELECTROCARDIOLOGY	23,831	·			23,831	4,748	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,615,874	23,147	7,433	259	1,646,713	328,098	71
73	DRUGS CHARGED TO PATIENTS	2,016,004	22,486	7,221	1,813	2,047,524	407,957	73
74	RENAL DIALYSIS	337,191			·	337,191	67,183	74
76.97	CARDIAC REHABILITATION							76.9
76.98	HYPERBARIC OXYGEN THERAPY							76.9
76.99	LITHOTRIPSY							76.9
	OUTPATIENT SERVICE COST CENTERS							
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.1
99.20	OUTPATIENT PHYSICAL THERAPY							99.2
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.3
99.40	OUTPATIENT SPEECH PATHOLOGY							99.4
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	17,726,404	923,509	296,557	23,258	17,726,232	2,941,927	118
	NONREIMBURSABLE COST CENTERS						, , , , <u>, , , , , , , , , , , , , , , </u>	
194	PROVIDER RELATIONS NRCC	94,557			172	94,729	18,874	194
	NRCC SUBLEASED SPACE	2.,507			2	,2	,-/	194.0
194.01								
194.01 200	CROSS FOOT ADJUSTMENTS							⊪ 200
194.01 200 201	CROSS FOOT ADJUSTMENTS NEGATIVE COST CENTER							200

Optimizer Systems, Inc.

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Micro System

Run Date: 05/23/2014

Run Time: 08:11

Version: 2014.03 In Lieu of Form Period: From: 02/01/2013 To: 01/31/2014 RH OF NORTHWEST INDIANA, LLC CMS-2552-10 Provider CCN: 15-2024

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B PART I

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY + LINEN SERVICE	HOUSE- KEEPING	DIETARY	NURSING ADMINIS- TRATION	MEDICAL RECORDS + LIBRARY	
		7	8	9	10	13	16	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	422,230						7
8	LAUNDRY & LINEN SERVICE	11,867	131,952					8
9	HOUSEKEEPING	6,893		29,754				9
10	DIETARY	5,883		434	343,423			10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	6,489		479		338,747		13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY	4,065		300			192,398	16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
20	INPATIENT ROUTINE SERV COST CENTERS	222.554	121.052	22.044	242.422	222 545	40.0 m 4	20
30	ADULTS & PEDIATRICS	323,554	131,952	23,861	343,423	338,747	68,876	30
#O	ANCILLARY SERVICE COST CENTERS						2.710	7 0
50	OPERATING ROOM						2,740	
54	RADIOLOGY-DIAGNOSTIC	4.410		226			3,163	54
60	LABORATORY	4,419		326			15,750	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS	0.460		(00			20.016	62.30
65	RESPIRATORY THERAPY	9,469		698			29,016	65
66 67	PHYSICAL THERAPY OCCUPATIONAL THERAPY	5,277 5,277		389 389			2,175 4.657	66 67
		2,399		177			,	
68	SPEECH PATHOLOGY	2,399		1//			686	68
69	ELECTROCARDIOLOGY	10.504		1.270			3,938	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	18,584		1,370			17,949	71
73 74	DRUGS CHARGED TO PATIENTS	18,054		1,331			39,227	73 74
76.97	RENAL DIALYSIS CARDIAC REHABILITATION						4,221	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY OUTPATIENT SERVICE COST CENTERS							76.99
92	OUTPATIENT SERVICE COST CENTERS OBSERVATION BEDS (NON-DISTINCT PART)							92
92	OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS							92
99.10	CORF CORF							99.10
99.10	OUTPATIENT PHYSICAL THERAPY							99.10
99.20	OUTPATIENT PHYSICAL THERAPY OUTPATIENT OCCUPATIONAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY OUTPATIENT SPEECH PATHOLOGY							99.30
99.4U	SPECIAL PURPOSE COST CENTERS							99.40
118	SUBTOTALS (sum of lines 1-117)	422,230	131,952	29,754	343,423	338,747	192,398	118
110	NONREIMBURSABLE COST CENTERS	422,230	131,932	29,734	343,423	330,747	174,398	110
194	PROVIDER RELATIONS NRCC							194
194.01	NRCC SUBLEASED SPACE							194.01
200	CROSS FOOT ADJUSTMENTS							200
200	NEGATIVE COST CENTER							200
202	TOTAL (sum of lines 118-201)	422,230	131,952	29,754	343,423	338,747	192,398	
202	101AL (Suill Of IIIICS 110-201)	422,230	131,932	29,734	343,423	330,747	172,398	1 202

Optimizer Systems, Inc.

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Micro System

Run Date: 05/23/2014

Run Time: 08:11

Version: 2014.03 In Lieu of Form Period: From: 02/01/2013 To: 01/31/2014 RH OF NORTHWEST INDIANA, LLC CMS-2552-10 Provider CCN: 15-2024

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B PART I

			I&R COST &			
	COST CENTER DESCRIPTIONS		POST STEP-			
		SUBTOTAL	DOWN ADJS	TOTAL		
		24	25	26		
	GENERAL SERVICE COST CENTERS					
1	CAP REL COSTS-BLDG & FIXT					1
2	CAP REL COSTS-MVBLE EQUIP					2
4	EMPLOYEE BENEFITS DEPARTMENT					4
5	ADMINISTRATIVE & GENERAL					5
6	MAINTENANCE & REPAIRS					6
7	OPERATION OF PLANT					7
8	LAUNDRY & LINEN SERVICE					8
9	HOUSEKEEPING					9
10	DIETARY					10
11	CAFETERIA MAINTENANCE OF BEDGONNEL					11 12
	MAINTENANCE OF PERSONNEL					
13	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY					13
15	PHARMACY					15
16	MEDICAL RECORDS & LIBRARY					16
17	SOCIAL SERVICE					17
19	NONPHYSICIAN ANESTHETISTS					19
20	NURSING SCHOOL					20
21	I&R SERVICES-SALARY & FRINGES APPRVD					21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD					22
23	PARAMED ED PRGM-(SPECIFY)					23
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS	8,633,010		8,633,010		30
	ANCILLARY SERVICE COST CENTERS					
50	OPERATING ROOM	528,010		528,010		50
54	RADIOLOGY-DIAGNOSTIC	208,504		208,504		54
60	LABORATORY	1,167,659		1,167,659		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS	4.074.045		4.054.045		62.30
65	RESPIRATORY THERAPY	1,376,815		1,376,815		65
66	PHYSICAL THERAPY	334,306		334,306		66
67	OCCUPATIONAL THERAPY	365,440		365,440		67
68	SPEECH PATHOLOGY	125,695		125,695		68
69 71	ELECTROCARDIOLOGY MEDICAL SUPPLIES CHARGED TO PATIENTS	32,517		32,517	-	69
73	DRUGS CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	2,012,714 2,514,093		2,012,714 2,514,093		71 73
74	RENAL DIALYSIS	408,595		408,595		73
76.97	CARDIAC REHABILITATION	400,393		+00,333		76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
, 0.,,	OUTPATIENT SERVICE COST CENTERS					70.57
92	OBSERVATION BEDS (NON-DISTINCT PART)					92
	OTHER REIMBURSABLE COST CENTERS					
99.10	CORF					99.10
99.20	OUTPATIENT PHYSICAL THERAPY					99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY					99.30
99.40	OUTPATIENT SPEECH PATHOLOGY					99.40
	SPECIAL PURPOSE COST CENTERS					
118	SUBTOTALS (sum of lines 1-117)	17,707,358		17,707,358		118
	NONREIMBURSABLE COST CENTERS					
194	PROVIDER RELATIONS NRCC	113,603		113,603		194
194.01	NRCC SUBLEASED SPACE					194.01
200	CROSS FOOT ADJUSTMENTS					200
201	NEGATIVE COST CENTER	17.020.031		17.020.051		201
202	TOTAL (sum of lines 118-201)	17,820,961		17,820,961		202

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WinLASH

Micro System

Run Date: 05/23/2014

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Version: 2014.03 In Lieu of Form Period: From: 02/01/2013 To: 01/31/2014 RH OF NORTHWEST INDIANA, LLC CMS-2552-10 Provider CCN: 15-2024

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B PART II

		DIR ASSGND	CAP	CAP		EMPLOYEE	ADMINIS-	
	COST CENTER DESCRIPTIONS	CAP-REL	BLDGS &	MOVABLE		BENEFITS	TRATIVE &	
		COSTS	FIXTURES	EQUIPMENT	SUBTOTAL	DEPARTMENT	GENERAL	
		0	1	2	2A	4	5	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT		4,717	1,515	6,232	6,232		4
5	ADMINISTRATIVE & GENERAL	13,968	126,395	40,588	180,951	810	181,761	5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT		266,501	85,579	352,080		4,306	7
8	LAUNDRY & LINEN SERVICE		14,781	4,747	19,528		1,225	8
9	HOUSEKEEPING		8,586	2,757	11,343		233	9
10	DIETARY		7,328	2,353	9,681	34	3,438	10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		8,082	2,595	10,677	156	3,384	13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY		5,063	1,626	6,689	85	1,918	16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS		402,992	129,408	532,400	3,533	75,505	30
	ANCILLARY SERVICE COST CENTERS		·	,				
50	OPERATING ROOM						5,357	50
54	RADIOLOGY-DIAGNOSTIC						2,094	54
60	LABORATORY		5,504	1,767	7,271		11,700	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	18,231	11,793	3,787	33,811	711	13,642	65
66	PHYSICAL THERAPY		6,573	2,111	8,684	87	3,330	66
67	OCCUPATIONAL THERAPY		6,573	2,111	8,684	185	3,622	67
68	SPEECH PATHOLOGY		2,988	959	3,947	34	1,249	68
69	ELECTROCARDIOLOGY						291	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	505,556	23,147	7,433	536,136	69	20,141	71
73	DRUGS CHARGED TO PATIENTS	22,089	22,486	7,221	51,796	482	25,043	73
74	RENAL DIALYSIS						4,124	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	559,844	923,509	296,557	1,779,910	6,186	180,602	118
	NONREIMBURSABLE COST CENTERS							
194	PROVIDER RELATIONS NRCC					46	1,159	194
194.01	NRCC SUBLEASED SPACE						,,,,,,	194.01
200	CROSS FOOT ADJUSTMENTS							200
								201
201	NEGATIVE COST CENTER			l l				

Optimizer Systems, Inc.

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Micro System
Run Date: 05/23/2014
Run Time: 08:11
Version: 2014.03 In Lieu of Form Period: From: 02/01/2013 To: 01/31/2014 RH OF NORTHWEST INDIANA, LLC CMS-2552-10 Provider CCN: 15-2024

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B PART II

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY + LINEN SERVICE	HOUSE- KEEPING	DIETARY	NURSING ADMINIS- TRATION	MEDICAL RECORDS + LIBRARY	
		7	8	9	10	13	16	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	356,386						7
8	LAUNDRY & LINEN SERVICE	10,017	30,770	45.004				8
9	HOUSEKEEPING	5,818		17,394	10.050			9
10	DIETARY	4,966		254	18,373			10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	5,477		280		19,974		13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY	2 424					42.200	15
16	MEDICAL RECORDS & LIBRARY	3,431		175			12,298	16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
20	INPATIENT ROUTINE SERV COST CENTERS	272.000	20.770	12.040	10 272	10.074	4 422	30
30	ADULTS & PEDIATRICS	273,098	30,770	13,949	18,373	19,974	4,422	30
50	ANCILLARY SERVICE COST CENTERS OPERATING ROOM						175	50
50 54	RADIOLOGY-DIAGNOSTIC						175 202	50 54
60	LABORATORY	3,730		190			1.004	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS	3,730		150			1,004	62.30
65	RESPIRATORY THERAPY	7,992		408			1,850	65
66	PHYSICAL THERAPY	4,454		228			139	66
67	OCCUPATIONAL THERAPY	4,454		228			297	67
68	SPEECH PATHOLOGY	2,025		103			44	68
69	ELECTROCARDIOLOGY	2,023		103			251	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,686		801			1,144	71
73	DRUGS CHARGED TO PATIENTS	15,238		778			2,501	73
74	RENAL DIALYSIS	13,230		770			269	74
76.97	CARDIAC REHABILITATION						20)	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
//	OUTPATIENT SERVICE COST CENTERS							
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	356,386	30,770	17,394	18,373	19,974	12,298	118
	NONREIMBURSABLE COST CENTERS							
194	PROVIDER RELATIONS NRCC							194
1	NRCC SUBLEASED SPACE							194.01
194.01								200
200	CROSS FOOT ADJUSTMENTS							
	CROSS FOOT ADJUSTMENTS NEGATIVE COST CENTER TOTAL (sum of lines 118-201)	356,386	30,770	17,394	18,373	19,974	12,298	200 201 202

Optimizer Systems, Inc.

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In Lieu of Form RH OF NORTHWEST INDIANA, LLC CMS-2552-10 Provider CCN: 15-2024

Period: From: 02/01/2013 To: 01/31/2014 Micro System

Run Date: 05/23/2014

Run Time: 08:11

Version: 2014.03

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B PART II

			I&D COST 9		
	GOOD OF THE PER OF THE CASE OF		I&R COST &		
	COST CENTER DESCRIPTIONS		POST STEP-		
		SUBTOTAL	DOWN ADJS	TOTAL	
	GENERAL GERMANIA GOAR GENERAL	24	25	26	
	GENERAL SERVICE COST CENTERS				
1	CAP REL COSTS-BLDG & FIXT				
2	CAP REL COSTS-MVBLE EQUIP				2
4	EMPLOYEE BENEFITS DEPARTMENT				
5	ADMINISTRATIVE & GENERAL				
6	MAINTENANCE & REPAIRS				
7	OPERATION OF PLANT				
8	LAUNDRY & LINEN SERVICE				
9	HOUSEKEEPING				9
10	DIETARY				1
11	CAFETERIA				1
12	MAINTENANCE OF PERSONNEL				1
13	NURSING ADMINISTRATION				1
14	CENTRAL SERVICES & SUPPLY				1
15	PHARMACY				1
16	MEDICAL RECORDS & LIBRARY				1
17	SOCIAL SERVICE				1
19	NONPHYSICIAN ANESTHETISTS				1
20	NURSING SCHOOL				2
21	I&R SERVICES-SALARY & FRINGES APPRVD				2
22	I&R SERVICES-OTHER PRGM COSTS APPRVD				2
23	PARAMED ED PRGM-(SPECIFY)				2
	INPATIENT ROUTINE SERV COST CENTERS				
30	ADULTS & PEDIATRICS	972.024		972,024	3
	ANCILLARY SERVICE COST CENTERS			, .	
50	OPERATING ROOM	5,532		5,532	5
54	RADIOLOGY-DIAGNOSTIC	2,296		2,296	5
60	LABORATORY	23,895		23,895	6
62.30	BLOOD CLOTTING FOR HEMOPHILIACS	-,		.,	6
65	RESPIRATORY THERAPY	58,414		58,414	6
66	PHYSICAL THERAPY	16,922		16,922	6
67	OCCUPATIONAL THERAPY	17,470		17,470	6
68	SPEECH PATHOLOGY	7,402		7,402	6
69	ELECTROCARDIOLOGY	542		542	6
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	573,977		573,977	7
73	DRUGS CHARGED TO PATIENTS	95,838		95,838	7
74	RENAL DIALYSIS	4,393		4,393	7
76.97	CARDIAC REHABILITATION	4,393		4,393	7
76.98	HYPERBARIC OXYGEN THERAPY				7
76.98	LITHOTRIPSY				7
/0.99					/
92	ODSERVATION REDS (NON DISTINCT BART)				9
92	OBSERVATION BEDS (NON-DISTINCT PART)				9
00.10	OTHER REIMBURSABLE COST CENTERS				
99.10	CORF				9
99.20	OUTPATIENT PHYSICAL THERAPY				9
99.30	OUTPATIENT OCCUPATIONAL THERAPY				9
99.40	OUTPATIENT SPEECH PATHOLOGY				9
	SPECIAL PURPOSE COST CENTERS				
118	SUBTOTALS (sum of lines 1-117)	1,778,705		1,778,705	11
	NONREIMBURSABLE COST CENTERS				
194	PROVIDER RELATIONS NRCC	1,205		1,205	19
194.01	NRCC SUBLEASED SPACE				19
200	CROSS FOOT ADJUSTMENTS				20
	NEGATIVE COST CENTER				20
201 202	NEGATIVE COST CENTER				20

Optimizer Systems, Inc.

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In Lieu of Form RH OF NORTHWEST INDIANA, LLC CMS-2552-10 Provider CCN: 15-2024

Period: From: 02/01/2013 To: 01/31/2014 Micro System
Run Date: 05/23/2014
Run Time: 08:11
Version: 2014.03

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

CONTINENT CONT									
COST CENTER DESCRIPTIONS			CAP	CAP	EMPLOYEE		ADMINIS-	OPERATION	
SOLARE SOLARE SOLARE SALARIES SALA			BLDGS &	MOVABLE	BENEFITS	RECON-	TRATIVE &	OF PLANT	
PRINT PRIN		COST CENTER DESCRIPTIONS	FIXTURES	EQUIPMENT	DEPARTMENT	CILIATION	GENERAL		
PRINT PRIN			SQUARE	SOUARE	GROSS		ACCUM	SQUARE	
GRINERAL SERVICE COST CENTERS									
CAP REL COSTS-BLOG & RIXT			1	2		5A	5	7	
2 CAP REL COSTS-AWRIE EQUIP 4 EMPLOYE BENEFITS DEPARTMENT 5 ADMINISTRATIVE & GENERAL 6 ADMINISTRATIVE & GENERAL 70 BEFARY 10 DIEFLARY 11 CAFETERIA 12 ADMINISTRATIVE & GENERAL 12 ADMINISTRATIVE & GENERAL 13 NURSING ADMINISTRATIVE 14 CAFETERIA 15 CASTRAL SERVICES & SUPPLY 16 ADMINISTRATIVE & GENERAL 16 ADMINISTRATIVE & GENERAL 17 ADMINISTRATIVE & GENERAL 18 CASTRAL SERVICES & SUPPLY 19 ADMINISTRATIVE & GENERAL 19 ADMINISTRATIVE & GENERAL 10 ADM		GENERAL SERVICE COST CENTERS							
2 CAP REL COSTS-AWRIE EQUIP 4 EMPLOYE BENEFITS DEPARTMENT 5 ADMINISTRATIVE & GENERAL 6 ADMINISTRATIVE & GENERAL 70 BEFARY 10 DIEFLARY 11 CAFETERIA 12 ADMINISTRATIVE & GENERAL 12 ADMINISTRATIVE & GENERAL 13 NURSING ADMINISTRATIVE 14 CAFETERIA 15 CASTRAL SERVICES & SUPPLY 16 ADMINISTRATIVE & GENERAL 16 ADMINISTRATIVE & GENERAL 17 ADMINISTRATIVE & GENERAL 18 CASTRAL SERVICES & SUPPLY 19 ADMINISTRATIVE & GENERAL 19 ADMINISTRATIVE & GENERAL 10 ADM	1		29,365						1
ADDITIONAL CONTRIBUTION OF PLANT 150 150 7,728,617 1,800,160 5 5 ADMINISTRATIVE & CEREREAL 4,919 4,919 1,004,849 2,969,801 1,800,160 5 5 6 MAINTENANCE & REPAIRS 2,721 2	2			29,365					2
MAINTENANCE & REPAIRS	4	EMPLOYEE BENEFITS DEPARTMENT	150	150	7,728,617				4
MAINTENANCE & REPAIRS	5	ADMINISTRATIVE & GENERAL	4,019	4,019	1,004,840	-2,960,801	14,860,160		5
ALINDRY & LINEN SERVICES	6	MAINTENANCE & REPAIRS							6
HOUSEKLEPING	7	OPERATION OF PLANT	8,474	8,474			352,080	16,722	7
DIETARY 233 233 42,190 281,099 233 10	8	LAUNDRY & LINEN SERVICE	470	470			100,134	470	8
11 CAPÉTERIA	9	HOUSEKEEPING	273	273			19,063	273	9
MAINTENANCE OF PERSONNEL 12 13 14 15 15 15 16 16 16 16 16	10	DIETARY	233	233	42,190		281,099	233	10
13 NURSING ADMINISTRATION 257 257 193,708 276,657 257 13	11	CAFETERIA							11
14 CENTRAL SERVICES & SUPPLY	12	MAINTENANCE OF PERSONNEL							12
15 PHARMACY	13	NURSING ADMINISTRATION	257	257	193,708		276,657	257	13
MEDICAL SERVICE	14	CENTRAL SERVICES & SUPPLY							14
17 NOCIAL SERVICE	15	PHARMACY							15
90 NONPHYSICIAN ANESTHEITSTS	16	MEDICAL RECORDS & LIBRARY	161	161	106,027		156,793	161	16
NURSING SCHOOL 20 21 22 23 24 25 25 26 27 27 27 27 27 27 27	17	SOCIAL SERVICE							17
1									
18. SERVICES-OTHER PROM COSTS APPRUD 22 3. PARAMED ED PROM (SPECIEV) 23 ANALIEAR ROUTINE SERV COST CENTERS 23 ANALIEAR SERVICE COST CENTERS 25 0. OPERATING ROOM 438,001 50 4. RADIOLOGY-DIAGNOSTIC 17.125 54 0. LAGRATING ROOM 438,001 50 4. RADIOLOGY-DIAGNOSTIC 17.125 54 0. LAGRATING ROOM 956,513 175 60 0. LAGRATING ROOM 17.125 54 0. LAGRATING ROOM REMOVED ROOM 17.125 54 0. LAGRATING ROOM 17.125 54 0. LAGRATING ROOM REMOVED ROOM 17.125 54 0. LAGRATING ROOM REMOVED ROOM 17.125 56 0. LAGRATING ROOM 17.125 17.5 17									
PARAMED ED PRGM-SPECIFY	21	I&R SERVICES-SALARY & FRINGES APPRVD							21
NPATIENT ROUTINE SERV COST CENTERS 12,814 12,814 4,378,388 6,172,716 12,814 30									
ADULTS & PEDIATRICS 12,814 12,814 4,378,388 6,172,716 12,814 30	23								23
ANCILLARY SERVICE COST CENTERS									
SO OPERATING ROOM	30		12,814	12,814	4,378,388		6,172,716	12,814	30
SADIOLOGY-DIAGNOSTIC									
60									
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							- / -		
SEPIRATORY THERAPY 375 375 882,680 1,115,396 375 65			175	175			956,573	175	
66 PHYSICAL THERAPY 209 209 108.470 272.226 209 66 67									
CCUPATIONAL THERAPY 209 209 229.595 296.117 209 67									
68 SPEECH PATHOLOGY 95 95 42,798 102,092 95 68 69 ELECTROCARDIOLOGY 23,831 69 69 71 MEDICAL SUPPLIES CHARGED TO PATIENTS 736 736 85,271 1,646,713 736 71 73 DRUGS CHARGED TO PATIENTS 715 715 598,081 2,047,524 715 73 74 RENAL DIALYSIS 337,191 74 76,97 CARDIAC REHABILITATION 76,97 76,97 76,98 76,97 76,98 76,99 76,99 76,99 76,99 76,99 76,99 76,99 76,99 76,99 76,99 92,00 99,10 92,00 99,10 99,10 99,10 99,10 99,10 99,10 99,10 99,10 99,10 99,10 99,20 99,10 99,20 99,10 99,20 99,10 99,20 99,10 99,20 99,10 99,20 99,10 99,20 99,10 99,20 99,10 99,20 99,10 99,20 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>									
ELECTROCARDIOLOGY									
The first content of the fir			95	95	42,798			95	
Table Tabl			726	724	05.071			726	
74 RENAL DIALYSIS 337,191 74 76.97 CARDIAC REHABILITATION 76.97 76.98 HYPERBARIC OXYGEN THERAPY 76.98 76.99 LITHOTRIPSY 76.99 OUTPATIENT SERVICE COST CENTERS 92 OBSERVATION BEDS (NON-DISTINCT PART) 92.10 99.10 CORF 99.10 99.20 OUTPATIENT PHYSICAL THERAPY 99.30 99.30 OUTPATIENT OCCUPATIONAL THERAPY 99.30 99.40 OUTPATIENT SPECH PATHOLOGY 99.40 SPECIAL PURPOSE COST CENTERS 99.40 18 SUBTOTALS (sum of lines 1-117) 29,365 29,365 7,672,048 -2,960,801 14,765,431 16,722 118 NONREIMBURSABLE COST CENTERS 94.01 194.01 NRCC SUBLEASED SPACE 94,729 194 194.01 NEGATIVE COST CENTER 200 CROSS FOOT ADJUSTMENTS 201 202 COST TO BE ALLOC PER B PT I 923,509 296,557 23,430 2,960,801 422,230 202 203 UNIT COST MULT-WS B PT I 31.449310 10.098995 0.003032 0.199244 25.249970 203 204 COST TO BE ALLOC PER B PT II 31.449310 10.098995 0.003032 0.199244 25.249970 203 204 COST TO BE ALLOC PER B PT II 31.449310 10.098995 0.003032 0.199244 25.249970 203 205 206 206 206 206 206 206 206 COST TO BE ALLOC PER B PT II 31.449310 10.098995 0.003032 0.199244 25.249970 203 206 207 208 208 208 208 208 208 208 207 COST TO BE ALLOC PER B PT II 31.449310 10.098995 0.003032 0.199244 25.249970 203 208 209 2									
76.97 CARDIAC REHABILITATION 76.98 76.97 76.98 HYPERBARIC OXYGEN THERAPY 76.98 76.99			/15	/15	598,081			/15	
76.98 HYPERBARIC OXYGEN THERAPY							337,191		
76.99									
OUTPATIENT SERVICE COST CENTERS 92									
92 OBSERVATION BEDS (NON-DISTINCT PART) 92 0THER REIMBURSABLE COST CENTERS 99.10 99.10 99.20 0UTPATIENT PHYSICAL THERAPY 99.20 0UTPATIENT OCCUPATIONAL THERAPY 99.30 0UTPATIENT SPEECH PATHOLOGY 99.40 99.	/6.99								/0.99
OTHER REIMBURSABLE COST CENTERS	02								02
99.10 CORF 99.10 99.10 99.20 OUTPATIENT PHYSICAL THERAPY 99.30 OUTPATIENT OCCUPATIONAL THERAPY 99.30 OUTPATIENT SPEECH PATHOLOGY 99.40 99.30 99.40	92								92
99.20 OUTPATIENT PHYSICAL THERAPY 99.20 99.30 OUTPATIENT OCCUPATIONAL THERAPY 99.30 99.40 99.30 99.40 99.40 99.40 99.30 99.4	99 10								99 10
99.30 OUTPATIENT OCCUPATIONAL THERAPY 99.40 OUTPATIENT SPEECH PATHOLOGY SPECIAL PURPOSE COST CENTERS 118 SUBTOTALS (sum of lines 1-117) 29.365 29.365 7,672,048 -2,960,801 14,765,431 16,722 118 NONREIMBURSABLE COST CENTERS 194 PROVIDER RELATIONS NRCC 194.01 NRCC SUBLEASED SPACE 200 CROSS FOOT ADJUSTMENTS 201 NEGATIVE COST CENTER 202 COST TO BE ALLOC PER B PT I 923,509 296,557 23,430 2,960,801 422,230 202 203 UNIT COST MULT-WS B PT I 31.449310 10.098995 0.003032 0.199244 25,249970 203 204 COST TO BE ALLOC PER B PT II 356,386 204									
99.40 OUTPATIENT SPEECH PATHOLOGY 99.40 SPECIAL PURPOSE COST CENTERS 99.40 118 SUBTOTALS (sum of lines 1-117) 29,365 29,365 7,672,048 -2,960,801 14,765,431 16,722 118 NONREIMBURSABLE COST CENTERS 94,729 194 194 194.01 NRCC SUBLEASED SPACE 94,729 194.01 200 CROSS FOOT ADJUSTMENTS 200 200 200 200 200 200 201 201 201 202 203 204 204 204 206,801 422,230 202 203 201 203 201 202 203 204 205 203 200 203 204 200 203 204 203 204 206,801 422,230 202 201 COST TO BE ALLOC PER B PT II 31,449310 10,098995 0,003032 0,199244 25,249970 203 204 COST TO BE ALLOC PER B PT II 6,232 181,761 356,386 204									
SPECIAL PURPOSE COST CENTERS									
118 SUBTOTALS (sum of lines 1-117) 29,365 29,365 7,672,048 -2,960,801 14,765,431 16,722 118	77.40								77.40
NONREIMBURSABLE COST CENTERS	118		29 365	29 365	7 672 048	-2,960 801	14,765,431	16 722	118
194 PROVIDER RELATIONS NRCC 56,569 94,729 194 194,01 NRCC SUBLEASED SPACE 194,01 200 CROSS FOOT ADJUSTMENTS 200 201 NEGATIVE COST CENTER 201 202 COST TO BE ALLOC PER B PT I 923,509 296,557 23,430 2,960,801 422,230 202 203 UNIT COST MULT-WS B PT I 31,449310 10,098995 0,003032 0,199244 25,249970 203 204 COST TO BE ALLOC PER B PT II 6,232 181,761 356,386 204	110		27,303	27,505	7,072,040	2,700,001	1,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	10,722	1
194.01 NRCC SUBLEASED SPACE 194.01 200	194				56 569		94 729		194
200 CROSS FOOT ADJUSTMENTS 200 201 NEGATIVE COST CENTER 201 202 COST TO BE ALLOC PER B PT I 923,509 296,557 23,430 2,960,801 422,230 202 203 UNIT COST MULT-WS B PT I 31,449310 10,098995 0,003032 0,199244 25,249970 203 204 COST TO BE ALLOC PER B PT II 6,232 181,761 356,386 204					20,207		2 .,. 22		
201 NEGATIVE COST CENTER 201 202 COST TO BE ALLOC PER B PT I 923,509 296,557 23,430 2,960,801 422,230 202 203 UNIT COST MULT-WS B PT I 31.449310 10.098995 0.003032 0.199244 25.249970 203 204 COST TO BE ALLOC PER B PT II 6,232 181,761 356,386 204									
202 COST TO BE ALLOC PER B PT I 923,509 296,557 23,430 2,960,801 422,230 202 203 UNIT COST MULT-WS B PT I 31.449310 10.098995 0.003032 0.199244 25.249970 203 204 COST TO BE ALLOC PER B PT II 6,232 181,761 356,386 204									
203 UNIT COST MULT-WS B PT I 31.449310 10.098995 0.003032 0.199244 25.249970 203 204 COST TO BE ALLOC PER B PT II 6,232 181,761 356,386 204			923,509	296,557	23,430		2,960,801	422,230	
204 COST TO BE ALLOC PER B PT II 6,232 181,761 356,386 204									
	205								205

Optimizer Systems, Inc.

99.10 CORF

99.30 99.40

118

194

201

202

203

204

194.01 200

99.20 OUTPATIENT PHYSICAL THERAPY

OUTPATIENT OCCUPATIONAL THERAPY

OUTPATIENT SPEECH PATHOLOGY

SUBTOTALS (sum of lines 1-117)

PROVIDER RELATIONS NRCC NRCC SUBLEASED SPACE

CROSS FOOT ADJUSTMENTS

COST TO BE ALLOC PER B PT I

COST TO BE ALLOC PER B PT II

UNIT COST MULT-WS B PT I

UNIT COST MULT-WS B PT II

NEGATIVE COST CENTER

SPECIAL PURPOSE COST CENTERS

NONREIMBURSABLE COST CENTERS

WinLASH

Micro System
Run Date: 05/23/2014 In Lieu of Form Period: RH OF NORTHWEST INDIANA, LLC CMS-2552-10 From: 02/01/2013 Run Time: 08:11 Provider CCN: 15-2024 To: 01/31/2014 Version: 2014.03

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

99.10

99.20

99.30

99.40

194.01

200

201

202

203

204

205

118

	COST CENTER DESCRIPTIONS	LAUNDRY + LINEN SERVICE PATIENT	HOUSE- KEEPING SQUARE	DIETARY PATIENT	NURSING ADMINIS- TRATION NURSING	MEDICAL RECORDS + LIBRARY GROSS	
		DAYS	FEET	DAYS	FTE'S	REVENUE	
		8	9	10	13	16	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5	ADMINISTRATIVE & GENERAL						5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE	13,381					8
9	HOUSEKEEPING		15,979				9
10	DIETARY		233	13,381			10
11	CAFETERIA			,			11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION		257		82		13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY		161			72,587,986	16
17	SOCIAL SERVICE		101			72,007,700	17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
23	INPATIENT ROUTINE SERV COST CENTERS						23
30	ADULTS & PEDIATRICS	13,381	12.814	13,381	82	25,993,282	30
30	ANCILLARY SERVICE COST CENTERS	13,361	12,014	13,361	82	23,393,202	30
50	OPERATING ROOM					1,033,626	50
54	RADIOLOGY-DIAGNOSTIC					1,192,964	54
60	LABORATORY		175			5.941.183	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS		1/3			3,941,163	62.
62.30 65	RESPIRATORY THERAPY		375			10,945,489	65
66	PHYSICAL THERAPY		209			820.381	66
67	OCCUPATIONAL THERAPY		209			1,756,664	67
68 69	SPEECH PATHOLOGY ELECTROCARDIOLOGY		95			258,797	68
69 <u> </u>	ELECTROCARDIOLOGY MEDICAL SUPPLIES CHARGED TO PATIENTS		736			1,485,454 6,770,686	71
			100			-,,	
73	DRUGS CHARGED TO PATIENTS		715			14,797,149	73
74	RENAL DIALYSIS					1,592,311	74
76.97	CARDIAC REHABILITATION						76.
76.98	HYPERBARIC OXYGEN THERAPY						76.
76.99	LITHOTRIPSY						76.
	OUTPATIENT SERVICE COST CENTERS						
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						

13,381

131,952

9.861146

30,770

15,979

29,754

1.862069

17,394

13,381

343,423

18,373

25.664973

82

338,747

19,974

4,131.060976

72,587,986

192,398

12,298

0.002651

Optimizer Systems, Inc.

WinLASH

RH OF NORTHWEST INDIANA, LLC Provider CCN: 15-2024

In Lieu of Form CMS-2552-10

Period: From: 02/01/2013 To: 01/31/2014 Micro System
Run Date: 05/23/2014
Run Time: 08:11
Version: 2014.03

POST STEPDOWN ADJUSTMENTS WORKSHEET B-2

	WO	RKSHEET		
DESCRIPTION	PART	LINE NO.	AMOUNT	
1	2	3	4	

Optimizer Systems, Inc.

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In Lieu of Form RH OF NORTHWEST INDIANA, LLC CMS-2552-10 Provider CCN: 15-2024

Period: From: 02/01/2013 To: 01/31/2014 Micro System

Run Date: 05/23/2014

Run Time: 08:11

Version: 2014.03

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C PART I

					COSTS		
	COST CENTER DESCRIPTIONS	TOTAL COST (from Wkst. B, Part I, col. 26)	THERAPY LIMIT ADJ.	TOTAL COSTS	RCE DISALLOW- ANCE	TOTAL COSTS	
		1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	8,633,010		8,633,010	34,814	8,667,824	30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	528,010		528,010		528,010	
54	RADIOLOGY-DIAGNOSTIC	208,504		208,504		208,504	54
60	LABORATORY	1,167,659		1,167,659		1,167,659	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	1,376,815		1,376,815		1,376,815	65
66	PHYSICAL THERAPY	334,306		334,306		334,306	66
67	OCCUPATIONAL THERAPY	365,440		365,440		365,440	67
68	SPEECH PATHOLOGY	125,695		125,695		125,695	68
69	ELECTROCARDIOLOGY	32,517		32,517		32,517	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,012,714		2,012,714		2,012,714	71
73	DRUGS CHARGED TO PATIENTS	2,514,093		2,514,093		2,514,093	73
74	RENAL DIALYSIS	408,595		408,595		408,595	74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
200	SUBTOTAL (SEE INSTRUCTIONS)	17,707,358		17,707,358	34,814	17,742,172	200
201	LESS OBSERVATION BEDS						201
202	TOTAL (SEE INSTRUCTIONS)	17,707,358		17,707,358		17,742,172	202

Optimizer Systems, Inc.

Provider CCN: 15-2024

RH OF NORTHWEST INDIANA, LLC

WinLASH

Micro System
Run Date: 05/23/2014
Run Time: 08:11
Version: 2014.03 In Lieu of Form Period: From: 02/01/2013 To: 01/31/2014 CMS-2552-10

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C PART I

			CHARGES					
	COST CENTER DESCRIPTIONS	INPATIENT	OUTPATIENT	TOTAL (column 6 + column 7)	COST OR OTHER RATIO	TEFRA INPATIENT RATIO	PPS INPATIENT RATIO	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	25,993,282		25,993,282				30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	1,033,626		1,033,626	0.510833	0.510833	0.510833	50
54	RADIOLOGY-DIAGNOSTIC	1,192,964		1,192,964	0.174778	0.174778	0.174778	54
60	LABORATORY	5,941,183		5,941,183	0.196536	0.196536	0.196536	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	10,945,489		10,945,489	0.125788	0.125788	0.125788	65
66	PHYSICAL THERAPY	820,381		820,381	0.407501	0.407501	0.407501	66
67	OCCUPATIONAL THERAPY	1,756,664		1,756,664	0.208031	0.208031	0.208031	67
68	SPEECH PATHOLOGY	258,797		258,797	0.485690	0.485690	0.485690	68
69	ELECTROCARDIOLOGY	1,485,454		1,485,454	0.021890	0.021890	0.021890	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,770,686		6,770,686	0.297269	0.297269	0.297269	71
73	DRUGS CHARGED TO PATIENTS	14,797,149		14,797,149	0.169904	0.169904	0.169904	73
74	RENAL DIALYSIS	1,592,311		1,592,311	0.256605	0.256605	0.256605	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
200	SUBTOTAL (SEE INSTRUCTIONS)	72,587,986		72,587,986				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)	72,587,986		72,587,986				202

Optimizer Systems, Inc.

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Micro System
Run Date: 05/23/2014 In Lieu of Form Period: RH OF NORTHWEST INDIANA, LLC CMS-2552-10 From: 02/01/2013 Run Time: 08:11 Provider CCN: 15-2024 To: 01/31/2014 Version: 2014.03

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D PART I

CHECK [] TITLE V [XX] PPS APPLICABLE [XX] TITLE XVIII, PART A [] TEFRA [] TITLE XIX BOXES:

		CAPITAL RELATED COST (from Wkst. B, Part II, (col. 26)	SWING BED ADJUST- MENT	REDUCED CAPITAL RELATED COST (col. 1 minus col. 2)	TOTAL PATIENT DAYS	PER DIEM (col. 3 ÷ col. 4)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM CAPITAL COST (col. 5 x col. 6)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS (General Routine Care)	972,024		972,024	13,381	72.64	10,095	733,301	30
31	INTENSIVE CARE UNIT								31
32	CORONARY CARE UNIT								32
33	BURN INTENSIVE CARE UNIT								33
34	SURGICAL INTENSIVE CARE UNIT								34
35	OTHER SPECIAL CARE (SPECIFY)								35
40	SUBPROVIDER - IPF								40
41	SUBPROVIDER - IRF								41
42	SUBPROVIDER I								42
43	NURSERY								43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	972,024		972,024	13,381		10.095	733,301	200

⁽A) Worksheet A line numbers

Optimizer Systems, Inc.

WinLASH

Micro System
Run Date: 05/23/2014 In Lieu of Form Period: RH OF NORTHWEST INDIANA, LLC CMS-2552-10 From: 02/01/2013 Run Time: 08:11 Provider CCN: 15-2024 To: 01/31/2014 Version: 2014.03

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 15-2024

WORKSHEET D PART II

[] TITLE V CHECK [XX] HOSPITAL [] SUB (OTHER) [XX] PPS APPLICABLE [XX] TITLE XVIII, PART A [] IPF [] TEFRA [] TITLE XIX BOXES: [] IRF

		CAPITAL RELATED COST (from Wkst. B, Part II (col. 26)	TOTAL CHARGES (from Wkst. C, Part I, (col. 8)	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	5,532	1,033,626	0.005352	860,731	4,607	50
54	RADIOLOGY-DIAGNOSTIC	2,296	1,192,964	0.001925	920,941	1,773	54
60	LABORATORY	23,895	5,941,183	0.004022	4,418,769	17,772	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	58,414	10,945,489	0.005337	8,208,119	43,807	65
66	PHYSICAL THERAPY	16,922	820,381	0.020627	602,236	12,422	66
67	OCCUPATIONAL THERAPY	17,470	1,756,664	0.009945	1,324,428	13,171	67
68	SPEECH PATHOLOGY	7,402	258,797	0.028602	178,414	5,103	68
69	ELECTROCARDIOLOGY	542	1,485,454	0.000365	1,114,770	407	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	573,977	6,770,686	0.084774	5,093,926	431,832	71
73	DRUGS CHARGED TO PATIENTS	95,838	14,797,149	0.006477	10,972,305	71,068	73
74	RENAL DIALYSIS	4,393	1,592,311	0.002759	1,228,106	3,388	74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	806,681	46,594,704		34,922,745	605,350	200

⁽A) Worksheet A line numbers

Page: 44 Win-LASH 2552-10

Optimizer Systems, Inc.

WinLASH

Micro System
Run Date: 05/23/2014 In Lieu of Form Period: From: 02/01/2013 To: 01/31/2014 RH OF NORTHWEST INDIANA, LLC CMS-2552-10 Run Time: 08:11 Version: 2014.03 Provider CCN: 15-2024

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D PART III

CHECK	[]	TITLE	v			[XX]	PPS
APPLICABLE	[XX]	TITLE	XVIII,	PART	Α	[]	TEFR#
BOXES:	[1	TITLE	XIX				

		NURSING SCHOOL	ALLIED HEALTH COST	ALL OTHER MEDICAL EDUCATION COST	SWING-BED ADJUST- MENT AMOUNT (see instruct- ions)	TOTAL COSTS (sum of cols. 1 through 3 minus col 4.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS						30
30	(General Routine Care)						30
31	INTENSIVE CARE UNIT						31
32	CORONARY CARE UNIT						32
33	BURN INTENSIVE CARE UNIT						33
34	SURGICAL INTENSIVE CARE UNIT						34
35	OTHER SPECIAL CARE (SPECIFY)						35
40	SUBPROVIDER - IPF						40
41	SUBPROVIDER - IRF						41
42	SUBPROVIDER I						42
43	NURSERY						43
44	SKILLED NURSING FACILITY						44
45	NURSING FACILITY						45
200	TOTAL (lines 30-199)						200

⁽A) Worksheet A line numbers

Optimizer Systems, Inc.

WinLASH

Micro System
Run Date: 05/23/2014 In Lieu of Form Period: RH OF NORTHWEST INDIANA, LLC CMS-2552-10 From: 02/01/2013 Run Time: 08:11 Provider CCN: 15-2024 To: 01/31/2014 Version: 2014.03

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D PART III

CHECK [] TITLE V [XX] PPS APPLICABLE [XX] TITLE XVIII, PART A [] TEFRA [] TITLE XIX BOXES:

		TOTAL PATIENT DAYS	PER DIEM (col. 5÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
(A)	COST CENTER DESCRIPTION	6	7	8	9	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS	13,381		10,095		30
30	(General Routine Care)	13,361		10,093		30
31	INTENSIVE CARE UNIT					31
32	CORONARY CARE UNIT					32
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT					34
35	OTHER SPECIAL CARE (SPECIFY)					35
40	SUBPROVIDER - IPF					40
41	SUBPROVIDER - IRF					41
42	SUBPROVIDER I					42
43	NURSERY					43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	13.381		10.095		200

⁽A) Worksheet A line numbers

 Optimizer Systems, Inc.
 Win LASH
 Micro System

 RH OF NORTHWEST INDIANA, LLC
 In Lieu of Form CMS-2552-10
 Period: From: 02/01/2013
 Run Date: 05/23/2014

 Period: From: 02/01/2013
 Run Time: 08:11

 To: 01/31/2014
 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE	COMPONENT CCN: 15-2024	WORKSHEET I
OTHER PASS THROUGH COSTS		PART IV

CHECK [] TITLE V [XX] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS

APPLICABLE [XX] TITLE XVIII, PART A [] IPF [] SNF [] TEFRA

BOXES: [] TITLE XIX [] IRF [] NF

		NON PHYSICIAN ANESTH- ETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPAT- IENT COST (sum of col. 2, 3, and 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
54	RADIOLOGY-DIAGNOSTIC							54
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY			_				76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)							200

⁽A) Worksheet A line numbers

Page: 47 Win-LASH 2552-10

Optimizer Systems, Inc.

WinLASH

Micro System
Run Date: 05/23/2014 In Lieu of Form Period: From: 02/01/2013 To: 01/31/2014 RH OF NORTHWEST INDIANA, LLC CMS-2552-10 Run Time: 08:11 Version: 2014.03 Provider CCN: 15-2024

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-2024

WORKSHEET D PART IV

CHECK	[]	TITLE V		[XX] :	HOSPITAL	[]	SUB (OTHER)	[]	ICF/MR	[xx]	PPS
APPLICABLE	[XX]	TITLE XVIII,	PART A	[]	IPF	[]	SNF				[]	TEFRA
BOXES:	[]	TITLE XIX		[]	IRF	[]	NF					

		TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5÷ col. 7)	OUTPAT- IENT RATIO OF COST TO CHARGES (col. 6÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS- THROUGH COSTS (col. 8 x col. 10)	OUTPAT- IENT PROGRAM CHARGES	OUTPAT- IENT PROGRAM PASS- THROUGH COSTS (col. 9 x col. 12)	
(A)	COST CENTER DESCRIPTION	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	1,033,626			860,731				50
54	RADIOLOGY-DIAGNOSTIC	1,192,964			920,941				54
60	LABORATORY	5,941,183			4,418,769				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	10,945,489			8,208,119				65
66	PHYSICAL THERAPY	820,381			602,236				66
67	OCCUPATIONAL THERAPY	1,756,664			1,324,428				67
68	SPEECH PATHOLOGY	258,797			178,414				68
69	ELECTROCARDIOLOGY	1,485,454			1,114,770				69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,770,686			5,093,926				71
73	DRUGS CHARGED TO PATIENTS	14,797,149			10,972,305				73
74	RENAL DIALYSIS	1,592,311			1,228,106				74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	OBSERVATION BEDS (NON-DISTINCT PART)								92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	46,594,704			34,922,745				200

⁽A) Worksheet A line numbers

Optimizer Systems, Inc.

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Micro System
Run Date: 05/23/2014 In Lieu of Form Period: From: 02/01/2013 To: 01/31/2014 RH OF NORTHWEST INDIANA, LLC CMS-2552-10 Run Time: 08:11 Version: 2014.03 Provider CCN: 15-2024

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 15-2024

WORKSHEET D PART V

CHECK	[]	TITLE	V - O/P		[XX]	[]	HOSPITAL	[]	SUB	(OTHER)	[]	SWING BE	SNF
APPLICABLE	[XX]	TITLE	XVIII, PART	В	[]	IPF	[]	SNF		[]	SWING BE) NF
BOXES:	[]	TITLE	XIX - O/P		[]	IRF	[]	NF		[]	ICF/MR	

			DD	OGRAM CHARO	EEC	1	PROGRAM COST	,	
			PK	OGRAM CHARC	COST		FROGRAM COST	COST	
		COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM- BURSED SERVICES (see inst.)	COST REIM- BURSED SUBJECT TO DED. & COINS. (see inst.)	REIM- BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM- BURSED SUBJECT TO DED. & COINS. (see inst.)	REIM- BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.510833							50
54	RADIOLOGY-DIAGNOSTIC	0.174778							54
60	LABORATORY	0.196536							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.125788							65
66	PHYSICAL THERAPY	0.407501							66
67	OCCUPATIONAL THERAPY	0.208031							67
68	SPEECH PATHOLOGY	0.485690							68
69	ELECTROCARDIOLOGY	0.021890							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.297269							71
73	DRUGS CHARGED TO PATIENTS	0.169904							73
74	RENAL DIALYSIS	0.256605							74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	OBSERVATION BEDS (NON-DISTINCT PART)		•						92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)								200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM								201
201	ONLY CHARGES								
202	NET CHARGES (line 200 - line 201)								202

⁽A) Worksheet A line numbers

Optimizer Systems, Inc.

WinLASH

Micro System
Run Date: 05/23/2014 In Lieu of Form Period: RH OF NORTHWEST INDIANA, LLC CMS-2552-10 From: 02/01/2013 Run Time: 08:11 Provider CCN: 15-2024 To: 01/31/2014 Version: 2014.03

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D PART I

CHECK [] TITLE V [XX] PPS APPLICABLE [] TITLE XVIII, PART A [] TEFRA [XX] TITLE XIX BOXES:

		CAPITAL RELATED COST (from Wkst. B, Part II, (col. 26)	SWING BED ADJUST- MENT	REDUCED CAPITAL RELATED COST (col. 1 minus col. 2)	TOTAL PATIENT DAYS	PER DIEM (col. 3 ÷ col. 4)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM CAPITAL COST (col. 5 x col. 6)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS (General Routine Care)	972,024		972,024	13,381	72.64			30
31	INTENSIVE CARE UNIT								31
32	CORONARY CARE UNIT								32
33	BURN INTENSIVE CARE UNIT								33
34	SURGICAL INTENSIVE CARE UNIT								34
35	OTHER SPECIAL CARE (SPECIFY)								35
40	SUBPROVIDER - IPF								40
41	SUBPROVIDER - IRF								41
42	SUBPROVIDER I								42
43	NURSERY								43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	972,024		972,024	13,381		l		200

⁽A) Worksheet A line numbers

Optimizer Systems, Inc.

WinLASH

Micro System
Run Date: 05/23/2014 In Lieu of Form Period: RH OF NORTHWEST INDIANA, LLC CMS-2552-10 From: 02/01/2013 Run Time: 08:11 Provider CCN: 15-2024 To: 01/31/2014 Version: 2014.03

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 15-2024

WORKSHEET D PART II

CHECK	[1	TITLE	v			[X	x]	HOSPITAL	[]	SUB	(OTHER)	[XX	[]	PPS
APPLICABLE	[]	TITLE	XVIII,	PART	A	[]	IPF					[]	TEFRA
BOXES:	[XX	[]	TITLE	XIX			[]	IRF							

		CAPITAL RELATED COST (from Wkst. B, Part II (col. 26)	TOTAL CHARGES (from Wkst. C, Part I, (col. 8)	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	5,532	1,033,626	0.005352			50
54	RADIOLOGY-DIAGNOSTIC	2,296	1,192,964	0.001925			54
60	LABORATORY	23,895	5,941,183	0.004022			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	58,414	10,945,489	0.005337			65
66	PHYSICAL THERAPY	16,922	820,381	0.020627			66
67	OCCUPATIONAL THERAPY	17,470	1,756,664	0.009945			67
68	SPEECH PATHOLOGY	7,402	258,797	0.028602			68
69	ELECTROCARDIOLOGY	542	1,485,454	0.000365			69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	573,977	6,770,686	0.084774			71
73	DRUGS CHARGED TO PATIENTS	95,838	14,797,149	0.006477			73
74	RENAL DIALYSIS	4,393	1,592,311	0.002759			74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	806,681	46,594,704				200

⁽A) Worksheet A line numbers

Optimizer Systems, Inc.

WinLASH

Micro System
Run Date: 05/23/2014 In Lieu of Form Period: RH OF NORTHWEST INDIANA, LLC CMS-2552-10 From: 02/01/2013 Run Time: 08:11 Provider CCN: 15-2024 To: 01/31/2014 Version: 2014.03

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D PART III

CHECK [] TITLE V [XX] PPS APPLICABLE [] TITLE XVIII, PART A [] TEFRA [XX] TITLE XIX BOXES:

		NURSING SCHOOL	ALLIED HEALTH COST	ALL OTHER MEDICAL EDUCATION COST	SWING-BED ADJUST- MENT AMOUNT (see instruct- ions)	TOTAL COSTS (sum of cols. 1 through 3 minus col 4.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS (General Routine Care)						30
31	INTENSIVE CARE UNIT						31
32	CORONARY CARE UNIT						32
33	BURN INTENSIVE CARE UNIT						33
34	SURGICAL INTENSIVE CARE UNIT						34
35	OTHER SPECIAL CARE (SPECIFY)						35
40	SUBPROVIDER - IPF						40
41	SUBPROVIDER - IRF						41
42	SUBPROVIDER I						42
43	NURSERY						43
44	SKILLED NURSING FACILITY						44
45	NURSING FACILITY						45
200	TOTAL (lines 30-199)						200

⁽A) Worksheet A line numbers

Optimizer Systems, Inc.

WinLASH

Micro System
Run Date: 05/23/2014 In Lieu of Form Period: RH OF NORTHWEST INDIANA, LLC CMS-2552-10 From: 02/01/2013 Run Time: 08:11 Provider CCN: 15-2024 To: 01/31/2014 Version: 2014.03

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D PART III

CHECK [] TITLE V [XX] PPS APPLICABLE [] TITLE XVIII, PART A [] TEFRA [XX] TITLE XIX BOXES:

		TOTAL PATIENT DAYS	PER DIEM (col. 5÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
(A)	COST CENTER DESCRIPTION	6	7	8	9	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS	13,381				30
30	(General Routine Care)	13,361				30
31	INTENSIVE CARE UNIT					31
32	CORONARY CARE UNIT					32
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT					34
35	OTHER SPECIAL CARE (SPECIFY)					35
40	SUBPROVIDER - IPF					40
41	SUBPROVIDER - IRF					41
42	SUBPROVIDER I					42
43	NURSERY					43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	13,381		I		200

(A) Worksheet A line numbers

Optimizer Systems, Inc.

WinLASH

Micro System
Run Date: 05/23/2014 In Lieu of Form Period: From: 02/01/2013 To: 01/31/2014 RH OF NORTHWEST INDIANA, LLC CMS-2552-10 Run Time: 08:11 Provider CCN: 15-2024 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-2024

WORKSHEET D PART IV

CHECK	[]	TITLE	v		[:	xx]	HOSPITAL	[] SUB (O	THER)	[]	ICF/MR	[XX	ζ]	PPS
APPLICABLE	[]	TITLE	XVIII,	PART A	. []	IPF	[] SNF					[]	TEFRA
BOXES:	[X	x]	TITLE	XIX		[]	IRF	[] NF							

		NON PHYSICIAN ANESTH- ETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPAT- IENT COST (sum of col. 2, 3, and 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
54	RADIOLOGY-DIAGNOSTIC							54
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)							200

⁽A) Worksheet A line numbers

 Optimizer Systems, Inc.
 Win LASH
 Micro System

 RH OF NORTHWEST INDIANA, LLC
 In Lieu of Form CMS-2552-10
 Period: From: 02/01/2013
 Run Date: 05/23/2014

 Provider CCN: 15-2024
 From: 02/01/2013
 Run Time: 08:11

 Version: 2014.03
 Version: 2014.03

WORKSHEET D PART IV

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE	COMPONENT CCN: 15-2024
OTHER PASS THROUGH COSTS	

CHECK [] TITLE V [XX] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
APPLICABLE [] TITLE XVIII, PART A [] IPF [] SNF [] TEFRA
BOXES: [XX] TITLE XIX [] IRF [] NF

		TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5÷ col. 7)	OUTPAT- IENT RATIO OF COST TO CHARGES (col. 6÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS- THROUGH COSTS (col. 8 x col. 10)	OUTPAT- IENT PROGRAM CHARGES	OUTPAT- IENT PROGRAM PASS- THROUGH COSTS (col. 9 x col. 12)	
(A)	COST CENTER DESCRIPTION	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	1,033,626							50
54	RADIOLOGY-DIAGNOSTIC	1,192,964							54
60	LABORATORY	5,941,183							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	10,945,489							65
66	PHYSICAL THERAPY	820,381							66
67	OCCUPATIONAL THERAPY	1,756,664							67
68	SPEECH PATHOLOGY	258,797							68
69	ELECTROCARDIOLOGY	1,485,454							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,770,686							71
73	DRUGS CHARGED TO PATIENTS	14,797,149							73
74	RENAL DIALYSIS	1,592,311							74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	OBSERVATION BEDS (NON-DISTINCT PART)								92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	46,594,704							200

⁽A) Worksheet A line numbers

Optimizer Systems, Inc.

WinLASH

Micro System
Run Date: 05/23/2014 In Lieu of Form Period: Run Time: 08:11 Version: 2014.03 From: 02/01/2013 To: 01/31/2014 RH OF NORTHWEST INDIANA, LLC CMS-2552-10 Provider CCN: 15-2024

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 15-2024

WORKSHEET D PART V

CHECK	[]	TITLE	v - o/	P		[XX	ζ]	HOSPITAL	[1	SUB (OTHER)	[1	SWING	BED	SNF
APPLICABLE	[]	TITLE	XVIII,	PART	В	[]	IPF	[]	SNF	[1	SWING	BED	NF
BOXES:	[XX	[]	TITLE	XIX - 0	O/P		[]	IRF	[]	NF	[]	ICF/MF	2	

			PR	OGRAM CHARC			PROGRAM COST		
		COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM- BURSED SERVICES (see inst.)	COST REIM- BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM- BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM- BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM- BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.510833							50
54	RADIOLOGY-DIAGNOSTIC	0.174778							54
60	LABORATORY	0.196536							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.125788							65
66	PHYSICAL THERAPY	0.407501							66
67	OCCUPATIONAL THERAPY	0.208031							67
68	SPEECH PATHOLOGY	0.485690							68
69	ELECTROCARDIOLOGY	0.021890							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.297269							71
73	DRUGS CHARGED TO PATIENTS	0.169904							73
74	RENAL DIALYSIS	0.256605							74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	OBSERVATION BEDS (NON-DISTINCT PART)								92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)								200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM								201
	ONLY CHARGES								
202	NET CHARGES (line 200 - line 201)								202

⁽A) Worksheet A line numbers

Optimizer Systems, Inc.

WinLASH

Micro System
Run Date: 05/23/2014 In Lieu of Form Period: RH OF NORTHWEST INDIANA, LLC Run Time: 08:11 Version: 2014.03 From: 02/01/2013 To: 01/31/2014 CMS-2552-10 Provider CCN: 15-2024

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-2024

WORKSHEET D-1 PART I

AP		PPS TEFRA OTHER								
PA	RT I - ALL PROVIDER COMPONENTS									
INPATIENT DAYS										
1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	13,381								
2		13,381								
	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3							
	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	13,381	_							
5			5							
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar		6							
	year, enter 0 on this line)									
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7							
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year,		8							
	enter 0 on this line)									
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	10,095	9							
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST		10							
<u> </u>	REPORTING PERIOD (see instructions)		+ -							
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) AFTER DECEMBER 31 OF THE COST		11							
	REPORTING PERIOD (if calendar year, enter 0 on this line)		+							
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) THROUGH DECEMBER 31 OF THE		12							
	COST REPORTING PERIOD SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) AFTER DECEMBER 31 OF THE COST									
13	REPORTING PERIOD (if calendar year, enter 0 on this line)		13							
14			14							
	TOTAL NURSERY DAYS (Title V or Title XIX only)		15							
	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)		16							
10	SWING-BED ADJUSTMENT SWING-BED ADJUSTMENT		10							
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17							
	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18							
	MEDICAID RATE FOR SWING-BED IN SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19							
	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20							
21		8.667.824								
22		0,007,02	22							
23			23							
	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 7 x line 19)		24							
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 8 x line 20)		25							
26	TOTAL SWING-BED COST (see instructions)		26							
27		8,667,824								
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		•							
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28							
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29							
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30							
31			31							
32			32							
	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33							
	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34							
35			35							
36			36							
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	8,667,824	1 37							

Win-LASH 2552-10

61

62

RELIEF PAYMENT (see instructions)

ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)

Page: 57 WinLASH Optimizer Systems, Inc. Micro System In Lieu of Form Run Date: 05/23/2014 Period: RH OF NORTHWEST INDIANA, LLC CMS-2552-10 Run Time: 08:11 From: 02/01/2013 Provider CCN: 15-2024 To: 01/31/2014 Version: 2014.03 COMPUTATION OF INPATIENT OPERATING COST COMPONENT CCN: 15-2024 WORKSHEET D-1 PART II CHECK [] TITLE V - I/P [XX] HOSPITAL [] SUB (OTHER) [XX] PPS APPLICABLE [XX] TITLE XVIII, PART A [] IPF] TEFRA 1 TITLE XIX - I/P 1 OTHER BOXES: 1 IRF [PART II - HOSPITALS AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions) 647.77 38 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38) 39 6,539,238 39 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (line 14 x line 35) 40 40 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 39 + line 40) 6 539 238 41 41 AVERAGE PROGRAM TOTAL TOTAL PER DIEM PROGRAM COST INPATIENT INPATIENT (col. 3 x (col. 1 ÷ DAYS COST DAYS col. 2) col. 4) NURSERY (Titles V and XIX only) 42 42 INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS 43 INTENSIVE CARE UNIT 43 CORONARY CARE UNIT 44 44 BURN INTENSIVE CARE UNIT 45 45 SURGICAL INTENSIVE CARE UNIT 46 46 OTHER SPECIAL CARE (SPECIFY) 47 47 PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200) 6,827,213 48 48 49 TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions) 13,366,451 49 PASS-THROUGH COST ADJUSTMENTS PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III) 50 733,301 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV) 605,350 51 1,338,651 52 52 TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51) TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION 53 12 027 800 53 COSTS (line 49 minus line 52) TARGET AMOUNT AND LIMIT COMPUTATION PROGRAM DISCHARGES 54 TARGET AMOUNT PER DISCHARGE 55 56 TARGET AMOUNT (line 54 x line 55) 56 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53) 57 58 BONUS PAYMENT (see instructions) 58 LESSER OF LINE 53 - LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET 59 59 60 LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET 60 IF LINE 53 ÷ 54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS 61

PROGRAM INPATIENT ROUTINE SWING BED COST MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title 64 64 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII 65 65 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions) 66 66 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19) 67 67 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20) 68 68 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68)

62

(line 53) ARE LESS THAN EXPECTED COSTS (line 54 x 60), OR 1% OF THE TARGET AMOUNT (line 56), OTHERWISE ENTER ZERO (see instructions)

 Optimizer Systems, Inc.
 Win L A S H
 Micro System

 RH OF NORTHWEST INDIANA, LLC
 In Lieu of Form CMS-2552-10
 Period: From: 02/01/2013 From: 02/01/2013 To: 01/31/2014
 Run Date: 05/23/2014 Run Time: 08:11

 Provider CCN: 15-2024
 To: 01/31/2014
 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-2024

WORKSHEET D-1
PARTS III & IV

CHECK [] TITLE V - I/P [XX] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS

APPLICABLE [XX] TITLE XVIII, PART A [] IPF [] SNF [] TEFRA

BOXES: [] TITLE XIX - I/P [] IRF [] NF [] OTHER

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)						87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)					647.77	88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)						89
		COST	ROUTINE COST (from line 27)	column 1 ÷ column 2	TOTAL OBSERV- ATION BED COST (from line89)	OBSERV- ATION BED PASS- THROUGH COST col. 3 x col. 4) (see instr- uctions	
		1	2	3	4	5	
90	CAPITAL-RELATED COST						90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

WinLASH Optimizer Systems, Inc.

Micro System
Run Date: 05/23/2014 In Lieu of Form Period: RH OF NORTHWEST INDIANA, LLC CMS-2552-10 From: 02/01/2013 Run Time: 08:11 Provider CCN: 15-2024 To: 01/31/2014 Version: 2014.03

co	MPUTATION OF INPATIENT OPERATING COST COMPONENT CCN: 15-2024	WORKSHEET D PART I		
ΑP		PPS TEFRA OTHER		
PA	RT I - ALL PROVIDER COMPONENTS INPATIENT DAYS			
1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	13,381	1	
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	13,381	_	
3	PRIVATE ROOM DAYS (excluding swing-bed private room days), IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.	13,361	3	
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	13,381		
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	10,001	5	
	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar			
6	year, enter 0 on this line)		6	
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7	
	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year,			
8	enter 0 on this line)		8	
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)		9	
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions)		10	
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) AFTER DECEMBER 31 OF THE COST		11	
	REPORTING PERIOD (if calendar year, enter 0 on this line) SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) THROUGH DECEMBER 31 OF THE		\vdash	
12	COST REPORTING PERIOD		12	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		13	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed days)		14	
	TOTAL NURSERY DAYS (Title V or Title XIX only)		15	
	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)		16	
	SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	8,667,824	21	
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 5 x line 17)		22	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 6 x line 18)		23	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 7 x line 19)		24	
	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 8 x line 20)		25	
26	TOTAL SWING-BED COST (see instructions)		26	
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	8,667,824	27	
20	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		T	
	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28	
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29	
	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30	
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31	
33	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3) AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33	
	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (life 30 – life 4) AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34	
24	A VENAGE FER DIEM FRI VATE ROOM CHARGE DITTERENTIAE (HIR 32 HIIIUS HIE 33) (SEE HISHUCUOIIS)		134	

35

8,667,824 37

35 AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)
36 PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)
37 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)

Win-LASH 2552-10

62

RELIEF PAYMENT (see instructions)

ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)

Page: 60 WinLASH Optimizer Systems, Inc. Micro System In Lieu of Form Run Date: 05/23/2014 Period: RH OF NORTHWEST INDIANA, LLC CMS-2552-10 Run Time: 08:11 From: 02/01/2013 Provider CCN: 15-2024 To: 01/31/2014 Version: 2014.03 COMPUTATION OF INPATIENT OPERATING COST COMPONENT CCN: 15-2024 WORKSHEET D-1 PART II CHECK 1 TITLE V - I/P [XX] HOSPITAL [] SUB (OTHER) [XX] PPS Γ APPLICABLE [] TITLE XVIII, PART A [] IPF] TEFRA [XX] TITLE XIX - I/P BOXES: 1 IRF 1 OTHER PART II - HOSPITALS AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions) 647.77 38 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38) 39 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (line 14 x line 35) 40 40 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 39 + line 40) 41 41 AVERAGE PROGRAM TOTAL TOTAL PER DIEM PROGRAM COST INPATIENT INPATIENT (col. 3 x (col. 1 ÷ DAYS COST DAYS col. 2) col. 4) NURSERY (Titles V and XIX only) 42 42 INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS 43 INTENSIVE CARE UNIT 43 CORONARY CARE UNIT 44 44 BURN INTENSIVE CARE UNIT 45 45 SURGICAL INTENSIVE CARE UNIT 46 46 OTHER SPECIAL CARE (SPECIFY) 47 47 PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200) 48 48 49 TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions) 49 PASS-THROUGH COST ADJUSTMENTS PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III) 50 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV) 51 52 TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51) 52 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION 53 53 COSTS (line 49 minus line 52) TARGET AMOUNT AND LIMIT COMPUTATION PROGRAM DISCHARGES 54 TARGET AMOUNT PER DISCHARGE 55 TARGET AMOUNT (line 54 x line 55) 56 56 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53) 57 58 BONUS PAYMENT (see instructions) 58 LESSER OF LINE 53 - LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET 59 59 60 LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET 60 IF LINE 53 ÷ 54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS 61 61 (line 53) ARE LESS THAN EXPECTED COSTS (line 54 x 60), OR 1% OF THE TARGET AMOUNT (line 56), OTHERWISE ENTER ZERO (see instructions)

PROGRAM INPATIENT ROUTINE SWING BED COST MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title 64 64 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII 65 65 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions) 66 66 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19) 67 67 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20) 68 68 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68)

62

 Optimizer Systems, Inc.
 Win LASH
 Micro System

 RH OF NORTHWEST INDIANA, LLC
 In Lieu of Form CMS-2552-10
 Period: From: 02/01/2013 Prom: 02/01/2013 Prom: 02/01/2014 Prom: 01/31/2014
 Run Date: 05/23/2014 Run Time: 08:11 Prom: 01/31/2014

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-2024

WORKSHEET D-1
PARTS III & IV

CHECK [] TITLE V - I/P [XX] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
APPLICABLE [] TITLE XVIII, PART A [] IPF [] SNF [] TEFRA
BOXES: [XX] TITLE XIX - I/P [] IRF [] NF [] OTHER

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)						87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)						88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)						89
		COST	ROUTINE COST (from line 27)	column 1 ÷ column 2	TOTAL OBSERV- ATION BED COST (from line89)	OBSERV- ATION BED PASS- THROUGH COST col. 3 x col. 4) (see instr- uctions	
		1	2	3	4	5	
90	CAPITAL-RELATED COST						90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

 Optimizer Systems, Inc.
 Win LASH
 Micro System

 RH OF NORTHWEST INDIANA, LLC
 In Lieu of Form CMS-2552-10
 Period: Run Date: 05/23/2014
 Run Date: 05/23/2014

 Provider CCN: 15-2024
 From: 02/01/2013
 Run Time: 08:11

 To: 01/31/2014
 Version: 2014.03

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT COMPONENT CCN: 15-2024 WORKSHEET D-3

CHECK	[] TITLE V - O/P	[XX] HOSPITAL	[] SUB (OTHER)	[] SWING BED SNF	[XX] PPS
APPLICABLE	[XX] TITLE XVIII, PART B	[] IPF	[] SNF	[] SWING BED NF	[] TEFRA
BOXES:	[] TITLE XIX - O/P	[] IRF	[] NF	[] ICF/MR	[] OTHER

		RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS		19,492,484		30
43	NURSERY				43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.510833	860,731	439,690	50
54	RADIOLOGY-DIAGNOSTIC	0.174778	920,941	160,960	54
60	LABORATORY	0.196536	4,418,769	868,447	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.125788	8,208,119	1,032,483	65
66	PHYSICAL THERAPY	0.407501	602,236	245,412	66
67	OCCUPATIONAL THERAPY	0.208031	1,324,428	275,522	67
68	SPEECH PATHOLOGY	0.485690	178,414	86,654	68
69	ELECTROCARDIOLOGY	0.021890	1,114,770	24,402	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.297269	5,093,926	1,514,266	71
73	DRUGS CHARGED TO PATIENTS	0.169904	10,972,305	1,864,239	73
74	RENAL DIALYSIS	0.256605	1,228,106	315,138	74
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
92	OBSERVATION BEDS (NON-DISTINCT PART)				92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		34,922,745	6,827,213	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		34,922,745		202

⁽A) Worksheet A line numbers

Optimizer Systems, Inc.

WinLASH

Micro System
Run Date: 05/23/2014 In Lieu of Form Period: RH OF NORTHWEST INDIANA, LLC From: 02/01/2013 To: 01/31/2014 CMS-2552-10 Run Time: 08:11 Provider CCN: 15-2024 Version: 2014.03

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 15-2024 WORKSHEET D-3

CHECK	[] TITLE V - O/P	[X3	[]	HOSPITAL	[]	SUB (OTHER)	[]	SWING BED SNF	[X	[X	PPS
APPLICABLE	[] TITLE XVIII, PART B	[1	IPF	[]	SNF	[]	SWING BED NF	[]	TEFRA
BOXES:	[XX] TITLE XIX - O/P	[]	IRF	[]	NF	[]	ICF/MR	[]	OTHER

	COST GENTER DESCRIPTION	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	<u>Z</u>	3	_
20	INPATIENT ROUTINE SERVICE COST CENTERS				20
30	ADULTS & PEDIATRICS				30
	ANCILLARY SERVICE COST CENTERS	0.510022			50
50	OPERATING ROOM	0.510833			50
54	RADIOLOGY-DIAGNOSTIC	0.174778			54
60	LABORATORY NAME OF THE PARTY O	0.196536			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.125788			65
66	PHYSICAL THERAPY	0.407501			66
67	OCCUPATIONAL THERAPY	0.208031			67
68	SPEECH PATHOLOGY	0.485690			68
69	ELECTROCARDIOLOGY	0.021890			69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.297269			71
73	DRUGS CHARGED TO PATIENTS	0.169904			73
74	RENAL DIALYSIS	0.256605			74
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
92	OBSERVATION BEDS (NON-DISTINCT PART)				92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)				200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)				202

(A) Worksheet A line numbers

Optimizer Systems, Inc.

WinLASH

Micro System
Run Date: 05/23/2014 In Lieu of Form Period: RH OF NORTHWEST INDIANA, LLC CMS-2552-10 From: 02/01/2013 Run Time: 08:11 Provider CCN: 15-2024 To: 01/31/2014 Version: 2014.03

CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-2024

WORKSHEET E PART B

CHECK APPLICABLE BOX: [XX] HOSPITAL [] IPF [] IRF [] SUB (OTHER) [] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

				1	
	MEDICAL AND OTHER CENTRES (1	1.01	1.02	1
1	MEDICAL AND OTHER SERVICES (see instructions)				-
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (see instructions) PPS PAYMENTS			<u> </u>	3
3	OUTLIER PAYMENT (see instructions)				4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (see instructions)				5
6	LINE 2 TIMES LINE 5				6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6				7 8
9	TRANSITIONAL CORRIDOR PAYMENT (see instructions) ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200				9
10					
_	ORGAN ACQUISITION				10
11	TOTAL COST (sum of lines 1 and 10) (see instructions)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
12	REASONABLE CHARGES				10
12	ANCILLARY SERVICE CHARGES				12
13	ORGAN ACQUISITION CHARGES (from Wkst D-4, Part III, line 69, col. 4)				13
14	TOTAL REASONABLE CHARGES (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR				15
	SERVICES ON A CHARGE BASIS				
	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR				
16	SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR				16
	413.13(e)				
17	RATIO OF LINE 15 TO LINE 16 (not to exceed 1.000000)	1.000000			17
18	TOTAL CUSTOMARY CHARGES (see instructions)				18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see				19
17	instructions)				17
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 11 exceeds line 18 (see				20
	instructions)				
21	LESSER OF COST OR CHARGES (line 11 minus line 20) (for CAH, see instructions)				21
22	INTERNS AND RESIDENTS (see instructions)				22
23	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)				23
24	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	DEDUCTIBLES AND COINSURANCE (see instructions)				25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)				26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)				27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Wkst E-4, line 50)				28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (from Wkst E-4, line 36)				29
30	SUBTOTAL (sum of lines 27 through 29)				30
31	PRIMARY PAYER PAYMENTS				31
32	SUBTOTAL (line 30 minus line 31)				32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	COMPOSITE RATE ESRD (from Wkst I-5, line 11)				33
34	ALLOWABLE BAD DEBTS (see instructions)				34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)				35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)				36
37	SUBTOTAL (see instructions)				37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R				38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				39
40	SUBTOTAL (see instructions)				40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)				40.01
41	INTERIM PAYMENTS				41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)				43
	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION				
44	115.2				44

TO BE COMPLETED BY CONTRACTOR

90	ORIGINAL OUTLIER AMOUNT (see instructions)		90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (see instructions)		91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY		92
93	TIME VALUE OF MONEY (see instructions)		93
94	TOTAL (sum of lines 91 and 93)		94

Optimizer Systems, Inc.

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Micro System
Run Date: 05/23/2014

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 15-2024

WORKSHEET E-1 PART I

CHECK [XX] HOSPITAL [] SUB (OTHER)
APPLICABLE [] IPF [] SNF
BOXES: [] IRF [] SWING BED SNF

		INPATIENT PART A		PAR'	ТВ			
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				14,833,959			1
	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUI	BMITTED OR TO	O BE		21,000,707			
2	SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN							2
_	REPORTING PERIOD. If NONE, WRITE 'NONE' OR ENTER A ZERO	1112 0001						
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT		.01	12/19/2013	861,577			3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM		.02	12/17/2015	001,077			3.02
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF	PROGRAM	.03					3.03
	EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	TO	.04					3.04
	Exercise the first that the first of the first terms (1)	PROVIDER	.05					3.05
		THOTEL	.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51	08/02/2013	1,895,666			3.51
		PROVIDER	.52	00/02/2013	1,0/5,000			3.52
		TO	.53					3.53
		PROGRAM	.54					3.54
		TROOKAW	.55					3.55
\dashv			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99		-1,034,089			3.99
	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99)		.,,,					
4	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				13,799,870			4
	(transfer to which 2 of which 2 of mic and column as appropriate)							
	TO BE COMPLETED BY CONTRACTOR							
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT		.01					5.01
_	AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT.		.02					5.02
	IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	PROGRAM	.03					5.03
		TO	.04					5.04
		PROVIDER	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		PROVIDER	.52					5.52
		TO	.53					5.53
		PROGRAM	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	DETERMINED NET SETTLEMENT AMOUNT (balance due)		.01					6.01
	BASED ON THE COST REPORT (1)		.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)							7
8	NAME OF CONTRACTOR		•	CONTRACTOR NU	JMBER	NPR DATE (Month/	Day/Year)	8
				1		1		

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

Win-LASH 2552-10

Optimizer Systems, Inc.

WinLASH

Page: 66

Period:

Micro System
Run Date: 05/23/2014

RH OF NORTHWEST INDIANA, LLC
Provider CCN: 15-2024

In Lieu of Form
CMS-2552-10

From: 02/01/2013 Run Time: 08:11
To: 01/31/2014 Version: 2014.03

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1 PART II

CHECK [XX] HOSPITAL [] CAH

APPLICABLE BOX:

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

THE TORRIGHT TECHNOLOGY BITTH COERECTION AND CHECCENTION		
TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14		1
MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12		2
MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2		3
TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	13,381	4
TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200		5
TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20		6
CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I,		7
LINE 168		i '
CALCULATION OF THE HIT INCENTIVE PAYMENT (see instructions)		8
SEQUESTRATION ADJUSTMENT AMOUNT (see instructions)		9
CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (see instructions)		10
	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14 MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12 MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2 TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, SUM OF LINES 1, 8-12 TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200 TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20 CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168 CALCULATION OF THE HIT INCENTIVE PAYMENT (see instructions) SEQUESTRATION ADJUSTMENT AMOUNT (see instructions)	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14 MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12 MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2 TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, SUM OF LINES 1, 8-12 TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200 TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20 CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168 CALCULATION OF THE HIT INCENTIVE PAYMENT (see instructions) SEQUESTRATION ADJUSTMENT AMOUNT (see instructions)

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

	30	INITIAL/INTERIM HIT PAYMENT(S)	30
ſ	31	OTHER ADJUSTMENTS ()	31
	32	BALANCE DUE PROVIDER (line 8 (or line 10) minus line 30 and line 31) (see instructions)	32

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Run Time: 08:11 Version: 2014.03

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3 PART IV

CHECK APPLICABLE BOX: [XX] HOSPITAL

PART IV - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER LTCH PPS

1	NET FEDERAL PPS PAYMENT (see instructions)	14,523,168	1
2	OUTLIER PAYMENTS	190,934	2
3	TOTAL PPS PAYMENTS (sum of lines 1 and 2)	14,714,102	3
4	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENTS (see instructions)		4
5	DO NOT USE THIS LINE		5
6	COST OF TEACHING PHYSICIANS		6
7	SUBTOTAL (see instructions)	14,714,102	7
8	PRIMARY PAYER PAYMENTS		8
9	SUBTOTAL (line 7 less line 8)	14,714,102	9
10	DEDUCTIBLES	20,206	10
11	SUBTOTAL (line 9 minus line 10)	14,693,896	11
12	COINSURANCE	896,987	12
13	SUBTOTAL (line 11 minus line 12)	13,796,909	13
14	ALLOWABLE BAD DEBTS (exclude bad debts for professional services) (see instructions)	442,587	14
15	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	287,682	15
16	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	340,896	16
17	SUBTOTAL (sum of lines 13 and 15)	14,084,591	17
18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4, line 49) (for freestanding LTCH only)		18
19	OTHER PASS THROUGH COSTS (see instructions)		19
20	OUTLIER PAYMENTS RECONCILIATION		20
21	OTHER ADJUSTMENTS (SPECIFY) (see instructions)		21
21.01	SEQUESTRATION TRU UP	-402	21.01
22	TOTAL AMOUNT PAYABLE TO THE PROVIDER (see instructions)	14,084,189	22
22.01	SEQUESTRATION ADJUSTMENT (see instructions)	236,614	22.01
23	INTERIM PAYMENTS	13,799,870	23
24	TENTATIVE SETTLEMENT (for contractor use only)		24
25	BALANCE DUE PROVIDER/PROGRAM (line 22 minus lines 22.01, 23 and 24)	47,705	25
26	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		26

TO BE	COMPLETED BY CONTRACTOR	
50	ORIGINAL PPS PAYMENT AND OUTLIER AMOUNT FROM WORKSHEET E-3, PART IV, LINE 3 (see instructions)	50
51	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (see instructions)	51
52	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (see instructions)	52
53	TIME VALUE OF MONEY (see instructions)	53

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•	In Lieu of Form	Period :	Run Date: 05/23/2014
RH OF NORTHWEST INDIANA, LLC	CMS-2552-10	From: 02/01/2013	Run Time: 08:11
Provider CCN: 15-2024		To: 01/31/2014	Version: 2014.03

CALCULATION OF REIMBURSEMENT SETTLEMENT COMPONENT CCN: 15-2024 WORKSHEET E-3
PART VII

CHECK	[]	TITLE	v	[XX	[]	HOSE	217	TAL	[1	NF	[XX]	PPS
APPLICABLE	[X	X]	TITLE	XIX	[1	SUB	((OTHER)	[1	ICF/MR	[]	TEFRA
BOXES:					[1	SNF						[1	OTHER

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

		INPATIENT	OUTPAT-	!
		TITLE V	IENT	!
		OR	TITLE V	!
		TITLE XIX	OR	!
		IIILE AIA	TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	INPATIENT HOSPITAL SNF/NF SERVICES			1
2	MEDICAL AND OTHER SERVICES			2
3	ORGAN ACQUISITION (certified transplant centers only)			3
4	SUBTOTAL (sum of lines 1, 2 and 3)			4
5	INPATIENT PRIMARY PAYER PAYMENTS			5
6	OUTPATIENT PRIMARY PAYER PAYMENTS			6
7	SUBTOTAL (line 4 less sum of lines 5 and 6)			7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			\perp
8	ROUTINE SERVICE CHARGES			8
9	ANCILLARY SERVICE CHARGES			9
10	ORGAN ACQUISITION CHARGES, NET OF REVENUE			10
11	INCENTIVE FROM TARGET AMOUNT COMPUTATION	-		11
12	TOTAL REASONABLE CHARGES (sum of lines 8-11)			12
	CUSTOMARY CHARGES			\perp
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			13
14	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE			14
	BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)			
15	RATIO OF LINE 13 TO LINE 14 (not to exceed 1.000000)	1	1	
16	TOTAL CUSTOMARY CHARGES (see instructions)			16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 16 exceeds line 4) (see instructions)			17
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 4 exceeds line 16) (see instructions)			18
19	INTERNS AND RESIDENTS (see instructions)			19
20	COST OF TEACHING PHYSICIANS (see instructions)			20
21	COST OF COVERED SERVICES (lesser of line 4 or line 16) (for CAH, see instructions)			21
	PROSPECTIVE PAYMENT AMOUNT			
22	OTHER THAN OUTLIER PAYMENTS			22
23	OUTLIER PAYMENTS			23
24	PROGRAM CAPITAL PAYMENTS			24
25	CAPITAL EXCEPTION PAYMENTS (see instructions)			25
26	ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS			26
27	SUBTOTAL (sum of lines 22 through 26)			27
28	CUSTOMARY CHARGES (Titles V or XIX PPS covered services only)			28
29	SUM OF LINES 27 AND 21	1		29
20	COMPUTATION OF REIMBURSEMENT SETTLEMENT			120
30	EXCESS OF REASONABLE COST (from line 18)			30
31	SUBTOTAL (sum of lines 19 and 20 plus 29 minus lines 5 and 6)			31
32	DEDUCTIBLES CONSULDANCE			32
33	COINSURANCE ALLOWABLE BAD DEBTS (con instructions)	1		34
35	ALLOWABLE BAD DEBTS (see instructions) UTILIZATION REVIEW			35
36	SUBTOTAL (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)			36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	SUBTOTAL (line 36 ± line 37)			38
				39
39 40	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4)			
40	TOTAL AMOUNT PAYABLE TO THE PROVIDER (sum of lines 38 and 39)			40
41	INTERIM PAYMENTS BALANCE DUE PROVIDER/PROGRAM (line 40 minus 41)			41 42
42	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2	1		42
+3	1 KOTESTED AWOONTS (nonanowable cost report nemis) in ACCONDANCE WITH CWS FOR 13-2, SECTION 113.2	1	ļ	143

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Micro System
Run Date: 05/23/2014

RH OF NORTHWEST INDIANA, LLC Provider CCN: 15-2024 In Lieu of Form CMS-2552-10

Period : From: 02/01/2013 To: 01/31/2014

Run Time: 08:11 Version: 2014.03

BALANCE SHEET WORKSHEET G

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

	ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
	(Omit Cents)	1	2	3	4	
1	CURRENT ASSETS CASH ON HAND AND IN BANKS					1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	1,579,824				4
5	OTHER RECEIVABLES					5
7	ALLOWANCES FOR UNCOLLECTIBLE NOTES AND ACCOUNTS RECEIVABLE	-238,067				7
8	INVENTORY PREPAID EXPENSES	25,327				8
9	OTHER CURRENT ASSETS	133,666				9
10	DUE FROM OTHER FUNDS					10
11	TOTAL CURRENT ASSETS (sum of lines 1-10)	1,500,750				11
	FIXED ASSETS					1.0
2	LAND					12
13	LAND IMPROVEMENTS ACCUMULATED DEPRECIATION					13
5	BUILDINGS	241,274				15
6	ACCUMULATED DEPRECIATION	-241,274				16
7	LEASEHOLD IMPROVEMENTS	241,180				17
8	ACCUMULATED AMORTIZATION					18
9	FIXED EQUIPMENT		·			19
20	ACCUMULATED DEPRECIATION					20
21	AUTOMOBILES AND TRUCKS					21
22	ACCUMULATED DEPRECIATION MAJOR MOVARI E FOURMENT	927 701				22
23 24	MAJOR MOVABLE EQUIPMENT ACCUMULATED DEPRECIATION	837,701 -521,224				23
25	MINOR EQUIPMENT DEPRECIABLE	-321,224				25
26	ACCUMULATED DEPRECIATION					26
27	HIT DESIGNATED ASSETS					27
28	ACCUMULATED DEPRECIATION					28
9	MINOR EQUIPMENT-NONDEPRECIABLE					29
80	TOTAL FIXED ASSETS (sum of lines 12-29)	557,657				30
	OTHER ASSETS					1 24
31 32	INVESTMENTS DEPOSITS ON LEASES					31
33	DUE FROM OWNERS/OFFICERS	7,620,907				33
34	OTHER ASSETS	16,538,105				34
35	TOTAL OTHER ASSETS (sum of lines 31-34)	24,159,012				35
36	TOTAL ASSETS (sum of lines 11, 30 and 35)	26,217,419				36
		GENERAL	SPECIFIC PURPOSE	ENDOWMENT	PLANT	
	LIABILITIES AND FUND BALANCES	FUND	PURPOSE FUND	FUND	FUND	
	(Omit Cents)		PURPOSE			
7	(Omit Cents) CURRENT LIABILITIES	FUND 1	PURPOSE FUND	FUND	FUND	27
	(Omit Cents) CURRENT LIABILITIES ACCOUNTS PAYABLE	FUND 1 521,611	PURPOSE FUND	FUND	FUND	37
8	(Omit Cents) CURRENT LIABILITIES ACCOUNTS PAYABLE SALARIES, WAGES & FEES PAYABLE	FUND 1	PURPOSE FUND	FUND	FUND	38
88 89	(Omit Cents) CURRENT LIABILITIES ACCOUNTS PAYABLE	FUND 1 521,611	PURPOSE FUND	FUND	FUND	_
88 89 10	(Omit Cents) CURRENT LIABILITIES ACCOUNTS PAYABLE SALARIES, WAGES & FEES PAYABLE PAYROLL TAXES PAYABLE	FUND 1 521,611	PURPOSE FUND	FUND	FUND	38 39
88 89 40	(Omit Cents) CURRENT LIABILITIES ACCOUNTS PAYABLE SALARIES, WAGES & FEES PAYABLE PAYROLL TAXES PAYABLE NOTES & LOANS PAYABLE (short term)	FUND 1 521,611	PURPOSE FUND	FUND	FUND	38 39 40
88 89 40 41 42 43	(Omit Cents) CURRENT LIABILITIES ACCOUNTS PAYABLE SALARIES, WAGES & FEES PAYABLE PAYROLL TAXES PAYABLE NOTES & LOANS PAYABLE (short term) DEFERRED INCOME ACCELERATED PAYMENTS DUE TO OTHER FUNDS	FUND 1 521,611	PURPOSE FUND	FUND	FUND	38 39 40 41 42 43
8 9 0 1 -2 -3 4	(Omit Cents) CURRENT LIABILITIES ACCOUNTS PAYABLE SALARIES, WAGES & FEES PAYABLE PAYROLL TAXES PAYABLE NOTES & LOANS PAYABLE (short term) DEFERRED INCOME ACCELERATED PAYMENTS DUE TO OTHER FUNDS OTHER CURRENT LIABILITIES	FUND 1 521,611 293,523 2,805,072	PURPOSE FUND	FUND	FUND	38 39 40 41 42 43 44
337 388 39 40 41 42 43 44 44 45	(Omit Cents) CURRENT LIABILITIES ACCOUNTS PAYABLE SALARIES, WAGES & FEES PAYABLE PAYROLL TAXES PAYABLE NOTES & LOANS PAYABLE (short term) DEFERRED INCOME ACCELERATED PAYMENTS DUE TO OTHER FUNDS	FUND 1 521,611 293,523	PURPOSE FUND	FUND	FUND	38 39 40 41 42 43
88 89 40 41 42 43 44 45	CURRENT LIABILITIES ACCOUNTS PAYABLE SALARIES, WAGES & FEES PAYABLE PAYROLL TAXES PAYABLE NOTES & LOANS PAYABLE (short term) DEFERRED INCOME ACCELERATED PAYMENTS DUE TO OTHER FUNDS OTHER CURRENT LIABILITIES TOTAL CURRENT LIABILITIES (sum of lines 37 thru 44) LONG TERM LIABILITIES MORTGAGE PAYABLE	FUND 1 521,611 293,523 2,805,072	PURPOSE FUND	FUND	FUND	38 39 40 41 42 43 44 45
88 89 40 41 42 43 44	CURRENT LIABILITIES ACCOUNTS PAYABLE SALARIES, WAGES & FEES PAYABLE PAYROLL TAXES PAYABLE NOTES & LOANS PAYABLE (short term) DEFERRED INCOME ACCELERATED PAYMENTS DUE TO OTHER FUNDS OTHER CURRENT LIABILITIES TOTAL CURRENT LIABILITIES (sum of lines 37 thru 44) LONG TERM LIABILITIES MORTGAGE PAYABLE NOTES PAYABLE	FUND 1 521,611 293,523 2,805,072	PURPOSE FUND	FUND	FUND	38 39 40 41 42 43 44 45
8 9 0 1 -2 -3 -4 -5	CURRENT LIABILITIES ACCOUNTS PAYABLE SALARIES, WAGES & FEES PAYABLE PAYROLL TAXES PAYABLE NOTES & LOANS PAYABLE (short term) DEFERRED INCOME ACCELERATED PAYMENTS DUE TO OTHER FUNDS OTHER CURRENT LIABILITIES TOTAL CURRENT LIABILITIES (sum of lines 37 thru 44) LONG TERM LIABILITIES MORTGAGE PAYABLE	FUND 1 521,611 293,523 2,805,072	PURPOSE FUND	FUND	FUND	38 39 40 41 42 43 44 45
8 9 0 1 1 2 3 4 5 6 7 8 9 0	CURRENT LIABILITIES ACCOUNTS PAYABLE SALARIES, WAGES & FEES PAYABLE PAYROLL TAXES PAYABLE NOTES & LOANS PAYABLE (short term) DEFERRED INCOME ACCELERATED PAYMENTS DUE TO OTHER FUNDS OTHER CURRENT LIABILITIES TOTAL CURRENT LIABILITIES (sum of lines 37 thru 44) LONG TERM LIABILITIES MORTGAGE PAYABLE NOTES PAYABLE UNSECURED LOANS OTHER LONG TERM LIABILITIES TOTAL LONG TERM LIABILITIES	FUND 1 521,611 293,523 2,805,072 3,620,206	PURPOSE FUND	FUND	FUND	38 39 40 41 42 43 44 45 46 47 48 49 50
8 9 0 1 2 2 3 4 5 6 7 8 9 0	CURRENT LIABILITIES ACCOUNTS PAYABLE SALARIES, WAGES & FEES PAYABLE PAYROLL TAXES PAYABLE NOTES & LOANS PAYABLE (short term) DEFERRED INCOME ACCELERATED PAYMENTS DUE TO OTHER FUNDS OTHER CURRENT LIABILITIES TOTAL CURRENT LIABILITIES (sum of lines 37 thru 44) LONG TERM LIABILITIES MORTGAGE PAYABLE NOTES PAYABLE UNSECURED LOANS OTHER LONG TERM LIABILITIES TOTAL LONG TERM LIABILITIES TOTAL LONG TERM LIABILITIES TOTAL LONG TERM LIABILITIES (sum of lines 46 thru 49) TOTAL LIABILITIES (sum of lines 45 and 50)	FUND 1 521,611 293,523 2,805,072	PURPOSE FUND	FUND	FUND	38 39 40 41 42 43 44 45 46 47 48 49
8 9 0 1 2 3 4 5 5 6 6 7 8 8 9 0 0	CURRENT LIABILITIES ACCOUNTS PAYABLE SALARIES, WAGES & FEES PAYABLE PAYROLL TAXES PAYABLE NOTES & LOANS PAYABLE (short term) DEFERRED INCOME ACCELERATED PAYMENTS DUE TO OTHER FUNDS OTHER CURRENT LIABILITIES TOTAL CURRENT LIABILITIES (sum of lines 37 thru 44) LONG TERM LIABILITIES MORTGAGE PAYABLE NOTES PAYABLE UNSECURED LOANS OTHER LONG TERM LIABILITIES TOTAL LONG TERM LIABILITIES TOTAL LONG TERM LIABILITIES TOTAL LONG TERM LIABILITIES (sum of lines 46 thru 49) TOTAL LIABILITIES (sum of lines 45 and 50) CAPITAL ACCOUNTS	521,611 293,523 2,805,072 3,620,206	PURPOSE FUND	FUND	FUND	38 39 40 41 42 43 44 45 46 47 48 49 50 51
8 9 0 1 2 3 4 5 6 7 8 9 0 0 1 1 2 2 3 1 1 1 1 2 1 1 1 1 1 1 1 1 1 1	CURRENT LIABILITIES ACCOUNTS PAYABLE SALARIES, WAGES & FEES PAYABLE PAYROLL TAXES PAYABLE NOTES & LOANS PAYABLE (short term) DEFERRED INCOME ACCELERATED PAYMENTS DUE TO OTHER FUNDS OTHER CURRENT LIABILITIES TOTAL CURRENT LIABILITIES (sum of lines 37 thru 44) LONG TERM LIABILITIES MORTGAGE PAYABLE UNSECURED LOANS OTHER LONG TERM LIABILITIES TOTAL LONG TERM LIABILITIES TOTAL LONG TERM LIABILITIES TOTAL LONG TERM LIABILITIES TOTAL LONG TERM LIABILITIES (sum of lines 46 thru 49) TOTAL LIABILITIES (sum of lines 45 and 50) CAPITAL ACCOUNTS GENERAL FUND BALANCE	FUND 1 521,611 293,523 2,805,072 3,620,206	PURPOSE FUND	FUND	FUND	38 39 40 41 42 43 44 45 46 47 48 49 50 51
8 9 0 1 2 3 4 4 5 6 7 8 9 0 1 1	CURRENT LIABILITIES ACCOUNTS PAYABLE SALARIES, WAGES & FEES PAYABLE PAYROLL TAXES PAYABLE NOTES & LOANS PAYABLE (short term) DEFERRED INCOME ACCELERATED PAYMENTS DUE TO OTHER FUNDS OTHER CURRENT LIABILITIES TOTAL CURRENT LIABILITIES (sum of lines 37 thru 44) LONG TERM LIABILITIES MORTGAGE PAYABLE NOTES PAYABLE UNSECURED LOANS OTHER LONG TERM LIABILITIES TOTAL LONG TERM LIABILITIES TOTAL LONG TERM LIABILITIES COTHER LONG TERM LIABILITIES TOTAL LONG TERM LIABILITIES TOTAL LONG TERM LIABILITIES TOTAL LONG TERM LIABILITIES (sum of lines 46 thru 49) TOTAL LIABILITIES (sum of lines 45 and 50) CAPITAL ACCOUNTS GENERAL FUND BALANCE	521,611 293,523 2,805,072 3,620,206	PURPOSE FUND	FUND	FUND	38 39 40 41 42 43 44 45 46 47 48 49 50 51
8 9 0 1 2 3 4 5 6 7 7 8 9 9 0 0 1 1 2 3 4 4 5 9 0 0 1 1 1 1 2 3 4 4 4 1 2 3 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	CURRENT LIABILITIES ACCOUNTS PAYABLE SALARIES, WAGES & FEES PAYABLE PAYROLL TAXES PAYABLE NOTES & LOANS PAYABLE (short term) DEFERRED INCOME ACCELERATED PAYMENTS DUE TO OTHER FUNDS OTHER CURRENT LIABILITIES TOTAL CURRENT LIABILITIES (sum of lines 37 thru 44) LONG TERM LIABILITIES MORTGAGE PAYABLE NOTES PAYABLE UNSECURED LOANS OTHER LONG TERM LIABILITIES TOTAL LONG TERM LIABILITIES (sum of lines 46 thru 49) TOTAL LIABILITIES (sum of lines 45 and 50) CAPITAL ACCOUNTS GENERAL FUND BALANCE SPECIFIC PURPOSE FUND BALANCE DONOR CREATED - ENDOWMENT FUND BALANCE - RESTRICTED	521,611 293,523 2,805,072 3,620,206	PURPOSE FUND	FUND	FUND	38 39 40 41 42 43 44 45 46 47 48 49 50 51
8 9 0 1 2 3 4 5 6 7 8 9 0 1 1 2 3 4 5 1 1 1 2 3 3 4 4 5 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	CURRENT LIABILITIES ACCOUNTS PAYABLE SALARIES, WAGES & FEES PAYABLE PAYROLL TAXES PAYABLE NOTES & LOANS PAYABLE (short term) DEFERRED INCOME ACCELERATED PAYMENTS DUE TO OTHER FUNDS OTHER CURRENT LIABILITIES TOTAL CURRENT LIABILITIES (sum of lines 37 thru 44) LONG TERM LIABILITIES MORTGAGE PAYABLE NOTES PAYABLE UNSECURED LOANS OTHER LONG TERM LIABILITIES TOTAL LONG TERM LIABILITIES CAPITAL ACCOUNTS GENERAL FUND BALANCE DONOR CREATED - ENDOWMENT FUND BALANCE - RESTRICTED DONOR CREATED - ENDOWMENT FUND BALANCE - UNRESTRICTED	521,611 293,523 2,805,072 3,620,206	PURPOSE FUND	FUND	FUND	38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55
8 9 0 1 2 3 4 5 6 7 8 9 0 1 1 2 3 4 5 1 1 2 3 4 5 1 1 1 1 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1	CURRENT LIABILITIES ACCOUNTS PAYABLE SALARIES, WAGES & FEES PAYABLE PAYROLL TAXES PAYABLE NOTES & LOANS PAYABLE (short term) DEFERRED INCOME ACCELERATED PAYMENTS DUE TO OTHER FUNDS OTHER CURRENT LIABILITIES TOTAL CURRENT LIABILITIES (sum of lines 37 thru 44) LONG TERM LIABILITIES MORTGAGE PAYABLE UNSECURED LOANS OTHER LONG TERM LIABILITIES TOTAL LONG TERM LIABILITIES TOTAL LONG TERM LIABILITIES GONG TERM LONG TERM LIABILITIES TOTAL LONG TERM LIABILITIES (sum of lines 46 thru 49) TOTAL LIABILITIES (sum of lines 45 and 50) CAPITAL ACCOUNTS GENERAL FUND BALANCE SPECIFIC PURPOSE FUND BALANCE DONOR CREATED - ENDOWMENT FUND BALANCE - UNRESTRICTED DONOR CREATED - ENDOWMENT FUND BALANCE	521,611 293,523 2,805,072 3,620,206	PURPOSE FUND	FUND	FUND	38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56
88 199 100 111 122 133 144 155 166 177 188 199 100 111 122 133 144 155 166 177 177 178 178 178 178 178 178	CURRENT LIABILITIES ACCOUNTS PAYABLE SALARIES, WAGES & FEES PAYABLE PAYROLL TAXES PAYABLE NOTES & LOANS PAYABLE (short term) DEFERRED INCOME ACCELERATED PAYMENTS DUE TO OTHER FUNDS OTHER CURRENT LIABILITIES TOTAL CURRENT LIABILITIES (sum of lines 37 thru 44) LONG TERM LIABILITIES MORTGAGE PAYABLE NOTES PAYABLE UNSECURED LOANS OTHER LONG TERM LIABILITIES TOTAL LONG TERM LIABILITIES CAPITAL ACCOUNTS GENERAL FUND BALANCE DONOR CREATED - ENDOWMENT FUND BALANCE - RESTRICTED DONOR CREATED - ENDOWMENT FUND BALANCE - UNRESTRICTED	521,611 293,523 2,805,072 3,620,206	PURPOSE FUND	FUND	FUND	38 39 40 41 42 43 44 45 50 51 52 53 54 55 56 57
188 190 111 121 131 141 151 161 17	CURRENT LIABILITIES ACCOUNTS PAYABLE SALARIES, WAGES & FEES PAYABLE PAYROLL TAXES PAYABLE NOTES & LOANS PAYABLE (short term) DEFERRED INCOME ACCELERATED PAYMENTS DUE TO OTHER FUNDS OTHER CURRENT LIABILITIES TOTAL CURRENT LIABILITIES (sum of lines 37 thru 44) LONG TERM LIABILITIES MORTGAGE PAYABLE NOTES PAYABLE UNSECURED LOANS OTHER LONG TERM LIABILITIES TOTAL LONG TERM LIABILITIES TOTAL LONG TERM LIABILITIES CHARLE (sum of lines 45 and 50) CAPITAL ACCOUNTS GENERAL FUND BALANCE SPECIFIC PURPOSE FUND BALANCE DONOR CREATED - ENDOWMENT FUND BALANCE - RESTRICTED DONOR CREATED - ENDOWMENT FUND BALANCE PLANT FUND BALANCE PLANT FUND BALANCE PLANT FUND BALANCE PLANT FUND BALANCE - INVESTED IN PLANT	521,611 293,523 2,805,072 3,620,206	PURPOSE FUND	FUND	FUND	38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56

Optimizer Systems, Inc.

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In Lieu of Form RH OF NORTHWEST INDIANA, LLC CMS-2552-10 Provider CCN: 15-2024

Period: From: 02/01/2013 To: 01/31/2014 Micro System
Run Date: 05/23/2014
Run Time: 08:11 Version: 2014.03

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

		GENERA	AL FUND	SPECIFIC PU	RPOSE FUND	
		1	2	3	4	
1	FUND BALANCES AT BEGINNING OF PERIOD		22,617,586			1
2	NET INCOME (loss) (from Worksheet G-3, line 29)		-20,373			2
3	TOTAL (sun of line 1 and line 2)		22,597,213			3
4	ADDITIONS (credit adjustments)					4
5	FUND BALANCE RECON					5
6						6
7						7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)					10
11	SUBTOTAL (line 3 plus line 10)		22,597,213			11
12	DEDUCTIONS (debit adjustments)					12
13						13
14						14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)					18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)		22,597,213			19

		ENDOW	MENT FUND	PLAN	T FUND	
		5	6	7	8	
1	FUND BALANCES AT BEGINNING OF PERIOD					1
2	NET INCOME (loss) (from Worksheet G-3, line 29)					2
3	TOTAL (sun of line 1 and line 2)					3
4	ADDITIONS (credit adjustments)					4
5	FUND BALANCE RECON					5
6						6
7						7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)					10
11	SUBTOTAL (line 3 plus line 10)					11
12	DEDUCTIONS (debit adjustments)					12
13						13
14						14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)					18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)					19

Optimizer Systems, Inc.

WinLASH

Micro System
Run Date: 05/23/2014

RH OF NORTHWEST INDIANA, LLC Provider CCN: 15-2024 In Lieu of Form CMS-2552-10

Period : From: 02/01/2013 To: 01/31/2014

Run Time: 08:11 Version: 2014.03

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2 PARTS I & II

PART I - PATIENT REVENUES

		INPATIENT	OUTPATIENT	TOTAL	
	REVENUE CENTER	1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	HOSPITAL	25,993,282		25,993,282	1
2	SUBPROVIDER IPF				2
3	SUBPROVIDER IRF				3
5	SWING BED - SNF				5
6	SWING BED - NF				6
7	SKILLED NURSING FACILITY				7
8	NURSING FACILITY				8
9	OTHER LONG TERM CARE				9
10	TOTAL GENERAL INPATIENT CARE SERVICES (sum of lines 1-9)	25,993,282		25,993,282	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	INTENSIVE CARE UNIT				11
12	CORONARY CARE UNIT				12
13	BURN INTENSIVE CARE UNIT				13
14	SURGICAL INTENSIVE CARE UNIT				14
15	OTHER SPECIAL CARE (SPECIFY)				15
16	TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (sum of lines 11-15)				16
17	TOTAL INPATIENT ROUTINE CARE SERVICES (sum of lines 10 and 16)	25,993,282		25,993,282	17
18	ANCILLARY SERVICES	46,594,704		46,594,704	18
19	OUTPATIENT SERVICES				19
20	RHC				20
21	FQHC				21
22	HOME HEALTH AGENCY				22
23	AMBULANCE				23
25	ASC				25
26	HOSPICE				26
27	OTHER (SPECIFY)				27
28	TOTAL PATIENT REVENUES (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	72,587,986		72,587,986	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (per Worksheet A, column 3, line 200)		17,651,716	29
30	ADD (SPECIFY)			30
31				31
32				32
33				33
34				34
35				35
36	TOTAL ADDITIONS (sum of lines 30-35)			36
37	**DEDUCT BAD DEBT EXPENSE**	-231,091		37
38				38
39				39
40				40
41				41
42	TOTAL DEDUCTIONS (sum of lines 37-41)		-231,091	42
43	TOTAL OPERATING EXPENSES (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		17,420,625	43

Optimizer Systems, Inc.

WinLASH

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STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (from Worksheet G-2, Part I, column 3, line 28)	72,587,986	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	52,796,601	2
3	NET PATIENT REVENUES (line 1 minus line 2)	19,791,385	3
4	LESS - TOTAL OPERATING EXPENSES (from Worksheet G-2, Part II, line 43)	17,420,625	4
5	NET INCOME FROM SERVICE TO PATIENTS (line 3 minus line 4)	2,370,760	5

OTHER INCOME

	_	
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	6
7	INCOME FROM INVESTMENTS	7
8	REVENUES FROM TELEPHONE AND OTHER MISCELLANEOUS COMMUNICATION SERVICES	8
9	REVENUE FROM TELEVISION AND RADIO SERVICE	9
10	PURCHASE DISCOUNTS	10
11	REBATES AND REFUNDS OF EXPENSES	11
12	PARKING LOT RECEIPTS	12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE	13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS	15
16	REVENUE FROM SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS	16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS	17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS 1,704	18
19	TUITION (fees, sale of textbooks, uniforms, etc.)	19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN	20
21	RENTAL OF VENDING MACHINES	21
22	RENTAL OF HOSPITAL SPACE	22
23	GOVERNMENTAL APPROPRIATIONS	23
24	OTHER (OTHER REVENUE) 356	24
24.01	OTHER (PHYSICIAN REVENUE)	24.01
25	TOTAL OTHER INCOME (sum of lines 6-24) 2,060	25
26	TOTAL (line 5 plus line 25) 2,372,820	26
27	OTHER EXPENSES (MANAGEMENT FEE) 1,107,278	27
27.01	OTHER EXPENSES (INTERCOMPANY INTEREST) -5,057	27.01
27.02	OTHER EXPENSES (TAXES) 1,290,972	27.02
27.03	OTHER EXPENSES (MISC)	27.03
28	TOTAL OTHER EXPENSES (sum of line 27 and subscripts) 2,393,193	28
29	NET INCOME (or loss) FOR THE PERIOD (line 26 minus line 28) -20,373	29