This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-2024 Worksheet S Peri od: From 02/01/2021 Parts I-III AND SETTLEMENT SUMMARY 01/31/2022 Date/Time Prepared: 6/1/2022 10:58 am PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically prepared cost report Date: 6/1/2022 Time: 10:58 am ] Manually prepared cost report use only Ilf this is an amended report enter the number of times the provider resubmitted this cost report [Medicare Utilization. Enter "F" for full or "L" for low. [1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Final Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. Contractor's Vendor Code:
[11] 12. [8] 13. Contractor's Vendor Code:
[12] 13. NPR Date:
[13] 14. Contractor's Vendor Code:
[14] 15. Contractor's Vendor Code:
[15] 16. NPR Date:
[16] 17. Contractor's Vendor Code:
[17] 18. Contractor's Vendor Code:
[18] 19. Contractor's Vendor Code:
[19] 19. Contractor's Vendor Code:
[1 Contractor use only (3) Settled with Audit number of times reopened = 0-9.

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

(4) Reopened (5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by RH OF NORTHWEST INDIANA, LLC (15-2024) for the cost reporting period beginning 02/01/2021 and ending 01/31/2022 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

			Title XVIII				
Cost Center Description		Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	-548, 406	0	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2. 00
3.00	Subprovider - IRF	0	0	0		0	3. 00
5.00	Swing Bed - SNF	0	0	0		0	5. 00
6.00	Swing Bed - NF	0				0	6. 00
200.00	Total	0	-548, 406	0	0	0	200. 00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

Health Financial Systems RH OF NORTHWEST INDIANA, LLC In Lieu of Form CMS-2552-10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-2024 Peri od: Worksheet S-2 From 02/01/2021 To 01/31/2022 Part I Date/Time Prepared: 6/1/2022 10:58 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: 1.00 Street: 4321 FIR STREET, 4TH FLOOR PO Box: 1.00 City: EAST CHICAGO State: IN 2.00 Zip Code: 46312 County: LAKE 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N)
V XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 RH OF NORTHWEST 152024 23844 02/01/2004 N 3.00 INDIANA, LLC Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 Subprovi der - (Other) 6.00 6.00 Swing Beds - SNF 7 00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: 1. 00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 02/01/2021 01/31/2022 20.00 21.00 Type of Control (see instructions) 21.00 4 1. 00 2. 00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for N N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this 22.01 Ν Ν 22.01 cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1.

Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)

Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) 22.02 22.02 N N Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to 22.03 N Ν Ν rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to 22.04 Ν Ν Ν rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, yes or "N" for no. 23 00 Which method is used to determine Medicaid days on lines 24 and/or 25 23 00 3 N below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.

GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.

57 00

58 00

59.00

N

57.00 | If line 56 is yes, is this the first cost reporting period during which residents in approved

58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.

59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.

	Financial Systems RH OF NOR AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		INDIANA, LLC	`N: 15_2024   Pa	In Lie	u of Form CMS-2 Worksheet S-2	
1103111	THE AND HOST THE HEALTH SAME COMMERCE TREATH TO ATTOM DA	17	Trovider ed		rom 02/01/2021	Part I Date/Time Pre	pared:
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
				1. 00	2. 00	3.00	
	Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in colis "Y", are you impacted by CR 11642 (or subsequent Cadjustement? Enter "Y" for yes or "N" for no in colu	85? (s umn 1. :R) NAHE	see If column 1	N			60.00
		Y/N	IME	Direct GME	I ME	Direct GME	
61. 00	Did your hospital receive FTE slots under ACA	1. 00 N	2. 00	3. 00	4. 00	5.00	61. 00
01.00	section 5503? Enter "Y" for yes or "N" for no in	IN			0.00	0.00	01.00
61. 01	column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see						61. 01
	instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61. 02
61. 03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61. 03
	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period (see instructions). Enter the difference between the baseline primary						61. 04
	and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						
	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61. 06
	, , , , , , , , , , , , , , , , , , ,	Pro	ogram Name	Program Code		Direct GME FTE Count	
	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME		1.00	2. 00	3.00	4.00	61. 10
61. 20	FTE unweighted count. Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4,				0.00	0.00	61. 20
	the direct GME FTE unweighted count.					1.00	
	ACA Provisions Affecting the Health Resources and Ser	vi ces /	Admi ni strati on	(HRSA)		1.00	
	Enter the number of FTE residents that your hospital	trai nec			od for which	0.00	62. 00
	your hospital received HRSA PCRE funding (see instruc Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovide	Teachi ram. (s	see instruction		your hospital	0.00	62. 01
63. 00	Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ttings	during this co		ictions)	N Ratio (col. 1/	63. 00
				FTEs Nonprovi der Si te	FTES in Hospital	(col. 1 + col. 2))	
	Section 5504 of the ACA Base Year FTE Residents in No			1.00 This base year	2.00 is your cost r	3.00 reporting	
	period that begins on or after July 1, 2009 and befor Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted non resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see	y trair -primar all nor   non-pr   columr	ned residents ry care nprovider rimary care n 3 the ratio	0. 00	0.00	0. 000000	64. 00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-2024 Peri od: Worksheet S-2 From 02/01/2021 Part I Date/Time Prepared: 01/31/2022 6/1/2022 10:58 am Program Code Unwei ghted Unwei ghted Program Name Ratio (col. (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0. 00 0. 00 0.000000 65.00 trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0. 00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Unwei ghted Ratio (col. 3/ Program Code Unwei ahted FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)) (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most O 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF N 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)

alth Financial Systems RH OF NORTHWEST SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der Co	CN: 15-2024	Peri od: From 02/01/2021 To 01/31/2022	u of Form CMS Worksheet S- Part I Date/Time Pi 6/1/2022 10:	-2 repared:
				1.00	
Long Term Care Hospital PPS					
<ul><li>Is this a long term care hospital (LTCH)? Enter "Y" for yes</li><li>Is this a LTCH co-located within another hospital for part of "Y" for yes and "N" for no.</li></ul>			ng period? Enter	Y	80. 0 81. 0
TEFRA Providers 5.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) 6.00 Did this facility establish a new Other subprovider (exclude				N	85. 0 86. 0
[\$413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.  7.00 Is this hospital an extended neoplastic disease care hospital 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	l classified	under sectio	n	N	87. 0
1.000(a) (1) (b) (41) 1. 211(a) 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.			V	XI X	
			1. 00	2.00	
Title V and XIX Services  1.00 Does this facility have title V and/or XIX inpatient hospital and the continuous continuous and the continuous c	I services? E	nter "Y" for	· N	N	90.0
yes or "N" for no in the applicable column.  1.00 Is this hospital reimbursed for title V and/or XIX through t full or in part? Enter "Y" for yes or "N" for no in the appl			N	N	91.0
2.00 Are title XIX NF patients occupying title XVIII SNF beds (du instructions) Enter "Y" for yes or "N" for no in the applica	al certificat			N	92. 0
B.00 Does this facility operate an ICF/IID facility for purposes "Y" for yes or "N" for no in the applicable column.		d XIX? Enter	N	N	93. 0
1.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, applicable column.	N	94. 0			
5.00   Fline 94 is "Y", enter the reduction percentage in the app 5.00   Does title V or XIX reduce operating cost? Enter "Y" for yes	0. 00 N	0. 00 N	95. 0 96. 0		
applicable column. 7.00   If line 96 is "Y", enter the reduction percentage in the app 8.00   Does title V or XIX follow Medicare (title XVIII) for the in stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" f column 1 for title V, and in column 2 for title XIX.	0. 00 Y	97. 0 98. 0			
3.01 Does title V or XIX follow Medicare (title XVIII) for the re C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for ti		Y	98. 0		
title XIX.  O2 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation N bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1					98. 0
for title V, and in column 2 for title XIX.  Does title V or XIX follow Medicare (title XVIII) for a crit reimbursed 101% of inpatient services cost? Enter "Y" for ye for title V, and in column 2 for title XIX.				N	98. 0
B. 04 Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no in in column 2 for title XIX.			n N	N	98. 0
3.05 Does title V or XIX follow Medicare (title XVIII) and add ba Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in c column 2 for title XIX.				Υ	98.0
3.06 Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.  Rural Providers			N	N	98. 0
05.00 Does this hospital qualify as a CAH? 06.00 If this facility qualifies as a CAH, has it elected the all- for outpatient services? (see instructions)	inclusive met	hod of payme	nt		105. C
07.00 Column 1: If line 105 is Y, is this facility eligible for co training programs? Enter "Y" for yes or "N" for no in column Column 2: If column 1 is Y and line 70 or line 75 is Y, do approved medical education program in the CAH's excluded IP	1. (see ins you train I&R F and/or IRF	tructions) s in an			107.0
Enter "Y" for yes or "N" for no in column 2. (see instructi 08.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		dul e? See 4	2 N		108. 0
	Physi cal 1.00	Occupation	<del></del>	Respiratory	/
09.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	1.00	2.00 N	3. 00 N	4. 00 N	109. 0
[0.00 Did this hospital participate in the Rural Community Hospita Demonstration) for the current cost reporting period? Enter "	Demonstrati	on project (	§410A	1. 00 N	110. 0

Health Financial Systems RH OF NORTHWEST I HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CC	`N: 15_2∩24	In Lie Period:	u of Form CMS Worksheet S	
IOSITTAL AND HOSITTAL HEALTH CARL COMMELLA TULINTHICATION DATA	Trovider co	SN. 13-2024	From 02/01/2021 To 01/31/2022	Part I Date/Time Pi	repared:
				6/1/2022 10:	58 am
111.00 If this facility qualifies as a CAH, did it participate in th Health Integration Project (FCHIP) demonstration for this cos "Y" for yes or "N" for no in column 1. If the response to colintegration prong of the FCHIP demo in which this CAH is part Enter all that apply: "A" for Ambulance services; "B" for add for tele-health services.	t reporting pumn 1 is Y, eicipating in	period? Enter enter the column 2.	1.00 N	2.00	111.00
		1. 00	2. 00	3.00	
demonstration for any portion of the current cost reporting p Enter "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceas participation in the demonstration, if applicable.	eri od? "Y", enter	N			112. 00
Miscellaneous Cost Reporting Information  115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or in column 1. If column 1 is yes, enter the method used (A, B, in column 2. If column 2 is "E", enter in column 3 either "93 for short term hospital or "98" percent for long term care (i psychiatric, rehabilitation and long term hospitals providers the definition in CMS Pub.15-1, chapter 22, §2208.1.	or E only) " percent ncl udes	N			0 115. 00
116.00 Is this facility classified as a referral center? Enter "Y" for N" for no.	or yes or	N			116. 00
117.00 S this facility legally-required to carry malpractice insura "Y" for yes or "N" for no.	nce? Enter	Y			117. 00
118.00 Is the malpractice insurance a claims-made or occurrence poli	,		1		118. 0
if the policy is claim-made. Enter 2 if the policy is occurre	nce.	Premi ums	Losses	Insurance	
10.01		1.00	2.00	3.00	0110.0
18.01 List amounts of malpractice premiums and paid losses:		178, 2	35 0		0 118. 0
18.02 Are malpractice premiums and paid losses reported in a cost c	enter other t	than the	1. 00 N	2.00	118. 0
Administrative and General? If yes, submit supporting schedu and amounts contained therein.  19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualified Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.	le listing co Harmless prov column 1, "Y" lifies for th	ost centers vision in ACA ' for yes or ne Outpatient	N N	N	119. 0 120. 0
21.00 Did this facility incur and report costs for high cost implan	table devices	s charged to	N		121. 0
patients? Enter "Y" for yes or "N" for no.  22.00 Does the cost report contain healthcare related taxes as defi Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.					122. 0
Transplant Center Information  25.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.  26.00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 2.  27.00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2.  28.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2.  29.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2.  30.00 If this is a Medicare certified pancreas transplant center, edate in column 1 and termination date, if applicable, in column 31.00 If this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in column 32.00 If this is a Medicare certified islet transplant center, enter in column 1 and termination date, if applicable, in column 32.00 Removed and reserved  34.00 Removed and reserved  34.00 If this is an organ procurement organization (OPO), enter the and termination date, if applicable, in column 2.	er the certifi r the certifi r the certifi the certific nter the cert mn 2. enter the ce mn 2. r the certifi	cation date cation date cation date itification date cation date itification cation date			125. C 126. C 127. C 128. C 129. C 130. C 131. C 132. C 134. C
40.00 Are there any related organization or home office costs as de chapter 10? Enter "Y" for yes or "N" for no in column 1. If y are claimed, enter in column 2 the home office chain number.	es, and home	office costs	, Y	HB0312	140. C

				From 02/01/2021 To 01/31/2022		
1.00		2. 00		3. 00		
If this facility is part of a cha home office and enter the home of				name and address	of the	
141. 00 Name: NAME: SELECT MEDICAL	Contractor's Name:			or's Number: 120	.01	141. 00
142.00 Street: STREET: 4714 GETTYSBURG	•					142.00
143.00 Ci ty: CI TY: MECHANI CSBURG	State:	PA	Zi p Code	: 170	55	143. 00
					1.00	
144.00 Are provider based physicians' co	sts included in Workshee	t A?			Y	144. 00
145 0016	Lairead are Wheat A Live	74 ++		1. 00 Y	2.00	145.00
<ul> <li>145.00 If costs for renal services are c inpatient services only? Enter "Y no, does the dialysis facility in period? Enter "Y" for yes or "N"</li> <li>146.00 Has the cost allocation methodol o Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/</li> </ul>	" for yes or "N" for no clude Medicare utilizati for no in column 2. gy changed from the prev n column 1. (See CMS Pub	in column 1. If on for this cost	column 1 is reporting t report?	N	N	145. 00
lyes, enter the approval date (IIIII)	Jazyyyy) in corumn 2.					
					1.00	
147.00 Was there a change in the statist					N	147. 00
148.00 Was there a change in the order o 149.00 Was there a change to the simplif				· no	N N	148. 00 149. 00
147. 00 was there a change to the shipin	red cost irriding method:	Part A	Part B	Title V	Title XIX	147.00
		1.00	2.00	3.00	4. 00	
Does this facility contain a prov						
or charges? Enter "Y" for yes or 155.00 Hospi tal	N for no for each comp	N	N And Part B.	N (See 42 CFR 941	3. 13) N	155.00
156. 00 Subprovi der – I PF		N	N N	N	N N	156. 00
157.00 Subprovi der - I RF		N	N	N	N	157. 00
158. 00 SUBPROVI DER						158. 00
159. 00 SNF 160. 00 HOME HEALTH AGENCY		N N	N N	N N	N N	159. 00 160. 00
161. 00 CMHC		IN	N N	N N	N N	161. 00
1011 00 0111110						101100
Mul +i compus					1.00	
Multicampus  165.00 Is this hospital part of a Multic	ampus hospital that has	one or more camp	uses in diffe	erent CBSAs?	l N	165. 00
Enter "Y" for yes or "N" for no.		<u> </u>				
	Name	County		p Code CBSA	FTE/Campus	
166.00 If line 165 is yes, for each	0	1. 00	2. 00	3.00 4.00	5.00	00 166. 00
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.0	700.00
					1.00	-
Health Information Technology (HI	T) incentive in the Amer	ican Recovery an	d Reinvestmer	nt Act	1.00	
167.00 is this provider a meaningful use 168.00 if this provider is a CAH (line 1 reasonable cost incurred for the	r under §1886(n)? Enter O5 is "Y") and is a mean	"Y" for yes or ingful user (line	"N" for no.		N	167. 00 168. 00
168.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii)	not a meaningful user, d	oes this provide				168. 01
169.00 If this provider is a meaningful transition factor. (see instructi	user (line 167 is "Y") a				0.0	00169.00
				Begi nni ng	Endi ng	
170.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)	beginning date and endin	g date for the r	eporti ng	1. 00	2.00	170. 00
171.00 If line 167 is "Y", does this pro section 1876 Medicare cost plans				1. 00 N	2.00	0 171. 00
"Y" for yes and "N" for no in col 1876 Medicare days in column 2. (	umn 1. If column 1 is ye			on		

	Financial Systems RH OF NORTHWEST AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-2024	Peri od:	u of Form CMS Worksheet S-		
				From 02/01/2021 To 01/31/2022	Part II	epared:	
				Y/N	Date		
	General Instruction: Enter Y for all YES responses. Enter N	for all NO re	snonses Enta	1.00	2.00		
	mm/dd/yyyy format.  COMPLETED BY ALL HOSPITALS	TOI AIT NO TE	sponses. Litte	er arr dates in t	.ne	-	
	Provider Organization and Operation						
1.00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in co			N		1. 00	
	preporting period: 11 yes, enter the date of the change in co	orumir 2. (see	Y/N	Date	V/I		
2.00	The the gardeness to the first term of the first	2.16	1.00	2. 00	3. 00	2.00	
2.00	Has the provider terminated participation in the Medicare Pryes, enter in column 2 the date of termination and in column voluntary or "I" for involuntary.	9	N			2.00	
3.00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other relationships? (see instructions)	fices, drug er or its the board	Y			3.00	
	,		Y/N	Туре	Date		
	Financial Data and Reports		1.00	2. 00	3. 00		
<ul><li>4. 00</li><li>5. 00</li></ul>	Column 1: Were the financial statements prepared by a Certi Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date avai column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues differ	or Compiled, lable in	Y	С		4. 00	
	those on the filed financial statements? If yes, submit reco		14			3.00	
				Y/N 1. 00	Legal Oper. 2.00		
6.00	Approved Educational Activities  Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider N is the legal operator of the program?						
7. 00 8. 00	Are costs claimed for Allied Health Programs? If "Y" see instructions.						
9. 00	Are costs claimed for Interns and Residents in an approved of		al education	N		9. 00	
10. 00	program in the current cost report? If yes, see instructions Was an approved Intern and Resident GME program initiated or cost reporting period? If yes, see instructions.		he current	N		10. 00	
11. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N	V (A)	11. 00	
					Y/N 1. 00		
	Bad Debts						
	Is the provider seeking reimbursement for bad debts? If yes, If line 12 is yes, did the provider's bad debt collection poperiod? If yes, submit copy.			ost reporting	Y N	12. 00 13. 00	
14. 00	1,	nts waived? If	yes, see ins	structi ons.	N	14. 00	
15. 00	Did total beds available change from the prior cost reporting	<del></del>	yes, see inst	tructions.	t B	15. 00	
		Y/N	Date	Y/N	Date		
	DC VD Data	1. 00	2.00	3. 00	4. 00		
16. 00	PS&R Data  Was the cost report prepared using the PS&R Report only?  If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see	N		N		16. 00	
17. 00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	N		N		17. 00	
18. 00	in columns 2 and 4. (see instructions)  If line 16 or 17 is yes, were adjustments made to PS&R  Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		18. 00	
19. 00	cost report? If yes, see instructions.  If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19. 00	

Heal th	Financial Systems RH OF NORTHWEST	ΓΙΝDΙΑΝΑ, LLC		In Lie	u of Form CM:	S-2552-10		
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CCN: 15-2024	Peri od: From 02/01/2021 To 01/31/2022	Worksheet S Part II Date/Time P 6/1/2022 10	repared:		
			iption	Y/N	Y/N			
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R		0	1. 00 N	3. 00 N	20.00		
20.00	Report data for Other? Describe the other adjustments:			IN	IN	20.00		
		Y/N	Date	Y/N	Date			
21. 00	Was the cost report prepared only using the provider's	1.00 Y	2.00	3. 00 N	4. 00	21. 00		
21.00	records? If yes, see instructions.	<u> </u>		IN .		21.00		
					1. 00			
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS I	HOSPI TALS)					
	Capital Related Cost							
22. 00 23. 00	Have assets been relifed for Medicare purposes? If yes, see Have changes occurred in the Medicare depreciation expense			ring the cost		22. 00		
23.00	reporting period? If yes, see instructions.	due to apprais	sai s illade dui	Tilg the cost		23.00		
24. 00	Were new leases and/or amendments to existing leases entere	ed into during	this cost re	eporting period?		24. 00		
25. 00	If yes, see instructions Have there been new capitalized leases entered into during	the cost repo	rting period?	'If yes, see		25. 00		
26. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acquired during the	he cost reporti	ina neriod2	f ves see		26. 00		
	instructions.	•	0.					
27. 00	Has the provider's capitalization policy changed during the copy.	e cost reportii	ng period? If	yes, submit		27. 00		
28. 00	Interest Expense Were new Loans, mortgage agreements or Letters of credit en	ntered into du	ring the cost	reporting		28. 00		
	period? If yes, see instructions.							
29. 00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see instr		ebt Service F	Reserve Fund)		29. 00		
30. 00	Has existing debt been replaced prior to its scheduled maturinstructions.	urity with new	debt? If yes	s, see		30. 00		
31. 00	00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see							
	instructions. Purchased Services							
32. 00	Have changes or new agreements occurred in patient care ser	rvices furnish	ed through co	ntractual		32. 00		
33. 00	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app		ng to competi	tive bidding? If		33. 00		
	no, see instructions.							
34. 00	Provider-Based Physicians  Are services furnished at the provider facility under an ar	rrangement wit	h provi der-ba	sed physicians?		34.00		
	If yes, see instructions.	o .	•	. ,				
35. 00	If line 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in		nts with the	provi der-based		35. 00		
				Y/N 1. 00	Date			
	Home Office Costs			1.00	2. 00			
36. 00	Were home office costs claimed on the cost report?					36. 00		
37. 00	If line 36 is yes, has a home office cost statement been pr If yes, see instructions.	repared by the	home office?			37. 00		
38. 00	If line 36 is yes , was the fiscal year end of the home of			-		38. 00		
39. 00	the provider? If yes, enter in column 2 the fiscal year end of line 36 is yes, did the provider render services to other			s,		39. 00		
40. 00	see instructions.  If line 36 is yes, did the provider render services to the	·	,			40. 00		
40.00	instructions.			40.00				
		1.00 2.						
	Cost Report Preparer Contact Information							
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	ANDREW		BUTZ		41. 00		
42. 00	respectively. Enter the employer/company name of the cost report	SELECT MEDICAL	_			42. 00		
43. 00	preparer. Enter the telephone number and email address of the cost	717-972-1391		APBUTZ@SELECTM	EDI CAL. COM	43.00		
	report preparer in columns 1 and 2, respectively.							

Heal th	Health Financial Systems RH OF NORTHW				In Lieu of Form CMS-2552-10			
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT (	QUESTI ONNAI RE	Provider CO	1	Period: From 02/01/2021 To 01/31/2022	Worksheet S-2 Part II Date/Time Pre 6/1/2022 10:5	pared:	
			3.	00	_			
	Cost Report Preparer Contact Information							
41. 00	Enter the first name, last name and the ti held by the cost report preparer in column respectively.		REIMBURSEMENT A	ANALYST			41. 00	
42. 00	Enter the employer/company name of the cospreparer.	st report					42. 00	
43. 00	Enter the telephone number and email addre report preparer in columns 1 and 2, respec						43. 00	

Health Financial Systems RH 0F NOF HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-2024

				Τ̈́	o 01/31/2022	Date/Time Pre 6/1/2022 10:5	
						I/P Days / 0/P	
						Visits / Trips	
	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	Title V	
		1. 00	2. 00	3.00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	61	22, 265	0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2. 00
3.00	HMO I PF Subprovi der						3. 00
4.00	HMO I RF Subprovi der						4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	
6.00	Hospital Adults & Peds. Swing Bed NF		/1	22.245	0.00	0	
7. 00	Total Adults and Peds. (exclude observation		61	22, 265	0.00	0	7. 00
8. 00	beds) (see instructions) INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13. 00	NURSERY						13.00
14. 00	Total (see instructions)		61	22, 265	0.00	0	14. 00
15. 00	CAH visits		01	22, 200	0.00	0	15. 00
16. 00	SUBPROVI DER - I PF					Ĭ	16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20. 00	NURSING FACILITY						20. 00
21.00	OTHER LONG TERM CARE						21. 00
22.00	HOME HEALTH AGENCY						22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)	30. 00					24. 10
25.00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	26. 25
27. 00	Total (sum of lines 14-26)		61				27. 00
28. 00	Observation Bed Days					0	28. 00
29. 00	Ambul ance Tri ps						29. 00
30. 00	Employee discount days (see instruction)						30. 00
31. 00	Employee discount days - IRF						31. 00
32. 00	Labor & delivery days (see instructions)		0	C			32. 00
32. 01	Total ancillary labor & delivery room						32. 01
00.00	outpatient days (see instructions)						00.00
33. 00	LTCH non-covered days						33. 00
33.01	LTCH site neutral days and discharges			l			33. 01

Health Financial Systems RH 0F NOF HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Peri od: | Worksheet S-3 | From 02/01/2021 | Part I | To 01/31/2022 | Date/Time Prepared: Provider CCN: 15-2024

				'	0 01/31/2022	6/1/2022 10: 5	
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6.00	7. 00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	7, 819	0	14, 400			1.00
2.00	HMO and other (see instructions)	1, 874	2, 045				2. 00
3.00	HMO IPF Subprovider	o	0				3. 00
4.00	HMO IRF Subprovider	o	0				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	o	o	0			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF	İ	o	0			6.00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	7, 819	0	14, 400			7. 00
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	7, 819	0	14, 400	0.00	130.00	
15.00	CAH vi si ts	0	o	. 0			15. 00
16. 00	SUBPROVIDER - IPF						16. 00
17. 00	SUBPROVI DER - I RF	1					17. 00
18. 00	SUBPROVI DER	İ					18. 00
19.00	SKILLED NURSING FACILITY	İ					19. 00
20.00	NURSING FACILITY	İ					20.00
21.00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY	1					22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)	1					23. 00
24.00	HOSPI CE	1					24. 00
24. 10	HOSPICE (non-distinct part)			0			24. 10
25.00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	o	0	0	0.00	0.00	26. 25
27. 00	Total (sum of lines 14-26)				0.00	130.00	27. 00
28. 00	Observation Bed Days		0	0			28. 00
29. 00	Ambul ance Trips	0					29. 00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32. 00
32. 01	Total ancillary labor & delivery room	1		0			32. 01
	outpatient days (see instructions)			_			
33.00	LTCH non-covered days	28					33. 00
33. 01	LTCH site neutral days and discharges	0					33. 01

| Period: | Worksheet S-3 | From 02/01/2021 | Part | To 01/31/2022 | Date/Time Prepared: Provider CCN: 15-2024

				To	01/31/2022	Date/Time Prep 6/1/2022 10:58	
		Full Time	'	Di sch	arges		
	Component	Equi val ents Nonpai d	Title V	Title XVIII	Title XIX	Total All	
	Component	Workers	Title v	TITLE AVIII	II ti e xi x	Patients	
		11.00	12. 00	13.00	14. 00	15. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and		0		0	597	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			67	72		2.00
3.00	HMO IPF Subprovider				0		3. 00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)			•			12.00
13. 00 14. 00	NURSERY	0. 00	0	332	0	597	13. 00 14. 00
15. 00	Total (see instructions) CAH visits	0.00	U	332	۷	597	15. 00
16. 00	SUBPROVIDER - IPF						16. 00
17. 00	SUBPROVIDER - I RF			•			17. 00
18. 00	SUBPROVI DER			•			18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20. 00	NURSING FACILITY			•			20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29. 00
30. 00	Employee discount days (see instruction)						30. 00
31. 00	Employee discount days - IRF						31. 00
32. 00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
22.00	outpatient days (see instructions)						22.00
	LTCH non-covered days			0			33. 00
33. U I	LTCH site neutral days and discharges			0			33. 01

| Period: | Worksheet S-3 | From 02/01/2021 | Part II | To 01/31/2022 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provi der CCN: 15-2024

					To	01/31/2022	Date/Time Pre 6/1/2022 10:58	
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst.	Adjusted Salaries (col.2 ± col.		Average Hourly Wage (col. 4 ÷ col. 5)	J am
				A-6)	3)	col. 4	,	
	PART II - WAGE DATA	1. 00	2.00	3.00	4. 00	5. 00	6. 00	
1 00	SALARI ES	200 00	10 004 153		10 004 157	270 200 05	20.04	1 00
1. 00	Total salaries (see instructions)	200. 00	10, 804, 157	0	10, 804, 157	270, 390. 05	39. 96	1.00
2.00	Non-physician anesthetist Part		C	0	0	0. 00	0. 00	2. 00
3. 00	Non-physician anesthetist Part		C	0	0	0.00	0. 00	3. 00
4. 00	Physician-Part A -		C	0	0	0.00	0. 00	4. 00
4. 01	Administrative Physicians - Part A - Teaching		C	1 ~	0	0.00		1
5. 00	Physician and Non Physician-Part B		С	0	0	0. 00	0.00	5. 00
6. 00	Non-physician-Part B for hospital-based RHC and FQHC services		C	0	0	0.00	0. 00	6. 00
7. 00	Interns & residents (in an approved program)	21. 00	C	0	0	0.00	0. 00	7. 00
7. 01	Contracted interns and residents (in an approved		C	0	0	0. 00	0. 00	7. 01
8. 00	programs) Home office and/or related organization personnel		C	0	0	0.00	0. 00	8. 00
9. 00 10. 00	SNF Excluded area salaries (see instructions)	44. 00	C	0 41, 443	0 41, 443	0. 00 1, 327. 53		1
11. 00	OTHER WAGES & RELATED COSTS  Contract labor: Direct Patient		4, 052, 220	0	4, 052, 220	36, 158. 13	112. 07	11. 00
	Care		4, 032, 220		4, 032, 220			
12. 00	Contract labor: Top level management and other management and administrative		C	0	0	0. 00	0.00	12. 00
13. 00	services Contract Labor: Physician-Part		142, 406	0	142, 406	660. 62	215. 56	13. 00
14. 00	A - Administrative Home office and/or related organization salaries and		C	0	0	0.00	0. 00	14. 00
14. 01	wage-related costs Home office salaries		1, 085, 379	o	1, 085, 379	20, 242. 00	53. 62	14. 01
14. 02	Related organization salaries		C	0	0	0.00	0.00	14. 02
15. 00	Home office: Physician Part A - Administrative		С	0	O	0.00		15. 00
16. 00	Home office and Contract Physicians Part A - Teaching		С	0	0	0. 00	0. 00	16. 00
16. 01	Home office Physicians Part A - Teaching		C	0	0	0.00	0.00	16. 01
16. 02	Home office contract Physicians Part A - Teaching WAGE-RELATED COSTS		C	0	0	0.00	0. 00	16. 02
17. 00	Wage-related costs (core) (see		1, 847, 847	0	1, 847, 847			17. 00
18. 00	instructions) Wage-related costs (other) (see instructions)							18. 00
	Excluded areas Non-physician anesthetist Part A		75, 539 C	0	75, 539 0			19. 00 20. 00
21. 00	Non-physician anesthetist Part		C	0	0			21. 00
22. 00	Physician Part A - Administrative		C	0	0			22. 00
	Physician Part A - Teaching		C	0	0			22. 01
	Physician Part B Wage-related costs (RHC/FQHC)		0	0	0			23. 00 24. 00
25. 00	Interns & residents (in an approved program)		C	Ö	0			25. 00
25. 50	Home office wage-related		186, 978	0	186, 978			25. 50
25. 51	(core) Related organization		C	0	0			25. 51
25. 52	wage-related (core) Home office: Physician Part A - Administrative -		C	0	0			25. 52
	wage-related (core)			1			I	l

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION

					T.	o 01/31/2022		
		Wkst. A Line	Amount	Reclassi fi cati	Adj usted	Pai d Hours	6/1/2022 10:5 Average Hourly	
		Number		on of Salaries			Wage (col. 4 ÷	
		Number	Reported	(from Wkst.	(col.2 ± col.	Salaries in	col. 5)	
				A-6)	3)	col . 4	COI . 3)	
		1. 00	2. 00	3.00	4.00	5. 00	6. 00	
25. 53	Home office: Physicians Part A		0	0	0			25. 53
	- Teaching - wage-related							
	(core)							
	OVERHEAD COSTS - DIRECT SALARIE							
26. 00	Employee Benefits Department	4. 00	55, 905	0	55, 905	1, 171. 44	47. 72	26. 00
27.00	Administrative & General	5. 00	2, 010, 700	-41, 443	1, 969, 257	39, 169. 13	50. 28	27. 00
28. 00	Administrative & General under		0	0	0	0.00	0.00	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00	0	0	0	0. 00		29. 00
30. 00	Operation of Plant	7. 00	0	0	0	0. 00		
31.00	Laundry & Linen Service	8. 00	0	0	0	0. 00		
32.00	Housekeepi ng	9. 00	0	0	0	0. 00		
33.00	Housekeeping under contract		0	0	0	0.00	0.00	33. 00
	(see instructions)							
34. 00	Di etary	10. 00	89, 204	0	89, 204	2, 753. 38	32. 40	34. 00
35.00	Di etary under contract (see		0	0	0	0.00	0.00	35. 00
	instructions)							
36. 00	Cafeteri a	11. 00	0	0	0	0. 00		36. 00
37. 00	Maintenance of Personnel	12. 00	0	0	0	0. 00		
38. 00	Nursing Administration	13. 00	651, 570	0	651, 570	10, 697. 33	60. 91	38. 00
39. 00	Central Services and Supply	14. 00	0	0	0	0.00	0.00	39. 00
40.00	Pharmacy	15. 00	0	0	0	0.00	0.00	40. 00
41.00	Medical Records & Medical	16. 00	139, 008	0	139, 008	6, 246. 64	22. 25	41.00
	Records Library							
42.00	Social Service	17. 00	0	0	0	0.00		42. 00
43.00	Other General Service	18. 00	0	0	0	0.00	0.00	43.00

Total overhead cost (see

instructions)

7.00

48. 39

7.00

HOSPITAL WAGE INDEX INFORMATION Worksheet S-3 Part III Date/Time Prepared: Provi der CCN: 15-2024 Peri od: From 02/01/2021 To 01/31/2022 6/1/2022 10:58 am Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours Average Hourly Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 (col . 2 ± col . col. 5) (from Salaries in Works<u>heet A-6)</u> 3) col. 4 1.00 2.00 4.00 6.00 5.00 3.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 10, 804, 157 10, 804, 157 270, 390. 05 39. 96 1.00 instructions) 2.00 Excluded area salaries (see 0 41, 443 41, 443 1, 327. 53 31. 22 2.00 instructions) 3.00 Subtotal salaries (line 1 10, 804, 157 -41, 443 10, 762, 714 269, 062. 52 40.00 3.00 minus line 2) 4.00 Subtotal other wages & related 5, 280, 005 5, 280, 005 57, 060. 75 92.53 4.00 costs (see inst.) Subtotal wage-related costs 5.00 2, 034, 825 Ω 2, 034, 825 0.00 18. 91 5.00 (see inst.) Total (sum of lines 3 thru 5) 6.00 6.00 18, 118, 987 -41, 443 18, 077, 544 326, 123. 27 55. 43

2, 946, 387

-41, 443

2, 904, 944

60, 037. 92

PART I V - WAGE RELATED COSTS   1.00		10 01/31/2022	Date/lime Pre   6/1/2022 10:5	
PART IV - WAGE RELATED COSTS   Part A - Core List				
PART IV - WAGE RELATED COSTS   Part A - Core   List   RETIREMENT COST   401K Empl oyer Contributions   66,027   1.00   2.00   Tax Sheltered Annuity (TSA) Employer Contribution   0.2.00   2.00   7.			Reported	
Part A - Core List			1. 00	
RETIREMENT COST		PART IV - WAGE RELATED COSTS		
1.00		Part A - Core List		
2.00		RETI REMENT COST		
3. 00   Nonqualified Defined Benefit Plan Cost (see instructions)   0   3. 00   0   0   0   0   0   0   0   0   0	1.00	401K Employer Contributions	66, 027	1.00
4.00	2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)   401K/TSA Pl an Administration Fees   0   5 .00   6.00   Legal /Accounting/Management Fees-Pension Pl an   0   6.00   Employee Managed Care Program Administration Fees   0   7.00   Employee Managed Care Program Administration Fees   0   7.00   HEALTH AND INSURANCE COST   8.00   Health Insurance (Purchased or Self Funded)   8.01   Health Insurance (Self Funded without a Third Party Administrator)   0   8.01   Health Insurance (Self Funded without a Third Party Administrator)   689,876   8.02   Health Insurance (Self Funded with a Third Party Administrator)   0   8.01   Health Insurance (Purchased)   0   8.03   Health Insurance (Purchased)   0   8.03   Health Insurance (Purchased)   0   8.03   Health Insurance (Purchased)   0   8.00   10.00   Health Insurance (If Employee is owner or beneficiary)   0   12,747   10.00   10.0	3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)   401K/TSA Pl an Administration Fees   0   5 .00   6.00   Legal /Accounting/Management Fees-Pension Pl an   0   6.00   Employee Managed Care Program Administration Fees   0   7.00   Employee Managed Care Program Administration Fees   0   7.00   HEALTH AND INSURANCE COST   8.00   Health Insurance (Purchased or Self Funded)   8.01   Health Insurance (Self Funded without a Third Party Administrator)   0   8.01   Health Insurance (Self Funded without a Third Party Administrator)   689,876   8.02   Health Insurance (Self Funded with a Third Party Administrator)   0   8.01   Health Insurance (Purchased)   0   8.03   Health Insurance (Purchased)   0   8.03   Health Insurance (Purchased)   0   8.03   Health Insurance (Purchased)   0   8.00   10.00   Health Insurance (If Employee is owner or beneficiary)   0   12,747   10.00   10.0	4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
The color of the	5.00	401K/TSA Plan Administration fees	0	5. 00
HEALTH AND INSURANCE COST	6.00	Legal/Accounting/Management Fees-Pension Plan	0	6. 00
Real th Insurance (Purchased or Self Funded)   Real th Insurance (Self Funded without a Third Party Administrator)   Real th Insurance (Self Funded without a Third Party Administrator)   Real th Insurance (Self Funded without a Third Party Administrator)   Real th Insurance (Self Funded without a Third Party Administrator)   Real th Insurance (Self Funded without a Third Party Administrator)   Real th Insurance (Purchased)   Rear in Insurance (If employee is owner or beneficiary)   Rear in Insurance (If employee is owner or beneficiary)   Rear in Insurance (If employee is owner or beneficiary)   Rear in Insurance (If employee is owner or beneficiary)   Rear in Insurance (If employee is owner or beneficiary)   Rear in Insurance (If employee is owner or beneficiary)   Rear in Insurance (If employee is owner or beneficiary)   Rear in Insurance (If employee is owner or beneficiary)   Rear in Insurance (If employee is owner or beneficiary)   Rear in Insurance (If employee is owner or beneficiary)   Rear in Insurance (Insurance (If employee is owner or beneficiary)   Rear insurance (If employee is owner or beneficiary)   Rear insurance	7.00	Employee Managed Care Program Administration Fees	0	7. 00
Heal th Insurance (Self Funded without a Third Party Administrator)   0   8. 01		HEALTH AND INSURANCE COST		
Real th Insurance (Self Funded with a Third Party Administrator)   689, 876   8.02	8.00	Health Insurance (Purchased or Self Funded)	0	8. 00
Real th Insurance (Purchased)   0   8.03   9.00   Prescription Drug Plan   0   9.00   10.00	8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
Prescription Drug Plan	8.02	Health Insurance (Self Funded with a Third Party Administrator)	689, 876	8. 02
10.00   Dental   Hearing and Vision Plan   12,747   10.00     11.00   Life Insurance (If employee is owner or beneficiary)   23,838   11.00     12.00   Accident Insurance (If employee is owner or beneficiary)   0   12.00     13.00   Disability Insurance (If employee is owner or beneficiary)   0   13.00     14.00   Long-Term Care Insurance (If employee is owner or beneficiary)   0   14.00     15.00   Workers' Compensation Insurance   225,465   15.00     16.00   Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.   0   16.00     Non cumulative portion   781,472   17.00     18.00   Medicare Taxes - Employers Portion Only   0   18.00     19.00   Unemployment Insurance   0   19.00     20.00   State or Federal Unemployment Taxes   19,044   20.00     21.00   Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see   0   21.00     10.00   10.00   10.00   10.00     22.00   Day Care Cost and Allowances   0   22.00     23.00   Tuition Reimbursement   29,378   23.00     24.00   Part B - Other than Core Related Cost   24.00     25.00   Part B - Other than Core Related Cost   20.00     26.00   Part B - Other than Core Related Cost   20.00     27.00   27.00   27.00   27.00     28.00   28.00   29.378	8.03	Health Insurance (Purchased)	0	8. 03
11.00   Life Insurance (If employee is owner or beneficiary)   23,838   11.00     12.00   Accident Insurance (If employee is owner or beneficiary)   0   12.00     13.00   Disability Insurance (If employee is owner or beneficiary)   0   13.00     14.00   Long-Term Care Insurance (If employee is owner or beneficiary)   0   14.00     15.00   Workers' Compensation Insurance   225,465   15.00     16.00   Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.   0     16.00   Non cumulative portion)   781,472     17.00   Medicare Taxes - Employers Portion Only   0   18.00     19.00   Unemployment Insurance   0   19.00     20.00   State or Federal Unemployment Taxes   19,044     20.00   OTHER   Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see   0   21.00     17.00   Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see   0   22.00     21.00   Tuition Reimbursement   29,378   23.00     23.00   Tuition Reimbursement   29,378   23.00     24.00   Part B - Other than Core Related Cost   24.00     24.00   Part B - Other than Core Related Cost   24.00     25.00   25.00   25.00   25.00     26.00   26.00   26.00   26.00     27.00   27.00   26.00   26.00     28.00   28.00   29,378   29.00     29,378   29.00     29,378   29.00     29,378   29.00     29,378   29.00     29,378   29.00     29,378   29.00     29,378   29.00     20.00   29.00   29.00	9.00	Prescription Drug Plan	0	9. 00
12.00	10.00	Dental, Hearing and Vision Plan	12, 747	10.00
13.00 Disability Insurance (If employee is owner or beneficiary)  14.00 Long-Term Care Insurance (If employee is owner or beneficiary)  15.00 'Workers' Compensation Insurance  16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.  17.00 Non cumulative portion)  18.00 Medicare Taxes - Employers Portion Only  19.00 Unemployment Insurance  20.00 State or Federal Unemployment Taxes  21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))  22.00 Day Care Cost and Allowances  10.00 Total Wage Related cost (Sum of Lines 1 -23)  Part B - Other than Core Related Cost	11. 00	Life Insurance (If employee is owner or beneficiary)	23, 838	11. 00
14. 00 Long-Term Care Insurance (If employee is owner or beneficiary)  15. 00 'Workers' Compensation Insurance Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)  TAXES  17. 00 FI CA-Employers Portion Only Redicare Taxes - Employers Portion Only Unemployment Insurance State or Federal Unemployment Taxes  19. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))  22. 00 Day Care Cost and Allowances Tuit ion Reimbursement Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost	12.00	Accident Insurance (If employee is owner or beneficiary)	0	12. 00
15. 00 'Workers' Compensation Insurance Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106.  Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106.  Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106.  Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106.  Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106.  Retirement Heal th Care Cost in Cost (Only current year, not the extraordinary accrual required by FASB 106.  Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106.  Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106.  Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106.  Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106.  Retirement Heal th Care Cost (Onle possible 16.  Retirement Heal th Care Cost (Onle possible 16.  Retirement Heal th Care Cost (No. 00 16.00  Rotal Wage Related Cost (Only current year, not the extraordinary accrual required by FASB 106.  Retirement Heal th Care Cost (Onle possible 16.  Retirement Heal th Care Cost (Onle possible 17.  Retirement Heal th Care Cost (Onle possible 17.  Retirement Heal th Care Cost (Onle possible 17.  Retirement Heal th Care Cost (Onle possible 17.  Retirement Heal th Care Cost (Onle possible 17.  Retirement Heal th Care Cost (Onle possible 17.  Retirement Heal th Care Cost (Onle possible 17.  Reti	13.00	Disability Insurance (If employee is owner or beneficiary)	0	13. 00
16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.  Non cumulative portion)  TAXES  17.00 FI CA-Employers Portion Only Medicare Taxes - Employers Portion Only Unemployment Insurance 20.00 State or Federal Unemployment Taxes  19,044  20.00  OTHER  21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))  22.00 Day Care Cost and Allowances  Tuition Reimbursement  24.00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost	14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
Non cumulative portion   TAXES   To A-Employers Portion Only   Taxes   To A-Employers Portion Only   To A-Employers Portion	15.00	'Workers' Compensation Insurance	225, 465	15. 00
TAXES     17. 00   FI CA-Employers Portion Only     781, 472   17. 00   18. 00   Medicare Taxes - Employers Portion Only   0   18. 00   19. 00	16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
17. 00   FI CA-Employers Portion Only   18. 00   Medicare Taxes - Employers Portion Only   0   18. 00   19. 0				
18.00       Medicare Taxes - Employers Portion Only       0       18.00         19.00       Unemployment Insurance       0       19.00         20.00       State or Federal Unemployment Taxes       19,044       20.00         OTHER         21.00       Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))       0       21.00         22.00       Day Care Cost and Allowances       0       22.00         23.00       Tuit ion Reimbursement       29,378       23.00         24.00       Total Wage Related cost (Sum of Lines 1 -23)       1,847,847       24.00         Part B - Other than Core Related Cost				
19. 00       Unempl oyment Insurance       0       19. 00         20. 00       State or Federal Unempl oyment Taxes       19, 044       20. 00         OTHER         21. 00       Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))       0       21. 00         22. 00       Day Care Cost and Allowances       0       22. 00         23. 00       Tuit ion Reimbursement       29, 378       23. 00         24. 00       Total Wage Related cost (Sum of Lines 1 -23)       1, 847, 847       24. 00         Part B - Other than Core Related Cost				
20.00 State or Federal Unemployment Taxes 19,044 20.00 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 0 22.00 Tuition Reimbursement 29,378 23.00 Total Wage Related cost (Sum of Lines 1 -23) 1,847,847 24.00 Part B - Other than Core Related Cost				
OTHER  21. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))  22. 00 Day Care Cost and Allowances  23. 00 Tuition Reimbursement  24. 00 Total Wage Related cost (Sum of Lines 1 -23)  Part B - Other than Core Related Cost  21. 00 21. 00  22. 00  22. 00  22. 00  24. 00  25. 00  26. 00  27. 00  29. 378  29. 378  20. 00  24. 00  24. 00			1	
21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))  22.00 Day Care Cost and Allowances  Tuition Reimbursement  24.00 Total Wage Related cost (Sum of Lines 1 -23)  Part B - Other than Core Related Cost	20. 00		19, 044	20.00
instructions))  22.00 Day Care Cost and Allowances  Tuition Reimbursement  24.00 Total Wage Related cost (Sum of lines 1 -23) Part B - Other than Core Related Cost				
22. 00       Day Care Cost and Allowances       0       22. 00         23. 00       Tuition Reimbursement       29, 378       23. 00         24. 00       Total Wage Related cost (Sum of lines 1 -23)       1,847,847       24. 00         Part B - Other than Core Related Cost       20. 00       22. 00       23. 00       24. 00	21. 00		0	21. 00
23. 00			_	
24.00 Total Wage Related cost (Sum of lines 1 -23) Part B - Other than Core Related Cost  1,847,847 24.00			_	
Part B - Other than Core Related Cost			1	
	24. 00		1, 847, 847	24.00
25. 00   OTHER WAGE RELATED COSTS (SPECIFY)   25. 00				
	25. 00	UTHER WAGE RELATED COSTS (SPECIFY)	I	25.00

Health Financial Systems	RH OF NORTHWEST	INDIANA, LLC		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der Co		Period: From 02/01/2021	Worksheet A	
				To 01/31/2022	Date/Time Pre 6/1/2022 10:5	
Cost Center Description	Sal ari es	Other	Total (col.	Reclassi fi cati	Recl assi fi ed	
			+ col . 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col . 4)	
	1.00	2.00	3.00	4. 00	5. 00	

				T	01/31/2022	Date/Time Prep 6/1/2022 10:58	
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Reclassi fi ed	
	'			+ col . 2)	ons (See A-6)	Trial Balance	
				,	, ,	(col. 3 +-	
						col. 4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT		0	0	946, 684	946, 684	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		1, 517, 221	1, 517, 221	-1, 163, 410	353, 811	2. 00
3.00	00300 OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	55, 905	14, 581	70, 486	23, 838	94, 324	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	2, 010, 700	1, 708, 863	3, 719, 563	134, 466	3, 854, 029	5.00
7.00	00700 OPERATION OF PLANT	0	4, 319	4, 319	0	4, 319	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	76, 463	76, 463	0	76, 463	8. 00
9.00	00900 HOUSEKEEPI NG	0	4, 400	4, 400	0	4, 400	9. 00
10.00	01000 DI ETARY	89, 204	268, 033	357, 237	0	357, 237	10.00
11. 00	01100 CAFETERI A	0	0	0	0	0	11.00
13.00	01300 NURSING ADMINISTRATION	651, 570	132, 656	784, 226	o	784, 226	13.00
16.00	01600 MEDICAL RECORDS & LIBRARY	139, 008	34, 227	173, 235	o	173, 235	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	5, 226, 721	4, 738, 295	9, 965, 016	0	9, 965, 016	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	2, 398	508, 070	·	•	435, 183	
54. 00	05400   RADI OLOGY-DI AGNOSTI C	0	317, 551	317, 551	75, 285	392, 836	
60.00	06000 LABORATORY	0	1, 221, 738	1, 221, 738	0	1, 221, 738	60.00
65.00	06500 RESPI RATORY THERAPY	1, 079, 692	685, 304		-38, 931	1, 726, 065	65.00
66. 00	06600 PHYSI CAL THERAPY	390, 630	105, 140	495, 770	0	495, 770	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	208, 343	21, 658	230, 001	0	230, 001	67.00
68. 00	06800 SPEECH PATHOLOGY	127, 314	35, 242	162, 556	0	162, 556	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	46, 357	46, 357	0	46, 357	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	118, 237	1, 449, 149	1, 567, 386	38, 931	1, 606, 317	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	704, 435	1, 081, 983	1, 786, 418	0	1, 786, 418	73.00
74.00	07400 RENAL DI ALYSI S	0	540, 919	540, 919	0	540, 919	74.00
76.00	03950 WOUND CARE	0	0	0	0	0	76.00
	SPECIAL PURPOSE COST CENTERS						
118.00		10, 804, 157	14, 512, 169	25, 316, 326	-58, 422	25, 257, 904	118. 00
	NONREI MBURSABLE COST CENTERS						
	07950 PROVIDER RELATIONS NRCC	0	0	0	58, 422	58, 422	
	07951 NRCC SUBLEASED SPACE	0	0	0	0		194. 01
200.00	TOTAL (SUM OF LINES 118 through 199)	10, 804, 157	14, 512, 169	25, 316, 326	0	25, 316, 326	200. 00

Provider CCN: 15-2024

				6/1/2022 10	): 58 am_
	Cost Center Description	Adjustments	Net Expenses		
			For Allocation		
		6. 00	7. 00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FIXT	0	946, 684		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	74, 522	428, 333		2. 0
3.00	00300 OTHER CAP REL COSTS	0	0		3. 0
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	94, 324		4. 0
5.00	00500 ADMINISTRATIVE & GENERAL	1, 405, 147	5, 259, 176		5. 0
7.00	00700 OPERATION OF PLANT	0	4, 319		7. 0
8.00	00800 LAUNDRY & LINEN SERVICE	0	76, 463		8. 0
9.00	00900 HOUSEKEEPI NG	0	4, 400		9. 0
10.00	01000 DI ETARY	0	357, 237		10.00
11.00	01100 CAFETERI A	0	O		11.0
13.00	01300 NURSING ADMINISTRATION	0	784, 226		13. 0
16. 00	01600 MEDICAL RECORDS & LIBRARY	-275	172, 960		16. 0
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	-25, 315	9, 939, 701		30.0
	ANCILLARY SERVICE COST CENTERS		, , , , ,		
50.00	05000 OPERATI NG ROOM	0	435, 183		50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	392, 836		54. 0
60.00	06000 LABORATORY	0	1, 221, 738		60. 0
65. 00	06500 RESPIRATORY THERAPY	0	1, 726, 065		65. 0
	06600 PHYSI CAL THERAPY	0	495, 770		66. 0
	06700 OCCUPATI ONAL THERAPY	0	230, 001		67. 0
	06800 SPEECH PATHOLOGY	0	162, 556		68. 0
	06900 ELECTROCARDI OLOGY	0	46, 357		69. 0
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1, 606, 317		71. 0
	07300 DRUGS CHARGED TO PATIENTS	0	1, 786, 418		73. 0
	07400 RENAL DI ALYSI S	0	540, 919		74. 0
	03950 WOUND CARE	0	0 10, 717		76. 0
70.00	SPECIAL PURPOSE COST CENTERS		O		- 70.0
118.00		1, 454, 079	26, 711, 983		118. 0
1 10.00	NONREI MBURSABLE COST CENTERS	1, 131, 077	20, 711, 700		-110.0
194 00	07950 PROVI DER RELATI ONS NRCC	0	58, 422		194. 0
	07951 NRCC SUBLEASED SPACE	١	0		194. 0
200.00		1, 454, 079			200. 0

Health Financial Systems	RH OF NORTHWEST INDIANA, LLC	In Lieu of Form CMS-2552-10
RECLASSI FI CATI ONS	Provi der CCN: 15-2024	Period: Worksheet A-6 From 02/01/2021

					То	01/31/2022	Date/Time Pr 6/1/2022 10:	epared: 58 am
		Increases					07 17 2022 10.	
	Cost Center	Li ne #	Sal ary	Other				
	2. 00	3. 00	4. 00	5. 00				
	A - FACILITY RENT							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	94 <u>6, 6</u> 84				1. 00
	TOTALS		0	946, 684				
	B - EMPLOYEE BENEFITS							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2 <u>3, 8</u> 38				1. 00
	TOTALS		0	23, 838				
	C - CAPITAL RECONCILIATION							
1.00	ADMI NI STRATI VE & GENERAL	5. 00	0_	21 <u>6, 7</u> 26				1. 00
	TOTALS		0	216, 726				
	D - PROVIDER RELATIONS NRCC							
1.00	PROVIDER RELATIONS NRCC	1 <u>94.</u> 00	4 <u>1, 4</u> 43	1 <u>6, 9</u> 79				1. 00
	TOTALS		41, 443	16, 979				_
	E - PICC LINE RECLASS							
1.00	RADI OLOGY-DI AGNOSTI C	<u>54.</u> 00	0	7 <u>5, 2</u> 85				1. 00
	TOTALS		0	75, 285				
	F - OXYGEN TANK RENTAL							
1. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	38, 931				1. 00
	PATI ENT		↓					
	TOTALS		0	38, 931				
500.00	Grand Total: Increases		41, 443	1, 318, 443				500.00

Health Financial Systems RECLASSIFICATIONS RH OF NORTHWEST INDIANA, LLC In Lieu of Form CMS-2552-10 Provider CCN: 15-2024 Worksheet A-6

Peri od: From 02/01/2021 To 01/31/2022 Date/Time Prepared: 6/1/2022 10:58 am Decreases Cost Center Li ne # Sal ary Other Wkst. A-7 Ref.

	6. 00	7. 00	8. 00	9. 00	10. 00	
	A - FACILITY RENT					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	94 <u>6, 6</u> 84	10	1.00
	TOTALS		0	946, 684		
	B - EMPLOYEE BENEFITS					
1.00	ADMI NI STRATI VE & GENERAL	5. 00	0	<u>23, 8</u> 38	0	1. 00
	TOTALS		0	23, 838		_
	C - CAPITAL RECONCILIATION					4
1.00	CAP REL COSTS-MVBLE EQUIP		0	<u>216, 7</u> 26	12	1.00
	TOTALS		0	216, 726		
	D - PROVIDER RELATIONS NRCC					4
1.00	ADMI NI STRATI VE & GENERAL		<u>41, 4</u> 43	1 <u>6, 9</u> 79	0	1. 00
	TOTALS		41, 443	16, 979		_
	E - PICC LINE RECLASS	,				4
1. 00	OPERATING ROOM	50.00	0	7 <u>5, 2</u> 85	0	1.00
	TOTALS		0	75, 285		_
	F - OXYGEN TANK RENTAL					4
1. 00	RESPIRATORY THERAPY	65.00	0	3 <u>8, 9</u> 31	0	1.00
	TOTALS		0	38, 931		
500.00	Grand Total: Decreases		41, 443	1, 318, 443		500.00

Subtotal (sum of lines 1-7)

Reconciling Items

10.00 Total (line 8 minus line 9)

8.00

9.00

8.00

9.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provi der CCN: 15-2024 Peri od: Worksheet A-7 From 02/01/2021 Part I Date/Time Prepared: 01/31/2022 6/1/2022 10:58 am Acqui si ti ons Begi nni ng Purchases Total Di sposal s and Donati on Bal ances Retirements 2.00 3.00 4. 00 5. 00 1 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 0 1.00 0 2.00 Land Improvements 0 0 0 2.00 3.00 Buildings and Fixtures 3.00 0 Building Improvements 0 4.00 274, 696 10,070 10, 070 0 4.00 5.00 Fixed Equipment 0 0 5.00 0 6.00 Movable Equipment 3, 257, 606 528, 080 528, 080 0 6.00 0 7.00 HIT designated Assets 0 7.00 0 8.00 Subtotal (sum of lines 1-7) 3, 532, 302 538, 150 538, 150 0 8.00 9.00 Reconciling Items 0 0 9.00 Total (line 8 minus line 9) 3, 532, 302 538, 150 538, 150 10.00 10.00 0 0 Endi ng Bal ance Fully Depreciated Assets 6.00 7. 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 0 1.00 2.00 Land Improvements 0 0 2.00 3.00 Buildings and Fixtures 0 0 3.00 0 4.00 Building Improvements 284, 766 4.00 5.00 Fi xed Equipment 0 5.00 Movable Equipment 0 6.00 3, 785, 686 6.00 7.00 HIT designated Assets 0 7.00

4,070,452

4,070,452

0

0

Heal th	Financial Systems	RH OF NORTHWEST	INDIANA, LLC		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co		eri od:	Worksheet A-7	
					rom 02/01/2021 o 01/31/2022	Part II   Date/Time Pre	narod:
				'	0 01/31/2022	6/1/2022 10: 58	
	·		Sl	JMMARY OF CAPIT	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
					instructions)		
		9. 00	10.00	11. 00	12. 00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	<u>IN 2, LINES 1 a</u>	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	0	(	0	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	315, 069				34, 614	2. 00
3.00	Total (sum of lines 1-2)	315, 069		3, 591	225, 248	34, 614	3. 00
		SUMMARY 0	F CAPITAL				
		0.11	F (4)				
	Cost Center Description		Total (1) (sum				
		Capi tal -Relate					
		d Costs (see	through 14)				
		instructions)	15.00				
	DART II DECONCILIATION OF AMOUNTS FROM WORK	14.00	15.00				
1 00	PART II - RECONCILIATION OF AMOUNTS FROM WORK	T A, CULUN	in Z, LINES I a	nd 2			1 00
1.00	CAP REL COSTS-BLDG & FLXT	0	1 517 001				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1, 517, 221	1			2.00
3.00	Total (sum of lines 1-2)	1 0	1, 517, 221	l		ı	3. 00

Heal th	n Financial Systems	RH OF NORTHWEST	INDIANA, LLC		In Lie	eu of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Period: From 02/01/2021 To 01/31/2022	Worksheet A-7 Part III Date/Time Pre 6/1/2022 10:58	pared:
		COM	PUTATION OF RAT	TI 0S	ALLOCATION OF	OTHER CAPITAL	J Gill
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
			Leases	for Ratio	instructions)		
				(col . 1 - col 2)			
		1.00	2.00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00	CAP REL COSTS-BLDG & FLXT	284, 766		284, 76			1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	3, 785, 686		3, 785, 68			2. 00
3.00	Total (sum of lines 1-2)	4, 070, 452		4, 070, 45			3. 00
		ALLOCA	TION OF OTHER (	CAPITAL	SUMMARY C	OF CAPITAL	
	Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)	0.00	10.00	
	DART III DECONOLILATION OF CARLTAL COCTO C	6. 00	7. 00	8. 00	9. 00	10.00	
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS	1			946, 684	1. 00
2.00	CAP REL COSTS-BEDG & TTAT	0			0 389, 591		2.00
3.00	Total (sum of lines 1-2)	0	0		0 389, 591	938, 699	3. 00
0.00	Total (Sam of Times 1 2)		SI	JMMARY OF CAPI		700, 077	0.00
	Cost Center Description	Interest	Insurance (see			Total (2) (sum	
			instructions)	instructions)	Capi tal -Relate		
					d Costs (see	through 14)	
		11 00	10.00	10.00	instructions)	45.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	11.00	12.00	13. 00	14. 00	15. 00	
1. 00	CAP REL COSTS-BLDG & FIXT	ENTERS	0		0 0	946, 684	1. 00
2.00	CAP REL COSTS-BLDG & FIXT	3, 591	1	1	-		2.00
3.00	Total (sum of lines 1-2)	3, 591		·		1	
0.00	1.2.2. (22 51 1.1.55 1.2)	3,071	0,022	0.,01	.1	1 ., 5.5, 517	0.00

Peri od: Worksheet A-8 From 02/01/2021 Date/Time Prepared: (1/2022 10:58 am Provider CCN: 15-2024

				To	01/31/2022	Date/Time Prep 6/1/2022 10:58	
				Expense Classification on To/From Which the Amount is		0/1/2022 10:30	J dill
	Cook Cooker December on	D:- (0-d- (2)	A	Cook Cooker	1: "	MI+ A 7 D-6	
	Cost Center Description	Basis/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4. 00	Wkst. A-7 Ref. 5.00	
00	Investment income - CAP REL			CAP REL COSTS-BLDG & FIXT	1. 00	0	1.
00	COSTS-BLDG & FIXT (chapter 2)		0	CAD DEL COSTS MADLE FOLLID	2. 00	o	2.
00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		U	CAP REL COSTS-MVBLE EQUIP	2.00	U	۷.
00	Investment income - other		0		0.00	0	3.
00	(chapter 2) Trade, quantity, and time		0		0. 00	o	4.
	di scounts (chapter 8)		· ·				
00	Refunds and rebates of expenses (chapter 8)		0		0. 00	0	5
00	Rental of provider space by		0		0. 00	О	6
00	suppliers (chapter 8)		0		0.00	o	7
)()	Tel ephone servi ces (pay stati ons excluded) (chapter 21)		U		0. 00	U	,
00	Television and radio service		0		0. 00	0	8
	(chapter 21)				0.00		
00	Parking Lot (chapter 21) Provider-based physician	A-8-2	-25, 315		0. 00	0  0	10
	adjustment						
00	Sale of scrap, waste, etc. (chapter 23)		0		0. 00	0	11
00	Related organization transactions (chapter 10)	A-8-1	987, 100			0	12
00	Laundry and linen service		0		0. 00	0	
00	Cafeteria-employees and guests Rental of quarters to employee	1	0		0. 00 0. 00	0	14 15
	and others		0				
00	Sale of medical and surgical supplies to other than patients		0		0. 00	0	16
00	Sale of drugs to other than		0		0. 00	О	17
00	patients Sale of medical records and		0		0.00	0	18
	abstracts		_				
00	Nursing and allied health education (tuition, fees, books, etc.)		0		0. 00	0	19
00	Vending machines		0		0. 00	0	20
00	Income from imposition of		0		0. 00	0	21
	interest, finance or penalty charges (chapter 21)						
00	Interest expense on Medicare overpayments and borrowings to		0		0. 00	0	22
00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65. 00		23
	therapy costs in excess of						
00	limitation (chapter 14) Adjustment for physical	A-8-3	0	PHYSICAL THERAPY	66.00		24
00	therapy costs in excess of	7. 0 0	· ·		00.00		
00	limitation (chapter 14) Utilization review -		0	*** Cost Center Deleted ***	114. 00		25
00	physicians' compensation		O	Gost Genter Bereteu	114.00		20
00	(chapter 21) Depreciation - CAP REL		0	CAD DEL COSTS DIDO 8 FLYT	1 00		2/
00	COSTS-BLDG & FLXT		Ü	CAP REL COSTS-BLDG & FIXT	1. 00	0	26
00	Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27
00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28
00	Physicians' assistant		0		0. 00	0	29
00	Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30
	limitation (chapter 14)						
99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30
00	instructions) Adjustment for speech	A-8-3	Ω	SPEECH PATHOLOGY	68. 00		31
_ 3	pathology costs in excess of		O		55. 50		51
ΩΩ	limitation (chapter 14) CAH HIT Adjustment for		0		0. 00	o	32
00	Depreciation and Interest		U		0.00	ď	32

Heal th	Financial Systems	R	RH OF NORTHWEST	INDIANA, LLC	In Lie	eu of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES				Peri od:	Worksheet A-8	
					From 02/01/2021 To 01/31/2022	Date/Time Pre 6/1/2022 10:5	
				Expense Classification or	n Worksheet A		
				To/From Which the Amount is	to be Adjusted		
	0 1 0 1 0 1 1	D : (0   (0)		2 1 2 1	1 1 1 11	W . A 7 D C	
	Cost Center Description	Basis/Code (2)		Cost Center		Wkst. A-7 Ref.	
		1.00	2. 00	3. 00	4. 00	5. 00	
33. 00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 00
	(3)						
35.00	OTHER PERSONNAL EXPENSE	A	-54, 858	ADMINISTRATIVE & GENERAL	5.00	0	35. 00
36.00	AHA DUES	Α	-1, 033	ADMINISTRATIVE & GENERAL	5. 00	0	36.00
37.00	MEDICAL RECORDS INCOME	В	-275	MEDICAL RECORDS & LIBRARY	16.00	0	37. 00
38.00	REVERSE OF GL EXP CR FOR CARES	В	548, 460	ADMINISTRATIVE & GENERAL	5.00	0	38. 00
50.00	TOTAL (sum of lines 1 thru 49)		1, 454, 079				50.00
	(Transfer to Worksheet A,						
						I .	I

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

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

  B. Amount Received - if cost cannot be determined.
  (3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
  Note: See instructions for column 5 referencing to Worksheet A-7.

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

0

0

663, 872

1,650,972

3.00

4.00

5.00

 	<u> </u>		cara bo illarcatea ili corallir i		
			Related Organization(s) and/	or Home Office	
			incrated organization(3) and	or mome orrice	
		_		I	-
Symbol (1)	Name	Percentage of	Name	Percentage of	
, ,					
		Ownershi p		Ownershi p	
1. 00	2.00	3, 00	4, 00	5. 00	
1. 00	2.00	3.00	4. 00	5.00	
R INTERRELATIONSHIP TO RELAT	ED ORGANIZATION(S) AND/OR HO	ME OFFICE.			
D. THILKKELATIONSHIT TO KELAT	LD ONGAINT LATTION (3) AND FOR THE	WL OITTOL.			

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

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

6. 00	В	0.00 SELECT MEDICAL 100.00	6. 00
7.00		0.00	7. 00
8.00		0.00	8. 00
9.00		0.00	9. 00
10.00		0.00	10.00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

(1) Use the following symbols to indicate interrelationship to related organizations:

0.00

0.00

TOTALS (sum of lines 1-4).

Transfer column 6, line 5 to Worksheet A-8, column 2,

4.00

5.00

line 12.

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- Corporation, partnership, or other organization has financial interest in provider.
- Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der

Heal th	Financial Syste	ems		RH OF NORTHWEST I	NDI ANA, LLC		In Lie	u of Form CMS	-2552-10
STATEME OFFI CE		SERVICES FROM	RELATED ORGANI	ZATIONS AND HOME	Provider CCN:	15-2024	Peri od: From 02/01/2021 To 01/31/2022	Worksheet A- Date/Time Pr 6/1/2022 10:	epared:
	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.						07172022 10.	Jo um
	6. 00	7. 00							
	A. COSTS INCUR HOME OFFICE CO		MENTS REQUIRED	AS A RESULT OF TR	ANSACTIONS WITH	RELATED (	ORGANIZATIONS OR (	CLAI MED	
1. 00 2. 00 3. 00 4. 00 5. 00	74, 522 912, 578 0 0 987, 100	0 0							1. 00 2. 00 3. 00 4. 00 5. 00
appropr	i ate. Posi ti ve	amounts increas	se cost and neg	propriate) are trangative amounts decr	rease cost. For	related or	ganization or hom	ne office cost	whi ch

Related Organization(s)
and/or Home Office

Type of Business

6.00

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

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

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

6.00	HEALTHCARE		6. 00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
7. 00 8. 00 9. 00 10. 00 100. 00		10	100.00

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-2024

							أ	To 01/31/2022	Date/Time Pre	
	Wkst. A Line #	Cost	Center/Physician	Total	Professi ona	al	Provi der	RCE Amount	Physi ci an/Prov	
			ldenti fi er	Remuneration	Component		Component		ider Component	
					·		·		Hours	
	1. 00		2.00	3.00	4.00		5. 00	6. 00	7. 00	
1.00	30. 00 D			10, 148		0	10, 148	211, 500	62	1. 00
2.00	30. 00 D			18, 000		0	18, 000	211, 500	120	2. 00
3.00	30. 00 D			12, 500		0	12, 500	211, 500	100	
4.00	30. 00 D	R. D		12, 500		0	12, 500	211, 500	100	4. 00
5.00	30. 00 D	R. E		10, 240		0	10, 240	211, 500	64	5.00
6.00	30. 00 D	R. F		12, 219		0	12, 219	211, 500	91	6. 00
7.00	30. 00 D	R. G		1, 075		0	1, 075	211, 500	9	7. 00
8.00	30. 00 D	R. H		4, 200		0	4, 200	211, 500	28	8. 00
9.00	30. 00 D	R. I		15, 000		0	15, 000	211, 500	120	9. 00
10.00	0.00			0		0	0	0	0	10.00
200.00				95, 882		0	95, 882		694	200.00
	Wkst. A Line #	Cost	Center/Physician	Unadjusted RCE	5 Percent o	of	Cost of	Provi der	Physician Cost	
			ldenti fi er	Limit	Unadjusted R	RCE	Memberships &	Component	of Malpractice	
					Limit		Conti nui ng	Share of col.	Insurance	
							Educati on	12		
	1. 00		2. 00	8. 00	9. 00		12. 00	13.00	14. 00	
1.00	30. 00 D			6, 304		315	0	0		
2.00	30. 00 D			12, 202	•	510	0	0		2. 00
3.00	30. 00 D			10, 168	•	508	0	0	0	3. 00
4.00	30. 00 D			10, 168		508	0	0	0	4. 00
5.00	30. 00 D			6, 508		325	0	0	0	5.00
6.00	30. 00 D			9, 253	i e	163	0	0	0	6. 00
7. 00	30. 00 D			915		46	0	0	0	7. 00
8.00	30. 00 D			2, 847		142	0	0	0	8. 00
9. 00	30. 00 D	R. I		12, 202	6	510	0	0		9. 00
10.00	0.00			0		0	0	0	_	10.00
200.00				70, 567			0	0	0	200.00
	Wkst. A Line #	Cost	Center/Physician	Provi der	Adjusted RC	CE	RCE	Adjustment		
			ldenti fi er	Component	Limit		Di sal I owance			
				Share of col.						
	1.00		2. 00	14 15. 00	16. 00		17. 00	18. 00		
1. 00	30. 00 D	ıD Λ	2. 00	15.00		204	3, 844	3, 844		1. 00
2. 00	30. 00 D			0			5, 798	5, 798	•	2. 00
3. 00	30. 00 D			0			2, 332	2, 332		3. 00
4. 00	30. 00 D			0	10, 1		2, 332	2, 332		4. 00
5. 00	30. 00 D			0			3, 732	3, 732		5. 00
6. 00	30. 00 D				9, 2		2, 966	2, 966		6. 00
7. 00	30. 00 D			0		915	2, 966 160	160		7. 00
8. 00	30. 00 D			0			1, 353	1, 353		8. 00
9. 00	30. 00 D				_, ~		1, 353 2, 798	2, 798		9. 00
	0.00	ır. I			'	0	2, 798	2, 798   0	•	9. 00 10. 00
10. 00 200. 00	0.00			0		-	25, 315	_	1	200. 00
200.00	I I			1	10,5	100	∠0, 315	20,315	I	200.00

Health Financial Systems		RH OF NORTHWEST INDIANA, LLC			In Lieu of Form CMS-2552-		
COST A	NLLOCATION - GENERAL SERVICE COSTS		Provider CO		Period: From 02/01/2021 To 01/31/2022	Worksheet B Part I Date/Time Pre 6/1/2022 10:5	pared: 8 am
			CAPI TAL REI	ATED COSTS			
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		0	1. 00	2. 00	4. 00	4A	
	GENERAL SERVICE COST CENTERS	,					
1.00	00100 CAP REL COSTS-BLDG & FIXT	946, 684	946, 684				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	428, 333		428, 33			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	94, 324	4, 761				4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	5, 259, 176	125, 647	56, 85			5. 00
7.00	00700 OPERATION OF PLANT	4, 319				416, 331	
8.00	00800 LAUNDRY & LINEN SERVICE	76, 463	14, 916			98, 128	
9.00	00900 HOUSEKEEPI NG	4, 400	8, 664			16, 984	
10.00	01000 DI ETARY	357, 237	7, 395	3, 34	6 840	368, 818	10.00
11. 00	01100  CAFETERI A	0	0		0	0	11. 00
13.00	01300 NURSING ADMINISTRATION	784, 226	8, 156	3, 69	0 6, 137	802, 209	13. 00
16. 00		172, 960	5, 110	2, 31	2 1, 309	181, 691	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00		9, 939, 701	406, 679	184, 00	49, 233	10, 579, 617	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	435, 183	0		0 23	435, 206	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	392, 836	0		0	392, 836	
60.00	06000 LABORATORY	1, 221, 738				1, 229, 805	
65.00	06500 RESPI RATORY THERAPY	1, 726, 065	11, 901	5, 38		1, 753, 521	65.00
66.00	06600 PHYSI CAL THERAPY	495, 770	6, 633	3, 00	1 3, 679	509, 083	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	230, 001	6, 633	3, 00	1, 962	241, 597	67. 00
68.00	06800 SPEECH PATHOLOGY	162, 556	3, 015	1, 36	4 1, 199	168, 134	68. 00
69. 00	06900 ELECTROCARDI OLOGY	46, 357	0		0	46, 357	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 606, 317	23, 358	10, 56	9 1, 114	1, 641, 358	71. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 786, 418	22, 692	10, 26	7 6, 635	1, 826, 012	73. 00
74.00	07400 RENAL DIALYSIS	540, 919	0		0	540, 919	74.00
76.00	03950 WOUND CARE	O	0		0	0	76. 00
	SPECIAL PURPOSE COST CENTERS						1
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	26, 711, 983	944, 780	427, 47	1 100, 849	26, 708, 827	118. 00
	NONREI MBURSABLE COST CENTERS						
	07950 PROVIDER RELATIONS NRCC	58, 422	1, 904	86	2 390	61, 578	194. 00
194. 01	07951 NRCC SUBLEASED SPACE	0	0		0		194. 01
200.00						0	200. 00
201.00	Negative Cost Centers		0		0		201. 00
202.00	TOTAL (sum lines 118 through 201)	26, 770, 405	946, 684	428, 33	3 101, 239	26, 770, 405	202. 00

Provider CCN: 15-2024

In Lieu of Form CMS-2552-10

| Period: | Worksheet B |
| From 02/01/2021 | Part |
| To 01/31/2022 | Date/Time Prepared: 6/1/2022 10:58 am

						6/1/2022 10:5	8 am
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVICE			
		5.00	7. 00	8. 00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL	5, 460, 221					5. 00
7.00	00700 OPERATION OF PLANT	106, 675	523, 006				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	25, 143	14, 647	137, 918			8. 00
9.00	00900 HOUSEKEEPI NG	4, 352	8, 508	0	29, 844		9. 00
10.00	01000 DI ETARY	94, 501	7, 261	0	434	471, 014	10.00
11. 00	01100 CAFETERI A	0	0	0	o	0	11. 00
13.00	01300 NURSING ADMINISTRATION	205, 547	8, 009	0	478	0	13. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	46, 554	5, 018	0	300	0	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	2, 710, 769	399, 345	137, 918	23, 842	471, 014	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	111, 511	0	0	0	0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	100, 655	0	0	0	0	54.00
60.00	06000 LABORATORY	315, 108	5, 454	0	326	0	60.00
65.00	06500 RESPI RATORY THERAPY	449, 298	11, 687	0	698	0	65. 00
66.00	06600 PHYSI CAL THERAPY	130, 440	6, 513	0	389	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	61, 903	6, 513	0	389	0	67. 00
68.00	06800 SPEECH PATHOLOGY	43, 080	2, 961	0	177	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	11, 878	0	0	0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	420, 559	22, 937	0	1, 369	0	71. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	467, 872	22, 283	0	1, 330	0	73. 00
74.00	07400 RENAL DIALYSIS	138, 598	0	0	o	0	74.00
76.00	03950 WOUND CARE	0	0	0	o	0	76. 00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	5, 444, 443	521, 136	137, 918	29, 732	471, 014	118. 00
	NONREI MBURSABLE COST CENTERS						
194.00	07950 PROVIDER RELATIONS NRCC	15, 778	1, 870	0	112	0	194. 00
194.0	1 07951 NRCC SUBLEASED SPACE	0	0	0	o	0	194. 01
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers	0	0	0	o	0	201. 00
202.00	TOTAL (sum lines 118 through 201)	5, 460, 221	523, 006	137, 918	29, 844	471, 014	202. 00

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 02/01/2021 Part I Provider CCN: 15-2024

					o 01/31/2022	Date/Time Prep 6/1/2022 10:58	
	Cost Center Description	CAFETERI A	NURSI NG	MEDI CAL	Subtotal	Intern &	
			ADMI NI STRATI ON	RECORDS &		Residents Cost	
				LI BRARY		& Post	
						Stepdown	
						Adjustments	
	1	11. 00	13. 00	16. 00	24. 00	25. 00	
	GENERAL SERVICE COST CENTERS	T	T T		T		
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10. 00
11. 00	01100 CAFETERI A	0					11. 00
13.00	01300 NURSING ADMINISTRATION	0	1, 016, 243				13. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0	233, 563			16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	0	1, 016, 243	81, 539	15, 420, 287	0	30. 00
	ANCILLARY SERVICE COST CENTERS		1				
50. 00	05000 OPERATI NG ROOM	0	0	1, 245		1	50. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0	4, 636	·	0	54. 00
60. 00	06000 LABORATORY	0	0	15, 257			60. 00
65.00	06500 RESPI RATORY THERAPY	0	0	72, 408		1	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0	3, 916	·	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	2, 827			67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	1, 244	·		68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	8, 043		1	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	20, 471	2, 106, 694	0	71. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	16, 612			73. 00
74.00	07400 RENAL DIALYSIS	0	0	5, 365		1	74. 00
76. 00	03950 WOUND CARE	0	0	0	0	0	76. 00
	SPECIAL PURPOSE COST CENTERS	T	,				
118.00		0	1, 016, 243	233, 563	26, 691, 067	0	118. 00
	NONREI MBURSABLE COST CENTERS	T					
	07950 PROVI DER RELATIONS NRCC	0	0	0	79, 338		194. 00
	07951 NRCC SUBLEASED SPACE	0	0	0	0		194. 01
200.00	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				0		200. 00
201.00		0	0	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	0	1, 016, 243	233, 563	26, 770, 405	, 0	202. 00

| Period: | Worksheet B | From 02/01/2021 | Part | To 01/31/2022 | Date/Time Prepared: Provider CCN: 15-2024

To 01/31/2022 Date/Time Pr 6/1/2022 10:	
Cost Center Description Total	Jo um
26.00	
GENERAL SERVICE COST CENTERS	
1.00 O0100 CAP REL COSTS-BLDG & FIXT	1.00
2. 00   00200   CAP REL COSTS-MVBLE EQUI P	2. 00
4.00 O0400 EMPLOYEE BENEFITS DEPARTMENT	4. 00
5.00   00500   ADMINISTRATIVE & GENERAL	5. 00
7.00   00700   OPERATION OF PLANT	7. 00
8.00   00800   LAUNDRY & LINEN SERVICE	8. 00
9. 00   00900   HOUSEKEEPI NG	9. 00
10. 00   01000   DI ETARY	10.00
11. 00   01100   CAFETERI A	11.00
13.00   01300   NURSI NG ADMI NI STRATI ON	13.00
16. 00 O1600 MEDICAL RECORDS & LIBRARY	16. 00
INPATIENT ROUTINE SERVICE COST CENTERS	
30. 00   03000  ADULTS & PEDI ATRI CS   15, 420, 287	30.00
ANCILLARY SERVICE COST CENTERS	
50. 00   05000   OPERATI NG ROOM   547, 962	50. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C 498, 127	54. 00
60. 00   06000   LABORATORY   1, 565, 950	60.00
65. 00   06500   RESPI RATORY THERAPY   2, 287, 612	65. 00
66. 00   06600   PHYSI CAL THERAPY   650, 341	66. 00
67. 00   06700   OCCUPATI ONAL THERAPY 313, 229	67. 00
68. 00   06800   SPEECH PATHOLOGY   215, 596	68. 00
69. 00   06900   ELECTROCARDI OLOGY   66, 278	69. 00
71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENT   2,106,694	71. 00
73.00   07300   DRUGS CHARGED TO PATIENTS   2,334,109	73. 00
74. 00   07400   RENAL DI ALYSI S   684, 882	74. 00
76. 00   03950  WOUND_CARE   0	76. 00
SPECIAL PURPOSE COST CENTERS	
118.00   SUBTOTALS (SUM OF LINES 1 through 117)   26,691,067	118. 00
NONREI MBURSABLE COST CENTERS	
194. 00 07950 PROVI DER RELATI ONS NRCC 79, 338	194. 00
194. 01 07951 NRCC SUBLEASED SPACE 0	194. 01
200.00 Cross Foot Adjustments 0	200. 00
201. 00 Negative Cost Centers 0	201. 00
202.00   TOTAL (sum lines 118 through 201)   26,770,405	202. 00

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-2024 Peri od: Worksheet B From 02/01/2021 Part II 01/31/2022 Date/Time Prepared: 6/1/2022 10:58 am CAPITAL RELATED COSTS **EMPLOYEE** Cost Center Description Directly BLDG & FIXT MVBLE EQUIP Subtotal Assigned New **BENEFITS** Capi tal DEPARTMENT Related Costs 0 1.00 2.00 2A 4.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4, 761 2, 154 6, 915 6, 915 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 132 125, 647 56,850 182, 629 1, 266 5.00 00700 OPERATION OF PLANT 0 7 00 283, 666 128 346 412, 012 7 00 0 00800 LAUNDRY & LINEN SERVICE 8.00 14, 916 6,749 21,665 0 8.00 0 9.00 00900 HOUSEKEEPI NG 8, 664 3, 920 12, 584 0 9.00 0 7, 395 01000 DI ETARY 10, 741 57 10.00 10 00 3, 346 01100 CAFETERI A 11.00 0 11.00 13.00 01300 NURSING ADMINISTRATION 0 8, 156 3, 690 11, 846 419 13.00 01600 MEDICAL RECORDS & LIBRARY <u>2, 3</u>12 16.00 0 5, 110 7, 422 89 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 406, 679 184,004 590, 683 3, 365 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54 00 60.00 06000 LABORATORY 0 5, 554 2, 513 8,067 0 60.00 38, 931 06500 RESPIRATORY THERAPY 11, 901 5, 385 56, 217 694 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 6, 633 3,001 9, 634 251 66.00 0 06700 OCCUPATIONAL THERAPY 9, 634 67.00 0 6, 633 3.001 134 67.00 68.00 06800 SPEECH PATHOLOGY 0 3, 015 1, 364 4, 379 82 68.00 06900 ELECTROCARDI OLOGY 69.00 69.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 23, 358 10, 569 310, 249 71.00 276, 322 76 71.00 07300 DRUGS CHARGED TO PATIENTS 73.00 22, 692 10, 267 32, 959 453 73.00 74.00 07400 RENAL DIALYSIS 0 74.00 0 03950 WOUND CARE 76.00 0 76.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 427, 471 6, 888 118. 00 118.00 315, 385 944, 780 1, 687, 636 NONREI MBURSABLE COST CENTERS 194. 00 07950 PROVI DER RELATIONS NRCC 0 1, 904 862 2.766 27 194. 00 194. 01 07951 NRCC SUBLEASED SPACE 0 0 194. 01 0 0 200.00 Cross Foot Adjustments 0 200.00 0 201.00 201.00 Negative Cost Centers

315, 385

946, 684

428, 333

1, 690, 402

6, 915 202. 00

202.00

TOTAL (sum lines 118 through 201)

Provider CCN: 15-2024

| Peri od: | Worksheet B | From 02/01/2021 | Part II | To 01/31/2022 | Date/Time Prepared:

				''	01/31/2022	6/1/2022 10:5	
	Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVICE			
		5. 00	7. 00	8. 00	9. 00	10. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	183, 895					5. 00
7.00	00700 OPERATION OF PLANT	3, 593	415, 605				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	847	11, 640	34, 152			8. 00
9.00	00900 HOUSEKEEPI NG	147	6, 761	0	19, 492		9. 00
10.00	01000 DI ETARY	3, 183	5, 770	0	283	20, 034	10.00
11. 00	01100 CAFETERI A	0	0	0	0	0	11. 00
13.00	01300 NURSING ADMINISTRATION	6, 922	6, 365	0	312	0	13.00
16.00	01600 MEDICAL RECORDS & LIBRARY	1, 568	3, 987	0	196	0	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	91, 299	317, 336	34, 152	15, 573	20, 034	30.00
	ANCILLARY SERVICE COST CENTERS		, , , , , , , , , , , , , , , , , , , ,		.,	.,	1
50.00	05000 OPERATI NG ROOM	3, 755	0	0	0	0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 390		0	o	0	54.00
60.00	06000 LABORATORY	10, 612	l e	0	213	0	60.00
65. 00	06500 RESPIRATORY THERAPY	15, 131	· ·		456	0	65. 00
66, 00	06600 PHYSI CAL THERAPY	4, 393	· ·		254	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	2, 085			254	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	1, 451	2, 353		115	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	400		0	0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	14, 163		0	894	0	71. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	15, 757		0	869	0	73. 00
74. 00	07400 RENAL DI ALYSI S	4, 668	· ·		0	0	74.00
	03950 WOUND CARE	0	0	آ م	0	0	
70.00	SPECIAL PURPOSE COST CENTERS				٩		70.00
118. 00		183, 364	414, 119	34, 152	19, 419	20 034	118. 00
110.00	NONREI MBURSABLE COST CENTERS	100,001	111, 117	01,102	17, 117	20,001	1110.00
194 00	07950 PROVI DER RELATI ONS NRCC	531	1, 486	0	73	0	194. 00
	07951 NRCC SUBLEASED SPACE	0	1, 400	١	, 9		194. 01
200.00			١		٩	O	200. 00
201.00	, ,	0	<u> </u>	n	0	Λ	201. 00
202.00	1 1 9	183, 895	415, 605	34, 152	19, 492		202. 00
202.00	/ TOTAL (Sum Titles The through 201)	103,093	1 415,005	] 34, 132	17,472	20, 034	1202.00

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-2024 Peri od: Worksheet B From 02/01/2021 Part II 01/31/2022 Date/Time Prepared: 6/1/2022 10:58 am Cost Center Description CAFETERI A NURSI NG MEDI CAL Subtotal Intern & ADMI NI STRATI ON RECORDS & Residents Cost LI BRARY & Post Stepdown Adjustments 11.00 13.00 16.00 24.00 25.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 0 13.00 25, 864 13.00 16.00 01600 MEDICAL RECORDS & LIBRARY 13, 262 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 0 25, 864 1, 102, 922 30.00 30 00 4, 616 n ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 50.00 71 3, 828 0 0 0 0 0 0 0 0 0 0 0 05400 RADI OLOGY-DI AGNOSTI C 54.00 54 00 0 264 3,654 0 24, 094 60.00 06000 LABORATORY 0 868 0 60.00 65.00 06500 RESPIRATORY THERAPY 0 4, 117 85, 902 0 65.00 06600 PHYSI CAL THERAPY 19, 931 66.00 223 0 66.00 06700 OCCUPATIONAL THERAPY 0 17, 444 67.00 67 00 Ω 161 06800 SPEECH PATHOLOGY 68.00 0 71 8, 451 0 68.00 69.00 06900 ELECTROCARDI OLOGY 457 857 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 0 1, 164 344, 773 0 71.00 07300 DRUGS CHARGED TO PATIENTS 73.00 Ω 945 68, 690 73.00 0 07400 RENAL DIALYSIS 74.00 305 4, 973 0 74.00 76.00 03950 WOUND CARE 0 76.00 SPECIAL PURPOSE COST CENTERS | SUBTOTALS (SUM OF LINES 1 through 117) | NONRE| MBURSABLE COST CENTERS 25, 864 0 118. 00 118.00 0 1, 685, 519 13, 262 194. 00 07950 PROVI DER RELATIONS NRCC 0 194. 00 4,883

o

C

25, 864

0

13, 262

0

0

1, 690, 402

0 194. 01

0 200. 00

0 201. 00

0 202.00

194. 01 07951 NRCC SUBLEASED SPACE

Cross Foot Adjustments

TOTAL (sum lines 118 through 201)

Negative Cost Centers

200.00

201.00

202.00

Period: Worksheet B
From 02/01/2021 Part II
To 01/21/2022 Part II
To 01/21/2022 Part II
To 01/21/2022 Part II
To 01/21/2022 Part II
To 01/21/2022 Part II
To 01/21/2022 Part II
To 01/21/2022 Part II
To 01/21/2022 Part II Provider CCN: 15-2024

			To 01/31/2	2022 Date/Time Prepared: 6/1/2022 10:58 am
	Cost Center Description	Total		07 17 2022 10. 38 4111
	oost conten beschiption	26, 00		
	GENERAL SERVICE COST CENTERS	20.00		
	00100 CAP REL COSTS-BLDG & FLXT			1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT			4. 00
5.00	00500 ADMINISTRATIVE & GENERAL			5. 00
7.00	00700 OPERATION OF PLANT			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE			8. 00
	00900 HOUSEKEEPI NG			9. 00
	01000 DI ETARY			10. 00
	01100 CAFETERI A			11. 00
	01300 NURSING ADMINISTRATION			13. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY			16. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	4 400 000		20.00
30.00	03000 ADULTS & PEDIATRICS ANCILLARY SERVICE COST CENTERS	1, 102, 922		30.00
50. 00	05000 OPERATING ROOM	3, 828		50.00
	05400 RADI OLOGY-DI AGNOSTI C	3, 654		54.00
	06000 LABORATORY	24, 094		60.00
	06500 RESPIRATORY THERAPY	85, 902		65. 00
	06600 PHYSI CAL THERAPY	19, 931		66.00
	06700 OCCUPATI ONAL THERAPY	17, 444		67. 00
	06800 SPEECH PATHOLOGY	8, 451		68.00
	06900 ELECTROCARDI OLOGY	857		69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	344, 773		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	68, 690		73. 00
74.00	07400 RENAL DIALYSIS	4, 973		74. 00
76.00	03950 WOUND CARE	0		76. 00
	SPECIAL PURPOSE COST CENTERS			
118.00	7	1, 685, 519		118. 00
	NONREI MBURSABLE COST CENTERS			
	07950 PROVI DER RELATI ONS NRCC	4, 883		194. 00
	07951 NRCC SUBLEASED SPACE	0		194. 01
200.00		0		200. 00
201.00	1 9	0		201. 00
202. 00	TOTAL (sum lines 118 through 201)	1, 690, 402		202. 00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-2024 Peri od: Worksheet B-1 From 02/01/2021 01/31/2022 Date/Time Prepared: 6/1/2022 10:58 am CAPITAL RELATED COSTS Reconciliation ADMINISTRATIVE Cost Center Description BLDG & FIXT MVBLE EQUIP **EMPLOYEE** (SQUARE FEET) (SQUARE FEET) BENEFITS & GENERAL DEPARTMENT (ACCUM COST) (GROSS SALARI ES) 1.00 2.00 5A 5. 00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 29 829 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 29, 829 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 150 10, 748, 252 4.00 150 00500 ADMINISTRATIVE & GENERAL 3. 959 5 00 3 959 1, 969, 257 -5, 460, 221 21, 310, 184 5 00 7.00 00700 OPERATION OF PLANT 8,938 8,938 C 416, 331 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 470 470 0 98, 128 8.00 0 9.00 00900 HOUSEKEEPI NG 273 273 16, 984 9.00 C 01000 DI ETARY 10.00 89, 204 368, 818 10 00 233 233 11.00 01100 CAFETERI A 0 0 Ω 11.00 01300 NURSING ADMINISTRATION 257 257 651, 570 0 802, 209 13.00 13.00 01600 MEDICAL RECORDS & LIBRARY 16, 00 139,008 181, 691 16, 00 161 161 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 12, 814 12, 814 5, 226, 721 0 10, 579, 617 30.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 435, 206 50.00 2, 398 0 0 50.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 0 C Ω 0 392, 836 54 00 60.00 06000 LABORATORY 175 175 0 1, 229, 805 60.00 65.00 06500 RESPIRATORY THERAPY 375 375 1, 079, 692 1, 753, 521 65.00 0 66.00 06600 PHYSI CAL THERAPY 209 390, 630 509, 083 66.00 209 06700 OCCUPATIONAL THERAPY 67.00 209 209 208, 343 241, 597 67.00 06800 SPEECH PATHOLOGY 95 95 127, 314 168, 134 68.00 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 46, 357 69.00 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 118, 237 1, 641, 358 71.00 736 736 0 73.00 07300 DRUGS CHARGED TO PATIENTS 715 715 704, 435 1, 826, 012 73.00 07400 RENAL DIALYSIS 540, 919 74.00 0 74.00 76.00 03950 WOUND CARE 0 0 0 76.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 29, 769 29, 769 10, 706, 809 21, 248, 606 118. 00 -5, 460, 221 NONREI MBURSABLE COST CENTERS 194, 00 07950 PROVIDER RELATIONS NRCC 61, 578 194. 00 60 60 41, 443 0 194. 01 07951 NRCC SUBLEASED SPACE O 0 194. 01 200. 00 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 201. 00 202.00 Cost to be allocated (per Wkst. B, 946, 684 428, 333 101, 239 5, 460, 221 202. 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 31. 737034 14. 359616 0.009419 0. 256226 203. 00 204.00 Cost to be allocated (per Wkst. B, 6, 915 183, 895 204. 00 Part II) 0.008629 205.00 205.00 Unit cost multiplier (Wkst. B, Part 0.000643 II)206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207.00 207.00 Parts III and IV)

Provider CCN: 15-2024

				Т	o 01/31/2022	Date/Time Pre 6/1/2022 10:5	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	alli
		PLANT	LINEN SERVICE	(SQUARE FEET)	(PATIENT DAYS)		
			(PATIENT DAYS)	,	,		
		7.00	8.00	9. 00	10.00	11. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7.00	00700 OPERATION OF PLANT	16, 782					7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	470	15, 672				8. 00
9.00	00900 HOUSEKEEPI NG	273	0	16, 039			9. 00
10.00	01000 DI ETARY	233	0	233	15, 672		10.00
11. 00	01100 CAFETERI A	0	0	0	0	0	11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	257	0	257	0	0	13. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	161	0	161	0	0	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	12, 814	15, 672	12, 814	15, 672	0	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	54.00
60.00	06000 LABORATORY	175	0	175	0	0	60.00
65.00	06500 RESPI RATORY THERAPY	375	0	375	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	209	0	209	0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	209	0	209	0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	95	0	95	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	736	0	736	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	715	0	715	0	0	73. 00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74. 00
76.00	03950 WOUND CARE	0	0	0	0	0	76. 00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	16, 722	15, 672	15, 979	15, 672	0	118. 00
	NONREI MBURSABLE COST CENTERS						
194.00	07950 PROVIDER RELATIONS NRCC	60	0	60	0	0	194. 00
194. 01	07951 NRCC SUBLEASED SPACE	0	0	0	0	0	194. 01
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201. 00
202.00	Cost to be allocated (per Wkst. B,	523, 006	137, 918	29, 844	471, 014	0	202. 00
	Part I)						
203.00		31. 164700	8. 800281	1. 860715	30. 054492		
204.00	Cost to be allocated (per Wkst. B,	415, 605	34, 152	19, 492	20, 034	0	204. 00
	Part II)						
205.00		24. 764927	2. 179173	1. 215288	1. 278331	0. 000000	205. 00
206. 00							206. 00
	(per Wkst. B-2)						
207. 00							207. 00
	Parts III and IV)	I	I	I		l	1

Health Financial Systems In Lieu of Form CMS-2552-10 RH OF NORTHWEST INDIANA, LLC COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-2024 Peri od: Worksheet B-1 From 02/01/2021 To 01/31/2022 Date/Time Prepared: 6/1/2022 10:58 am Cost Center Description NURSI NG MEDI CAL ADMI NI STRATI ON RECORDS & LI BRARY (NURSI NG (GROSS REVENUE) FTE'S) 13.00 16.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11.00 11 00 01300 NURSING ADMINISTRATION 13.00 13.00 16.00 01600 MEDICAL RECORDS & LIBRARY 189, 660, 371 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 72 30.00 30 00 66, 164, 627 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 0 1, 011, 061 50.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0000000000 54.00 3, 766, 391 06000 LABORATORY 60.00 12, 393, 791 60.00 65.00 06500 RESPIRATORY THERAPY 58, 820, 243 65.00 66. 00 06600 PHYSI CAL THERAPY 3, 181, 220 66.00 67. 00 06700 OCCUPATIONAL THERAPY 2, 296, 901 67.00 68.00 06800 SPEECH PATHOLOGY 1, 010, 559 68.00 69. 00 06900 ELECTROCARDI OLOGY 6, 533, 324 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 16, 629, 303 71.00 07300 DRUGS CHARGED TO PATIENTS 13, 494, 478 73.00 73.00 74.00 07400 RENAL DIALYSIS 4, 358, 473 74.00 03950 WOUND CARE 76.00 76.00 SPECIAL PURPOSE COST CENTERS 72 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 189, 660, 371 NONREI MBURSABLE COST CENTERS 194. 00 07950 PROVI DER RELATIONS NRCC 194.00 194. 01 07951 NRCC SUBLEASED SPACE 0 194. 01 0 200.00 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 1,016,243 233, 563 202.00 Part I) 203. 00 203.00 Unit cost multiplier (Wkst. B, Part I) 14, 114. 486111 0.001231 204.00 Cost to be allocated (per Wkst. B, 25, 864 13, 262 204.00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 359. 222222 0.000070 205.00 II)206,00 NAHE adjustment amount to be allocated 206, 00 (per Wkst. B-2)

207.00

207.00

NAHE unit cost multiplier (Wkst. D,

Parts III and IV)

Health Financial Systems	RH OF NORTHWEST	INDIANA, LLC		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CC		Period: From 02/01/2021 To 01/31/2022		pared: 8 am
		Title	XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1. 00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	15, 420, 287		15, 420, 28	7 25, 315	15, 445, 602	30. 00
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	547, 962		547, 96	2 0	547, 962	50.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	498, 127		498, 12	7 0	498, 127	54. 00
60. 00   06000   LABORATORY	1, 565, 950		1, 565, 95	0	1, 565, 950	60.00
65. 00 06500 RESPI RATORY THERAPY	2, 287, 612	0	2, 287, 61	2 0	2, 287, 612	65. 00
66. 00 06600 PHYSI CAL THERAPY	650, 341	0	650, 34	1 0	650, 341	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	313, 229	0	313, 22	9 0	313, 229	67. 00
68. 00 06800 SPEECH PATHOLOGY	215, 596	0	215, 59	6 0	215, 596	68. 00
69. 00 06900 ELECTROCARDI OLOGY	66, 278		66, 27	8 0	66, 278	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 106, 694		2, 106, 69	4 0	2, 106, 694	71. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 334, 109		2, 334, 10	9 0	2, 334, 109	73. 00
74.00 07400 RENAL DIALYSIS	684, 882		684, 88	2 0	684, 882	74. 00
76. 00   03950   WOUND CARE	0			0	0	76. 00
200 00 (0.64-4-1 ( !+)	2/ /01 0/7		2/ /01 0/	7 25 245	2/ 71/ 202	1200 00

26, 691, 067

26, 691, 067

26, 691, 067

26, 691, 067

0 76. 00 26, 716, 382 200. 00 0 201. 00

26, 716, 382 202. 00

25, 315

25, 315

200. 00 201. 00

202.00

Subtotal (see instructions) Less Observation Beds

Total (see instructions)

Heal th Financial Systems	RH OF NORTHWEST	INDIANA IIC		In Lio	u of Form CMS-2	DEE2 10
Health Financial Systems F COMPUTATION OF RATIO OF COSTS TO CHARGES	KH OF NOKIHWESI	Provi der Co		Period: From 02/01/2021	Worksheet C	pared:
		Title	: XVIII	Hospi tal	PPS	
Cost Center Description	I npati ent	Charges Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient	

		IIIIe	XVIII	ноѕрі таі	PP3	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
			+ col. 7)	Ratio	I npati ent	
					Ratio	
	6. 00	7. 00	8. 00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	66, 164, 627		66, 164, 627			30. 00
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	1, 011, 061	0	1, 011, 061	0. 541967	0. 000000	50. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	3, 766, 391	0	3, 766, 391	0. 132256	0.000000	54.00
60. 00   06000   LABORATORY	12, 393, 791	0	12, 393, 791	0. 126350	0.000000	60.00
65. 00 06500 RESPIRATORY THERAPY	58, 820, 243	0	58, 820, 243	0. 038892	0.000000	65. 00
66. 00   06600   PHYSI CAL THERAPY	3, 181, 220	0	3, 181, 220	0. 204431	0.000000	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	2, 296, 901	0	2, 296, 901	0. 136370	0.000000	67.00
68. 00 06800 SPEECH PATHOLOGY	1, 010, 559	0	1, 010, 559	0. 213343	0.000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	6, 533, 324	0	6, 533, 324	0. 010145	0.000000	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	16, 629, 303	0	16, 629, 303	0. 126686	0.000000	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	13, 494, 478	0	13, 494, 478	0. 172968	0.000000	73. 00
74. 00 07400 RENAL DIALYSIS	4, 358, 473	0	4, 358, 473	0. 157138	0.000000	74. 00
76. 00 03950 WOUND CARE	0	0	0	0. 000000	0.000000	76. 00
200.00 Subtotal (see instructions)	189, 660, 371	0	189, 660, 371			200. 00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	189, 660, 371	0	189, 660, 371			202. 00
		1		'		•

Health Financial Systems	RH OF NORTHWEST INDIANA, LLC In Lieu of Form CMS				
COMPUTATION OF RATIO OF COSTS TO CHARGES	NI G. NOKHIMEST	Provi der CCN: 15-2024	Peri od: From 02/01/2021 To 01/31/2022	Worksheet C Part I Date/Time Prepared: 6/1/2022 10:58 am	
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient Ratio 11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS				30.00	
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0. 541967			50.00	
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 132256			54.00	
60. 00   06000   LABORATORY	0. 126350			60.00	
65. 00 06500 RESPI RATORY THERAPY	0. 038892			65. 00	
66. 00 06600 PHYSI CAL THERAPY	0. 204431			66. 00	
67. 00 06700 OCCUPATI ONAL THERAPY	0. 136370			67. 00	
68. 00 06800 SPEECH PATHOLOGY	0. 213343			68. 00	
69. 00 06900 ELECTROCARDI OLOGY	0. 010145			69. 00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 126686			71.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 172968			73.00	
74.00 07400 RENAL DIALYSIS	0. 157138			74.00	
76.00 03950 WOUND CARE	0. 000000			76. 00	
200 00 Subtatal (ass instructions)	1			200.00	

200. 00 201. 00 202. 00

200. 00 201. 00

202.00

Subtotal (see instructions) Less Observation Beds

Total (see instructions)

Health Financial Systems	RH OF NORTHWEST	INDIANA, LLC		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CC		Period: From 02/01/2021 Fo 01/31/2022	Worksheet C Part I Date/Time Pre 6/1/2022 10:5	
		Titl	e XIX	Hospi tal	PPS	
				Costs		
Cost Center Description		Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)	0.00	0.00			
INDATI FAT DOUTING OFFINIAG OCCUR OFFITEDO	1.00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	15 100 007		45 400 00		45 445 400	
30. 00 03000 ADULTS & PEDI ATRI CS	15, 420, 287		15, 420, 28	7 25, 315	15, 445, 602	30. 00
ANCILLARY SERVICE COST CENTERS	1			_1		
50.00   05000   OPERATING ROOM	547, 962		547, 96		547, 962	
54. 00   05400   RADI OLOGY-DI AGNOSTI C	498, 127		498, 12		498, 127	
60. 00   06000   LABORATORY	1, 565, 950		1, 565, 95		1, 565, 950	1
65. 00 06500 RESPI RATORY THERAPY	2, 287, 612		2, 287, 61		2, 287, 612	1
66. 00 06600 PHYSI CAL THERAPY	650, 341		650, 34		650, 341	•
67. 00 06700 OCCUPATI ONAL THERAPY	313, 229		313, 22		313, 229	67. 00
68. 00  06800 SPEECH PATHOLOGY	215, 596		215, 59		215, 596	1
69. 00  06900  ELECTROCARDI OLOGY	66, 278		66, 27		66, 278	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 106, 694		2, 106, 69	4 0	2, 106, 694	71. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 334, 109		2, 334, 10	9 0	2, 334, 109	73. 00
74. 00   07400   RENAL DI ALYSI S	684, 882		684, 88	2 0	684, 882	74. 00
7. 00 00000 90000 0400			1			1 7/ 00

26, 691, 067

26, 691, 067

26, 691, 067

26, 691, 067

0 76.00

0 201.00

26, 716, 382 200. 00

26, 716, 382 202. 00

25, 315

25, 315

76. 00 03950 WOUND CARE

Subtotal (see instructions) Less Observation Beds

Total (see instructions)

200. 00 201. 00

202.00

Health Financial Systems	RH OF NORTHWEST	INDIANA, LLC		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider Co		Period: From 02/01/2021 To 01/31/2022	Worksheet C Part I Date/Time Pre 6/1/2022 10:5	
		Ti tl	e XIX	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpati ent	

		ΙΙΤΙ	e XIX	ноѕрі таі	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
			+ col . 7)	Ratio	I npati ent	
					Ratio	
	6.00	7.00	8. 00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	66, 164, 627		66, 164, 627			30. 00
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	1, 011, 061	0	1, 011, 061	0. 541967	0.000000	50.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	3, 766, 391	0	3, 766, 391	0. 132256	0.000000	54.00
60. 00   06000   LABORATORY	12, 393, 791	0	12, 393, 791	0. 126350	0.000000	60.00
65. 00 06500 RESPIRATORY THERAPY	58, 820, 243	0	58, 820, 243	0. 038892	0.000000	65. 00
66. 00 06600 PHYSI CAL THERAPY	3, 181, 220	0	3, 181, 220	0. 204431	0.000000	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	2, 296, 901	0	2, 296, 901	0. 136370	0.000000	67. 00
68. 00 06800 SPEECH PATHOLOGY	1, 010, 559	0	1, 010, 559	0. 213343	0.000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	6, 533, 324	0	6, 533, 324	0. 010145	0.000000	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	16, 629, 303	0	16, 629, 303	0. 126686	0.000000	71. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	13, 494, 478	0	13, 494, 478	0. 172968	0.000000	73. 00
74.00 07400 RENAL DIALYSIS	4, 358, 473	0	4, 358, 473	0. 157138	0.000000	74. 00
76. 00   03950   WOUND CARE	o	0	C	0.000000	0.000000	76. 00
200.00 Subtotal (see instructions)	189, 660, 371	0	189, 660, 371			200. 00
201.00 Less Observation Beds						201. 00
202.00 Total (see instructions)	189, 660, 371	0	189, 660, 371			202. 00

Health Financial Systems	RH OF NORTHWEST I	NDI ANA, LLC	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-2024	Peri od: From 02/01/2021 To 01/31/2022	Worksheet C Part I Date/Time Pre 6/1/2022 10:5	pared: 8 am
		Title XIX	Hospi tal	PPS	
Cost Center Description	PPS Inpatient Ratio 11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS					30. 00
ANCILLARY SERVICE COST CENTERS					
50.00   05000   OPERATING ROOM	0. 541967				50. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 132256				54.00
60. 00   06000   LABORATORY	0. 126350				60.00
65. 00 06500 RESPIRATORY THERAPY	0. 038892				65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 204431				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 136370				67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 213343				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 010145				69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 126686				71. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 172968				73. 00
74.00 07400 RENAL DIALYSIS	0. 157138				74. 00
76. 00  03950   WOUND CARE	0. 000000				76. 00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202. 00
·	•				

Health Financial Systems	RH OF NORTHWEST IN	IDI ANA, LLC	In Lie	u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE COST REDUCTIONS FOR MEDICALD ONLY	TO CHARGE RATIOS NET OF	Provider CCN: 15-2024		Worksheet C Part II Date/Time Prepared: 6/1/2022 10:58 am

						6/1/2022 10:5	8 am
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost	Capital Cost	Operating Cost	Capi tal	Operating Cost	
		(Wkst. B, Part	(Wkst. B, Part	Net of Capital	Reduction	Reducti on	
		I, col. 26)	II col. 26)	Cost (col. 1 -		Amount	
				col . 2)			
		1.00	2. 00	3. 00	4. 00	5. 00	
Į.	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	547, 962	3, 828	544, 134	C	0	50. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	498, 127	3, 654	494, 473	S C	0	54. 00
60.00	06000 LABORATORY	1, 565, 950	24, 094	1, 541, 856	o C	0	60.00
65.00	06500 RESPI RATORY THERAPY	2, 287, 612	85, 902	2, 201, 710	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	650, 341	19, 931	630, 410	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	313, 229	17, 444	295, 785	5 C	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	215, 596	8, 451	207, 145	5 0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	66, 278	857	65, 421	C	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 106, 694	344, 773	1, 761, 921	C	0	71. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	2, 334, 109	68, 690	2, 265, 419	0	0	73. 00
74.00	07400 RENAL DIALYSIS	684, 882	4, 973	679, 909		0	74. 00
76. 00	03950 WOUND CARE	0	0	) (	0	0	76. 00
200.00	Subtotal (sum of lines 50 thru 199)	11, 270, 780	582, 597	10, 688, 183	S C	0	200. 00
201.00	Less Observation Beds	0	0	) (	) (	0	201. 00
202.00	Total (line 200 minus line 201)	11, 270, 780	582, 597	10, 688, 183	sl c	0	202. 00

Health Financial Systems	RH OF NORTHWEST IN	In Lieu of Form CMS-2552-10			
CALCULATION OF OUTPATIENT SERVICE COST TO REDUCTIONS FOR MEDICALD ONLY	CHARGE RATIOS NET OF	Provi der CCN: 15-2024	From 02/01/2021 To 01/31/2022	Worksheet C Part II Date/Time Prepared: 6/1/2022 10:58 am	

			Ti tl	e XIX	Hospi tal PPS		
	Cost Center Description	Cost Net of	Total Charges	Outpati ent			
		Capital and		Cost to Charge			
		Operating Cost	Part I, column	Ratio (col. 6			
		Reduction	8)	/ col. 7)			
		6. 00	7. 00	8. 00			
Α	NCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	547, 962	1, 011, 061	0. 541967			50.00
54.00 0	05400 RADI OLOGY-DI AGNOSTI C	498, 127	3, 766, 391	0. 132256			54.00
60.00	06000 LABORATORY	1, 565, 950	12, 393, 791	0. 126350			60.00
65.00	06500 RESPI RATORY THERAPY	2, 287, 612	58, 820, 243	0. 038892			65. 00
66.00	06600 PHYSI CAL THERAPY	650, 341	3, 181, 220	0. 204431			66. 00
67.00	06700 OCCUPATI ONAL THERAPY	313, 229	2, 296, 901	0. 136370			67. 00
68.00	06800 SPEECH PATHOLOGY	215, 596	1, 010, 559	0. 213343			68. 00
69.00	06900 ELECTROCARDI OLOGY	66, 278	6, 533, 324	0. 010145			69. 00
71.00 0	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 106, 694	16, 629, 303	0. 126686			71. 00
73.00 0	07300 DRUGS CHARGED TO PATIENTS	2, 334, 109	13, 494, 478	0. 172968			73. 00
74.00 0	07400 RENAL DIALYSIS	684, 882	4, 358, 473	0. 157138			74. 00
76.00 0	03950 WOUND CARE	0	0	0.000000			76. 00
200.00	Subtotal (sum of lines 50 thru 199)	11, 270, 780	123, 495, 744				200. 00
201.00	Less Observation Beds	0	0				201.00
202.00	Total (line 200 minus line 201)	11, 270, 780	123, 495, 744				202. 00

Health Financial Systems	RH OF NORTHWEST	INDIANA, LLC		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C	1	Period: From 02/01/2021 Fo 01/31/2022	Worksheet D Part I Date/Time Pre 6/1/2022 10:5	pared:
		Title	XVIII	Hospi tal	PPS	o alli
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col.	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col.	Total Patient Days	Per Diem (col. 3 / col. 4)	
	26)		2)	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3. 00	4. 00	5. 00	
30. 00 ADULTS & PEDIATRICS 200. 00  Total (lines 30 through 199)	1, 102, 922 1, 102, 922	ł	1, 102, 92; 1, 102, 92;		l .	30. 00 200. 00
Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6) 7.00	., 102, 72			200.00
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00				
30. 00 ADULTS & PEDIATRICS	7, 819	598, 857				30.00
200.00 Total (lines 30 through 199)	7, 819	1				200.00

Health Financi	Health Financial Systems RH OF NORTHWEST INDIANA, LLC In Lieu of Form CMS-2552-10										
	OF INPATIENT ANCILLARY SERVICE CAPIT.		Provi der Co		Period: From 02/01/2021 To 01/31/2022	Worksheet D Part II	pared:				
			Title	xVIII	Hospi tal	PPS	o alli				
Co	ost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C,	Ratio of Cos to Charges	t Inpatient Program	Capital Costs (column 3 x column 4)					
		1.00	2.00	3.00	4. 00	5. 00					
ANCI LLAI	RY SERVICE COST CENTERS	1		0.00		0.00					
50. 00 05000 OF	PERATING ROOM	3, 828	1, 011, 061	0.00378	6 665, 045	2, 518	50. 00				
54. 00   05400 RA	ADI OLOGY-DI AGNOSTI C	3, 654	3, 766, 391	0. 00097	0 1, 892, 148	1, 835	54.00				
60. 00 06000 LA	ABORATORY	24, 094	12, 393, 791	0. 00194	4 6, 720, 520	13, 065	60.00				
65. 00   06500 RE	ESPI RATORY THERAPY	85, 902		0. 00146	0 24, 807, 374	36, 219	65. 00				
66. 00 06600 PH	HYSI CAL THERAPY	19, 931	3, 181, 220	0. 00626	5 1, 778, 914	11, 145	66. 00				
67. 00 06700 00	CCUPATI ONAL THERAPY	17, 444	2, 296, 901	0. 00759	5 1, 258, 409	9, 558	67. 00				
68. 00 06800 SF	PEECH PATHOLOGY	8, 451	1, 010, 559	0.00836	3 487, 251	4, 075	68. 00				
69. 00 06900 EL	LECTROCARDI OLOGY	857	6, 533, 324	0.00013	1 3, 406, 949	446	69. 00				
71.00 07100 ME	EDICAL SUPPLIES CHARGED TO PATIENT	344, 773	16, 629, 303	0. 02073	3 9, 061, 686	187, 876	71. 00				
73. 00 07300 DF	RUGS CHARGED TO PATIENTS	68, 690	13, 494, 478	0. 00509	0 7, 647, 957	38, 928	73. 00				
74. 00   07400 RE	ENAL DIALYSIS	4, 973	4, 358, 473	0. 00114	1 2, 590, 541	2, 956	74. 00				
76.00 03950 W	OUND CARE	0	0	0.00000	0	0	76. 00				
200. 00 To	otal (lines 50 through 199)	582, 597	123, 495, 744		60, 316, 794	308, 621	200. 00				

Health Financial Systems	RH OF NORTHWEST	INDIANA, LLC		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COST	S Provider Co		Period: From 02/01/2021	Worksheet D Part III	
				To 01/31/2022	Date/Time Pre 6/1/2022 10:5	
		Title	: XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
	Program	Program	Post-Stepdown	Cost	Medi cal	
	Post-Stepdown	· ·	Adjustments		Education Cost	
	Adjustments					
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	1	0 0	0	30. 00
200.00 Total (lines 30 through 199)	o	0	)	0	0	200. 00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	Inpati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
	instructions)	minus col. 4)				
	4. 00	5. 00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	14, 40	0.00	7, 819	30.00
200.00 Total (lines 30 through 199)		0	14, 40	O	7, 819	200. 00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS	0					30. 00
200.00 Total (lines 30 through 199)	0					200. 00

Health Financial Systems	u of Form CMS-2	552-10				
APPORTIONMENT OF INPATIENT/OUTPATIENT AN THROUGH COSTS	ICILLARY SERVICE OTHER PASS	S Provider CO	CN: 15-2024	Peri od: From 02/01/2021 To 01/31/2022	Worksheet D Part IV Date/Time Prep 6/1/2022 10:58	
			: XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician Anesthetist	Program	Nursi ng Program	Allied Health Post-Stepdown		
	Cost	Post-Stendown		Adiustments		

		litle	XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anestheti st	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1.00	2A	2. 00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	C	0	0	50.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0	C	0	0	54.00
60. 00   06000   LABORATORY	0	0	C	0	0	60.00
65. 00 06500 RESPIRATORY THERAPY	0	0	C	0	0	65. 00
66. 00   06600 PHYSI CAL THERAPY	0	0		0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	l c	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	l c	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	l c	0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1 0	0	l c	0	0	71. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	1 0	0	l c	0	0	73. 00
74.00 07400 RENAL DIALYSIS	0	0	l c	0	o	74. 00
76. 00 03950 WOUND CARE	0	0	l c	0	0	76. 00
200.00 Total (lines 50 through 199)		0		0	0	200. 00
	1	1	'		٠ - ١	

Health Financial Systems	RH OF NORTHWEST	INDIANA IIC		In lie	u of Form CMS-2	2552_10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER			CN: 15-2024	Peri od:	Worksheet D	2332-10
THROUGH COSTS				From 02/01/2021	Part IV	
				To 01/31/2022		
		Ti +l o	V// I I	Hospi tal	6/1/2022 10: 5 PPS	8 am
Cost Center Description	All Other	Total Cost	Title XVIII Total Cost Total		Ratio of Cost	
cost center bescription	Medi cal	(sum of cols.	Outpatient	(from Wkst. C,		
	Education Cost				(col. 5 ÷ col.	
	Luucati on cost	1, 2, 3, and 4)	col s. 2, 3,	8)	7)	
		4)	and 4)	0)	(see	
			and 4)		instructions)	
	4.00	5. 00	6, 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS	1.00	0.00	0.00	71.00	0.00	
50. 00 05000 OPERATING ROOM	0	0		0 1, 011, 061	0.000000	50.00
54. 00   05400 RADI OLOGY-DI AGNOSTI C	0	0		0 3, 766, 391		
60. 00 06000 LABORATORY	0	0		0 12, 393, 791		
65. 00 06500 RESPIRATORY THERAPY	0	0		0 58, 820, 243		
66. 00 06600 PHYSI CAL THERAPY	O	0		0 3, 181, 220		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	O	0		0 2, 296, 901	0. 000000	67. 00
68. 00 06800 SPEECH PATHOLOGY	o	0		0 1, 010, 559		68. 00
69. 00 06900 ELECTROCARDI OLOGY	O	0		0 6, 533, 324		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 16, 629, 303		
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 13, 494, 478		
74. 00 07400 RENAL DI ALYSI S	o	0		0 4, 358, 473	0. 000000	74. 00
76. 00 03950 WOUND CARE	o	0		0 0	0. 000000	
200.00 Total (lines 50 through 199)	0	0		0 123, 495, 744		200. 00

Health Financial Systems	RH OF NORTHWEST	INDIANA, LLC		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEITHROUGH COSTS	RVICE OTHER PASS	Provi der CC	CN: 15-2024	Peri od: From 02/01/2021 To 01/31/2022		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col.	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col.		Outpatient Program Pass-Through Costs (col. 9	
	7)		x col . 10)		x col . 12)	
	9.00	10.00	11.00	12. 00	13.00	
ANCILLARY SERVICE COST CENTERS			•			
50. 00 05000 OPERATING ROOM	0. 000000	665, 045		0 0	0	50.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 000000	1, 892, 148		0 0	0	54.00
60. 00   06000   LABORATORY	0. 000000	6, 720, 520		0 0	0	60.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	24, 807, 374		0 0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	1, 778, 914		0 0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	1, 258, 409		0 0	0	67. 00
68.00 06800 SPEECH PATHOLOGY	0. 000000	487, 251		0 0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	3, 406, 949		0 0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	9, 061, 686		0 0	0	71. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	7, 647, 957		0 0	0	73. 00
74. 00   07400   RENAL DI ALYSI S	0. 000000	2, 590, 541		0 0	0	74.00
76. 00   03950   WOUND CARE	0. 000000	0		0 0	0	76. 00
200.00   Total (lines 50 through 199)		60, 316, 794		0 0	0	200. 00

Health Financial Systems	RH OF NORTHWEST	INDIANA, LLC		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C		Period: From 02/01/2021 To 01/31/2022		
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B,	Swing Bed Adjustment	Reduced Capital Related Cost	Days	Per Diem (col. 3 / col. 4)	
	Part II, col.		(col . 1 - col 2)			
	1.00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	1, 102, 922	0	1, 102, 92	2 14, 400	76. 59	30.00
200.00 Total (lines 30 through 199)	1, 102, 922		1, 102, 92	2 14, 400		200. 00
Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6) 7.00	-			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS 200.00 Total (lines 30 through 199)	0	0				30. 00 200. 00

Heal th	Financial Systems	RH OF NORTHWEST	T IND	IANA, LLC		In Lie	u of Form CMS-	2552-10
APPORT	IONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	F	Provider C	CN: 15-2024	Peri od: From 02/01/2021 To 01/31/2022	Worksheet D Part II Date/Time Pre 6/1/2022 10:5	pared: 8 am
				Titl	e XIX	Hospi tal	PPS	
	Cost Center Description	Capi tal			Ratio of Cos		Capital Costs	
		Related Cost	(fro	m Wkst. C,	to Charges	Program	(column 3 x	
		(from Wkst. B,	Par	t I, col.	(col . 1 + co	l. Charges	column 4)	
		Part II, col.		8)	2)			
		26)						
		1.00		2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	3, 828	3	1, 011, 061	0.0037	36 0	0	50.00

Health Financial Systems	RH OF NORTHWEST	INDIANA, LLC		In Li€	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COST			Period: From 02/01/2021 To 01/31/2022	Date/Time Pre 6/1/2022 10:5	
			e XIX	Hospi tal	PPS	
Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursi ng Program	Allied Health Post-Stepdowr Adjustments	Allied Health Cost	All Other Medical Education Cost	
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			•			
30.00   03000   ADULTS & PEDIATRICS 200.00   Total (Lines 30 through 199)	0	0		0 0	0	30. 00 200. 00
Cost Center Description		Total Costs (sum of cols. 1 through 3, minus col. 4)	Days	Per Diem (col. 5 ÷ col. 6)	Program Days	
	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00   03000   ADULTS & PEDLATRICS 200.00   Total (lines 30 through 199)	0	0	14, 40 14, 40			30. 00 200. 00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					
INPATIENT ROUTINE SERVICE COST CENTERS	0					30. 00 200. 00

Health Financial Systems R	H OF NORTHWEST	INDIANA, LLC		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVITHROUGH COSTS	VICE OTHER PASS	S Provider Co		Period: From 02/01/2021 To 01/31/2022	Worksheet D Part IV Date/Time Pre 6/1/2022 10:5	pared:
		Ti tl	e XIX	Hospi tal	PPS	o alli
Cost Center Description	Non Physician Anesthetist Cost	Nursi ng Program Post-Stepdown Adj ustments	Nursi ng Program	Allied Health Post-Stepdown Adjustments	Allied Health	
	1. 00	2A	2. 00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	0	0		0 0	0	50. 00

	Cost Center Description	Non Physician	Nursi ng	Nursi ng		Allied Health	
		Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1. 00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0	0	0	50. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	54. 00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
65. 00	06500 RESPI RATORY THERAPY	0	0	0	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0	0	0	0	66. 00
67. 00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76. 00	03950 WOUND CARE	0	0	0	0	0	76. 00
200.00	Total (lines 50 through 199)	0	0	0	0	0	200. 00
	, ,	1	'	'	!	'	'

Health Financial Systems	RH OF NORTHWEST	INDIANA. LLC		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS				Period: From 02/01/2021	Worksheet D	
				To 01/31/2022		
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4.00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	0	0		0 1, 011, 061	0.000000	50.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0		0 3, 766, 391	0.000000	54. 00
60. 00   06000   LABORATORY	0	0		0 12, 393, 791	0.000000	60.00
65. 00 06500 RESPIRATORY THERAPY	0	0		0 58, 820, 243	0.000000	65. 00
66. 00   06600 PHYSI CAL THERAPY	0	0		0 3, 181, 220	0.000000	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0 2, 296, 901	0.000000	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0		0 1, 010, 559	0.000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 6, 533, 324	0.000000	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 16, 629, 303		71. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 13, 494, 478		73. 00
74. 00 07400 RENAL DI ALYSI S	0	0		0 4, 358, 473	0.000000	74. 00
76. 00 03950 WOUND CARE	1 0	l o		ol c	0.000000	1
200.00   Total (lines 50 through 199)	0	0		0 123, 495, 744	1	200. 00

Health Financial Systems	RH OF NORTHWEST	INDIANA, LLC		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVI CE OTHER PASS	Provi der C	CN: 15-2024	Period: From 02/01/2021 To 01/31/2022	Worksheet D Part IV Date/Time Pre 6/1/2022 10:5	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col.	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. x col. 10)		Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	9, 00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS	7.00	10.00	11.00	12.00	13.00	
50. 00 05000 OPERATING ROOM	0. 000000	0		0 0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	0	,	o o	0	54.00
60. 00   06000   LABORATORY	0. 000000	0	)	0 0	0	60.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	0	)	0 0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	0	)	0 0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	0	)	0 0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	Ō	1	0 0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0	)	0 0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	0	)	0 0	0	71. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	0	)	0 0	0	73. 00
74.00 07400 RENAL DIALYSIS	0. 000000	0	)	0 0	0	74. 00
76. 00 03950 WOUND CARE	0. 000000	0	)	0 0	0	76. 00
200.00   Total (lines 50 through 199)		0		0 0	0	200. 00

Health Financial Systems	RH OF NORTHWEST INDIANA, LLC	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-2024	Peri od: From 02/01/2021	Worksheet D-1	
			Date/Time Pre 6/1/2022 10:5	
	Title XVIII	Hospi tal	PPS	
Cost Center Description				

Cost Center Description    1, 00			Title XVIII	Hospi tal	6/1/2022 10: 5 PPS	8 am		
INPACTED TO ALL PROVIDER COMPONENTS   INPACTED TO ALL PROVIDER COMPONENTS   INPACTED TO ALL PROVIDER COMPONENTS   INPACTED TO ALL PROVIDER COMPONENTS   INPACTED TO ALL PROVIDER COMPONENTS   INPACTED TO ALL PROVIDER COMPONENTS   INPACTED TO ALL PROVIDER COMPONENTS   INPACTED TO ALL PROVIDER COMPONENTS   INPACTED TO ALL PROVIDER COMPONENTS   INPACTED TO ALL PROVIDER COMPONENTS   INPACTED TO ALL PROVIDER COMPONENTS   INPACTED TO ALL PROVIDER COMPONENTS   INPACTED TO ALL PROVIDER COMPONENTS   INPACTED TO ALL PROVIDER COMPONENTS   INPACTED TO ALL PROVIDER COMPONENTS   INPACTED COMPONENTS		Cost Center Description	THE AVIII	1103рт саг	113			
IMPATEENT DAYS		DADT I ALL DROW DED COMPONENTS			1. 00			
Impatient days (including private room days and sain ay-bed days, excluding newborn)   14,400   1.00								
Private room days (excluding swing-bed and observation bed days)   If you have only private room days   0   3.00	1.00		s, excluding newborn)		14, 400	1. 00		
do not complete this line.  5.00 Semi-private room days (excluding swing-bed and observation bed days)  1.00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost of total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period  7.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period  8.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period  8.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and reporting period (if calendar year, enter 0 on this line)  10.00 Independent of the cost reporting period (if calendar year, enter 0 on this line)  11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  12.00 Swing-bed SNF type inpatient days applicable to title SV or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  13.00 Swing-bed SNF 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)  13.00 Swing-bed SNF type inpatient days applicable to the Program (excluding private room days)  13.00 Swing-bed SNF type inpatient days applicable to services through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  14.00 The December 31 of the cost reporting period (if calendar year, enter 0 on this line)  15.00 Number 20 Swing-bed SNF services applicable to services through December 31 of the cost reporting period (if calendar year,								
5.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if called are year, enter 0 on this line)  7.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if called are year, enter 0 on this line)  7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if called are year, enter 0 on this line)  7.00 Total inpatient days (including private room days) after December 31 of the cost reporting period (if called are year, enter 0 on this line)  7.00 Saing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if called are year, enter 0 on this line)  7.00 Saing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  8.00 Saing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions)  8.00 Saing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions)  8.00 Saing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if called are year, enter 0 on this line)  8.00 Saing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  9.01 1.00 Saing-bed KF type inpatient days applicable to title XVIII only (including private room days)  10.10 Saing-bed KF type inpatient days applicable to title XVIII only (including private room days)  11.00 Saing-bed KF type inpatient days applicable to title XVIII only (including private room days)  12.00 Saing-bed KF type inpatient days applicable to services after December 31 of the cost reporting period (including private room days)  13.00 Saing-bed KF type inpatient days applicable t	3.00		ys). If you have only pri	vate room days,	0	3.00		
reporting period (if calendar year, enter 0 on this line)  7. 00 Total saying-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  7. 00 Total sing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  7. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newtorn days) is instructions)  10. 00 Swing-bed SNF type inpatient days applicable to the Program (excluding private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  11. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  12. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  13. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  14. 00 Medical (including private room days)  15. 00 Total inpatient days applicable to title XV or XX only (including private room days)  16. 00 Medical (including private room days)  17. 00 Medical (including private room days)  18. 00 Total nursery days (title V or XIX only)  18. 00 Medical (including private room days)  19. 00 Medical (including private room days)  19. 00 Medical (including private room days)  19. 00 Medical (including private room days)  19. 00 Medical (including private room days)  19. 00 Medical (including private room days)  19. 00 Medical (including private room days)  19. 00 Medical (including private room days)  19. 00 Medical (including private room days)  19. 00 Medical (including private room days)  19. 00 Medical (including private room days)  19. 00 Medical (including private room days)  19. 00 Medical (including private room days)  19. 00 Medical (including private room days)  19. 00 Medica	4.00	·	ed days)		14, 400	4. 00		
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (ir calendary syear, enter 0 on this line)   7.00	5.00							
reporting period (if calendar year, enter 0 on this line) 7.00 Totals saying-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period 8.00 Total saying-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 10.00 May 10.00 M	6 00		om days) after December '	31 of the cost	0	6.00		
reporting period  8. 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  9. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)  10. 00 Swing-bed SNF type inpatient days applicable to it it is XVIII only (including private room days)  11. 00 Swing-bed SNF type inpatient days applicable to it it is XVIII only (including private room days) after through December 31 of the cost reporting period (see Instructions) through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  12. 00 Swing-bed NF type inpatient days applicable to ititles 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. 00 Swing-bed NF type inpatient days applicable to ititles V or XIX only (including private room days) on through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  14. 00 Medically necessary private room days applicable to the Program (excluding swing-bed days) on 14. 00 Mursery days (title V or XIX only)  15. 00 Total nursery days (title V or XIX only)  16. 00 Nursery days (title V or XIX only)  17. 00 Nursery days (title V or XIX only)  18. 00 December 31 of the cost reporting period (if calendar year, enter 0 on this line)  18. 00 December 31 of the cost reporting period (if calendar year, enter 0 on this line)  19. 00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  19. 00 December 31 of the cost reporting period (if calendar year, enter 0 on this line)  19. 00 Medically necessary private room days applicable to services through December 31 of the cost reporting period (including private room days)  19. 00 Medically necessary private room days applicable to services after December 31 of the cost reporting period (including private room days)  19. 00 Medi	0.00		om days) arter becomber .	or or the cost		0.00		
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	7. 00		n days) through December	31 of the cost	0	7. 00		
reporting period (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 10.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) 11.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed NET type inpatient days applicable to titles V or XIX only (including private room days) 12.00 through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 13.00 Swing-bed NE type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NE type inpatient days applicable to titles V or XIX only (including private room days) 15.00 Swing-bed NE type year (including private room days) 15.00 Swing-bed Sw	8 00		m days) after December 3	1 of the cost	0	8 00		
newborn days) (see instructions)  10. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions)  11. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  12. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  13. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  14. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  15. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  16. 00 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days)  17. 01 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days)  18. 00 Swing-bed NF type (intle V or XIX only)  18. 00 Swing-bed NF type (intle V or XIX only)  18. 00 Swing-bed NF type (intle V or XIX only)  18. 00 Swing-bed NF type services applicable to services after December 31 of the cost or exporting period (interior period or reporting period (interior period or reporting period or reporting period (interior period or reporting period or reporting period (interior period or reporting period or reporting period (interior period or reporting period or reporting period (interior period or reporting period or reporting period (interior period or reporting period or reporting period (interior period or reporting period or reporting period (interior period or reporting period or reporting period (interior period or reporting period (interior period or reporting period (interior period or reporting period (interior period or reporting period (interior period or reporting period (interior period or reporting period or reporting period (interior period or reporting period (	0.00		ii days) arter becomber s	i or the cost				
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through December 31 of the cost reporting period (see instructions)  11.00 Sung-bed SNF type inpatient days applicable to tittle XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  12.00 Sung-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  13.00 Sung-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days)  15.00 Total nursery days (title V or XIX only)  16.00 Norsery days (title V or XIX only)  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (including private room days applicable to services after December 31 of the cost (including period (including private room days)  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost (including period (including private room days)  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost (including period (including period (including private room days)  19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost (including period (includin	10 00		nlv (including private ro	nom days)	0	10 00		
December 31 of the cost reporting period (if calendar year, enter 0 on this line)   12.00   Sung-bed NF type inpatient days applicable to titles V or XIX only (including private room days)   0   12.00     13.00   Sung-bed NF type inpatient days applicable to titles V or XIX only (including private room days)   0   13.00     14.00   Modically necessary private room days applicable to titles V or XIX only (including private room days)   0   14.00     15.00   Total nursery days (title V or XIX only)   0   16.00     15.00   Total nursery days (title V or XIX only)   0   16.00     16.00   Nursery days (title V or XIX only)   0   16.00     17.00   Modicare rate for swing-bed SNF services applicable to services through December 31 of the cost   0.00   17.00     18.00   Modicare rate for swing-bed SNF services applicable to services after December 31 of the cost   0.00   18.00     19.00   Modicare rate for swing-bed NF services applicable to services after December 31 of the cost   0.00   19.00     19.00   Modicare rate for swing-bed NF services applicable to services after December 31 of the cost   0.00   19.00     19.00   Modical drate for swing-bed NF services applicable to services after December 31 of the cost   0.00   19.00     19.00   Modical drate for swing-bed NF services applicable to services after December 31 of the cost   0.00   19.00     19.00   Modical drate for swing-bed NF services applicable to services after December 31 of the cost   0.00   19.00     19.00   Modical drate for swing-bed NF services after December 31 of the cost reporting period (line   5 × 11ine 19)   19.00     19.00   Modical drate for swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line   5 × 11ine 18)   19.00     19.00   Modical drate for swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line   0 × 11ine 19)   19.00     19.00   Modical drate for swing-bed cost and private room charges (excluding swing-bed cost (line 21 minus line 26)   15.4	10.00			Join days)		10.00		
12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period of the reporting peri	11. 00			oom days) after	0	11. 00		
through December 31 of the cost reporting period after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  14.00 Motically necessary private room days applicable to titles V or XIX only (including private room days) 0 14.00 15.00 Total nursery days (title V or XIX only) 0 15.00 Total nursery days (title V or XIX only) 0 16.00 New Year of Victive V or XIX only) 0 16.00 New Year of Victive V or XIX only) 0 16.00 New Year of Victive V or XIX only) 0 16.00 New Year Order of Victive V or XIX only) 0 16.00 New Year Order of Victive V or XIX only) 0 16.00 New Year Order of Victive V or XIX only) 0 16.00 New Year Order of Victive V or XIX only) 0 17.00 New Year Order Ord	12 00			e room days)	0	12 00		
after December 31 of the cost reporting period (if callendar year, enter 0 on this line) 14.00 15.00 17.00 18.00 1	12.00	through December 31 of the cost reporting period	t only (Theraaring private	o room days)	Ü	12.00		
14.00   Modically necessary private room days applicable to the Program (excluding swing-bed days)   0   14.00   15.00   15.00   15.00   16.00   15.00   16.00   15.00   16.	13. 00				0	13. 00		
15.00 Total nursery days (title V or XIX only)  16.00 Nursery days (title V or XIX only)  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period  19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period  20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18)  25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 x line 19)  26.00 Total swing-bed cost (see instructions)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 Total swing-bed cost (see instructions)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Average private room per diem charge (line 29 + line 3)  30.00 Average per idem private room cost differential (line 32 minus line 33)(see instructions)  20.00 Average per idem private room cost differential (line 32 minus line 33)  31.00 Average per idem private room cost differential (line 32 minus line 33)  32.00 Average per idem private room cost differential (line 32 minus line 33)  33.00 Average per idem private room cost differential (li	14. 00				0	14. 00		
SWI NG BED ADJUSTMENT  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost (19.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost (19.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost (19.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost (19.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost (19.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (19.00 Medicaid rate for swing-bed to SNF type services through December 31 of the cost reporting period (19.00 Medicaid rate for swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (19.00 Medicaid rate for swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (19.00 Medicaid rate for swing-bed cost applicable to NF type services after December 31 of the cost reporting period (19.00 Medicaid rate for swing-bed cost (19.00 Medicaid rate for swing-bed cost (19.00 Medicaid rate for swing-bed cost (19.00 Medicaid rate for swing-bed cost (19.00 Medicaid rate for swing-bed cost (19.00 Medicaid rate for swing-bed cost (19.00 Medicaid rate for swing-bed cost (19.00 Medicaid rate for swing-bed cost (19.00 Medicaid rate for swing-bed charges) (19.00 Medicaid rate for swing-bed charges) (19.00 Medicaid rate for swing-bed charges) (19.00 Medicaid rate for swing-bed cost and private room charges (excluding swing-bed charges) (19.00 Medicaid rate for swing-bed cost and private room cost differential dijustment (19.00 Medicaid rate for swing-bed cost and private room cost differentia		Total nursery days (title V or XIX only)	_	15. 00				
17.00   Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period   18.00   18.00   18.00   18.00   19.00   1	16. 00		0	16. 00				
reporting period  Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period  20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  21.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  22.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  23.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  24.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service cost net of swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Overlage period (line 20 x line 21)  30.00 Average period (line 20 x line 21)  30.00 Average period (line 20 x line 21)  30.00 Average period emprivate room charge (line 29 x line 3)  30.00 Average period emprivate room charge (line 29 x line 3)  30.00 Average period emprivate room charge (line 30 x line 41)  30.00 Average period emprivate room charge (line 30 x line 41)  30.00 Average period emprivate room charge (line 30 x line 41)  30.00 Average period emprivate room charg	17 00		0.00	17 00				
reporting period  Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period  20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18)  25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  27.00 FIVATE ROMO DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room per diem charge (line 29 + line 3)  30.00 Average per diem private room charge (line 30 + line 4)  34.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions)  37.00 General inpatient routine service cost reporting period (line 15, 445, 602)  37.00 Fivate room cost differential (line 30 + line 4)  38.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions)  38.00 Average per diem private room cost differential (line 32 minus line 33)  38.00 Average per diem private room cost differential (line 32 minus line 33)  39.00 Fivate room cost differential adjustmen		1	0.00	17.00				
19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 FRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 32.00 Average private room per diem charge (line 29 + line 3) 33.00 Average per diem private room per diem charge (line 30 + line 4) 34.00 Average per diem private room cost differential (line 3 x line 31) 35.00 Average per diem private room cost differential (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) 37.00 Private room cost differential (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) 37.00 General inpatient routine service cost net of swing-bed cost and private room co	18. 00		0.00	18. 00				
reporting period  20.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 + line 28)  32.00 Average perivate room per diem charge (line 29 + line 3)  33.00 Average semi-private room per diem charge (line 30 + line 4)  34.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential (line 3 x line 35)  37.00 General inpatient routine service cost/charge ratio (line 37 x line 38)  37.00 General inpatient routine service cost cost net of swing-bed cost and private room cost differential (line 37 x line 38)  37.00 General inpatient routine service cost cost net of swing-bed cost and private room cost differential (line 37 x line 38)  37.00 General inpatient routine service cost cost net of swing-bed cost and private room cost differential (line 37 x line 38)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 38)  37.00 General in	19. 00		0.00	19. 00				
reporting period Total general inpatient routine service cost (see instructions)  22.00  22.00  23.00  24.00  25.00  25.00  25.00  26.00  27.00  28.00  28.00  28.00  29.00  29.00  20.0								
21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18)  25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room per diem charge (line 29 + line 3)  30.00 Average per diem private room charge differential (line 34 x line 31)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Private room cost differential dissemble cost and private room cost differential (line 34 x line 31)  30.00 Private room cost differential dissemble cost and private room cost differential (line 37 minus line 36)  30.00 Private room cost differential dissemble cost and private room cost differential (line 37 minus line 36)  30.00 Private room cost differential dissemble cost and private room cost differential (line 27 minus line 36)  30.00 Private room cost differential fine 35 minus line 35)  30.00 Private room cost differential dissemble cost and private room cost differential (line 27 minus line 36)  30.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	20. 00		0.00	20.00				
5 x line 17) Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions) Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 Ceneral inpatient routine service charges (excluding swing-bed and observation bed charges) Ceneral inpatient routine service cost/charges Ceneral inpatient routine service cost/charge ratio (line 27 + line 28) Ceneral inpatient routine service cost/charge ratio (line 27 + line 28) Ceneral inpatient routine service cost/charge ratio (line 27 + line 28) Ceneral inpatient routine service cost/charge ratio (line 30 + line 4) Ceneral inpatient routine service cost (line 30 + line 4) Ceneral inpatient routine service cost (line 30 + line 4) Ceneral inpatient routine service cost (line 30 + line 31) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 35 tine 31) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 35 tine 35) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 35 tine 35) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 35 tine 35) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 35 tine 35) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 35 tine 35) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 36) C	21. 00	, , , , , , , , , , , , , , , , , , , ,	15, 445, 602	21. 00				
23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 + line 28)  32.00 Average private room per diem charge (line 29 + line 3)  32.00 Average semi-private room per diem charge (line 30 + line 4)  33.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 15, 445, 602)  27 minus line 36)  28.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	22. 00		er 31 of the cost reporti	ing period (line	0	22. 00		
x line 18)  24.00  Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00  Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  25.00  X line 20)  Total swing-bed cost (see instructions)  General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00  General inpatient routine service charges (excluding swing-bed and observation bed charges)  Private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  30.00  31.00  Average private room per diem charge (line 29 + line 3)  32.00  Average semi-private room per diem charge (line 30 + line 4)  34.00  Average per diem private room charge differential (line 32 minus line 33) (see instructions)  Average per diem private room cost differential (line 34 x line 31)  Private room cost differential adjustment (line 3 x line 35)  General inpatient routine service cost net of swing-bed cost and private room cost differential (line 15, 445, 602)  Average per diem private room cost differential adjustment (line 3 x line 35)  General inpatient routine service cost net of swing-bed cost and private room cost differential (line 15, 445, 602)  AVERTILI - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	23. 00		31 of the cost reporting	g period (line 6	0	23. 00		
7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8		x line 18)	•					
25. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26. 00 Total swing-bed cost (see instructions)  27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  27. 00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29. 00 Private room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32. 00 Average private room per diem charge (line 29 + line 3)  33. 00 Average semi-private room per diem charge (line 30 ÷ line 4)  34. 00 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  35. 00 Average per diem private room cost differential (line 34 x line 31)  36. 00 Private room cost differential adjustment (line 3 x line 35)  37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	24. 00		1 31 of the cost reportion	ng period (line	0	24.00		
Total swing-bed cost (see instructions)  26.00  27.00  General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00  PRIVATE ROOM DIFFERNTIAL ADJUSTMENT  General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00  29.00  30.00  Semi-private room charges (excluding swing-bed charges)  General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  Average private room per diem charge (line 29 ÷ line 3)  Average semi-private room per diem charge (line 30 ÷ line 4)  Average per diem private room cost differential (line 32 minus line 33) (see instructions)  Average per diem private room cost differential (line 34 x line 31)  Private room cost differential adjustment (line 3 x line 35)  General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	25. 00		31 of the cost reporting	period (line 8	0	25. 00		
27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  9.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  32.00 Average semi-private room per diem charge (line 30 ÷ line 4)  33.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  34.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 37.00 and private room cost differential (line 34.00 and private room cost differential (line 37.00 an	0/ 00					0, 00		
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  O 29.00 Private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  O 0.000000  O 0.000000  O 0.000000  O 0.000000  O 0.000000  O 0.000000  O 0.000000  O 0.000000  O 0.000000  O 0.000000  O 0.000000  O 0.000000  O 0.000000  O 0.000000  O 0.000000  O 0.0000000  O 0.000000  O 0.0000000  O 0.000000  O 0.000000  O 0.000000  O 0.0000000	, ,	(line 21 minus line 26)		_				
29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 in nus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			, ,			
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 37.00 are room cost differential (line 36.00 are room cost differe			d and observation bed cha	arges)				
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 37.00 and private room cost di						ł		
33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			: line 28)		_			
34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	32.00	Average private room per diem charge (line 29 ÷ line 3)	ŕ		0.00	32. 00		
35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33. 00		
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				tions)				
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			ne 31)		0.00			
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		1			_	1		
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	37. 00		and private room cost di	rrerential (line	15, 445, 602	37. 00		
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS								
		PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU						
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,072.61 38.00		, , , , , , , , , , , , , , , , , , , ,						
39.00 Program general inpatient routine service cost (line 9 x line 38) 8,386,738 39.00		,	-			ı		
40.00   Medically necessary private room cost applicable to the Program (line 14 x line 35) 0   40.00   41.00   Total Program general inpatient routine service cost (line 39 + line 40) 8,386,738   41.00					_	ł		
11. 00   10 tal 11 0g tal 11 patrolit routine 361 vice 603t (11 lie 37 + 11 lie 40)	71.00	Total Trogram general impatient routine service cost (IIIIe 37	11110 <del>1</del> 0)		0,300,730	1 -1.00		

Heal th	Financial Systems	RH OF NORTHWEST	INDIANA, LLC		In Lie	u of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST			CN: 15-2024	Peri od: From 02/01/2021	Worksheet D-1	
					To 01/31/2022	Date/Time Pre 6/1/2022 10:5	
	Cost Center Description	Total Inpatient Costl	Total			PPS Program Cost (col. 3 x col.	
		1.00	2. 00	3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)						42. 00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT						43. 00
44. 00	CORONARY CARE UNIT						44. 00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)  Cost Center Description						47. 00
						1. 00	
	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS			ons)		5, 976, 328 14, 363, 066	1
50. 00	Pass through costs applicable to Program inp	atient routine s	services (from	n Wkst. D, sur	n of Parts I and	598, 857	50. 00
51. 00	Pass through costs applicable to Program inp and IV)	Ĩ	/ services (fr	om Wkst. D, s	sum of Parts II	308, 621	51. 00
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu	ding capital rel	ated, non-phy	ysician anestl	netist, and	907, 478 13, 455, 588	
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
54. 00	Program di scharges					0	54. 00
55.00	Target amount per discharge						55. 00
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and tar	ract amount (	ino 56 minus	lino 52)	0	
58. 00	Bonus payment (see instructions)	0	58.00				
59. 00	Lesser of lines 53/54 or 55 from the cost re		59. 00				
40.00	market basket						
60. 00 61. 00	.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target						60. 00
62 00	amount (line 56), otherwise enter zero (see instructions) 62.00 Relief payment (see instructions)						
	3.00 Allowable Inpatient cost plus incentive payment (see instructions)						
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST  4.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See						
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decembe	er 31 of the d	cost reporting	g period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	54 plus line 6	55)(title XVI	l only). For	0	66. 00
67. 00	9 '	e costs through	December 31 c	of the cost re	eporting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after De	ecember 31 of	the cost repo	orting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69. 00
70. 00	Skilled nursing facility/other nursing facil				)		70. 00
71.00	Adjusted general inpatient routine service c	,	ne 70 ÷ line	2)			71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic		(line 14 x li	ne 35)			72. 00 73. 00
74. 00	Total Program general inpatient routine serv						74. 00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	costs (from V	Vorksheet B, I	Part II, column		75. 00
76.00	Per diem capital related costs (line 75 ÷ li	•					76.00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for exces		rovi der record	ds)			79. 00
80.00	Total Program routine service costs for comp	arison to the co			nus line 79)		80. 00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I		1				81. 00 82. 00
83. 00	Reasonable inpatient routine service costs (						83. 00
84. 00	Program inpatient ancillary services (see in	structions)					84. 00
85. 00	Utilization review - physician compensation						85. 00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS		ougn 85)				86. 00
87. 00	Total observation bed days (see instructions	)					87. 00
88. 00 89. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se	•	ııne 2)				88. 00 89. 00
57.00	(Se	o moti doti ons)					1 57.00

Health Financial Systems	RH OF NORTHWEST	INDIANA, LLC		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 02/01/2021 To 01/31/2022	Date/Time Pre 6/1/2022 10:5	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	1, 102, 922	15, 445, 602	0. 07140	7 0	0	90. 00
91.00 Nursing Program cost	0	15, 445, 602	0.00000	0	0	91.00
92.00 Allied health cost	0	15, 445, 602	0.00000	0 0	0	92.00
93 00 All other Medical Education	0	15 445 602	0.00000	0	0	93 00

Health Financial Systems	RH OF NORTHWEST INDIANA, LLC	In Lieu of Form CMS-2552-			
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-2024	Peri od: From 02/01/2021	Worksheet D-1		
		To 01/31/2022	Date/Time Pre 6/1/2022 10:5		
	Title XIX	Hospi tal	PPS		
Cost Center Description					
			1 00		

		Title XIX	Hospi tal	PPS	8 8111		
	Cost Center Description						
	PART I - ALL PROVIDER COMPONENTS			1. 00			
	I NPATI ENT DAYS				-		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn) 14,400						
2.00	Inpatient days (including private room days, excluding swing-b			14, 400			
3.00	Private room days (excluding swing-bed and observation bed day do not complete this line.	ys). If you have only pri	vate room days,	0	3. 00		
4.00	Semi-private room days (excluding swing-bed and observation be	ed davs)		14, 400	4. 00		
5.00	Total swing-bed SNF type inpatient days (including private room		31 of the cost	0	5. 00		
	reporting period						
6. 00	Total swing-bed SNF type inpatient days (including private roof reporting period (if calendar year, enter 0 on this line)	om days) after December 3	31 of the cost	0	6. 00		
7. 00	Total swing-bed NF type inpatient days (including private room	n davs) through December	31 of the cost	0	7. 00		
	reporting period						
8.00	Total swing-bed NF type inpatient days (including private room	n days) after December 3	l of the cost	0	8. 00		
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Program (eycluding	swing_bed and	o	9. 00		
9.00	newborn days) (see instructions)	The Frogram (excluding	swifig-bed and	١	7.00		
10.00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private ro	oom days)	0	10.00		
	through December 31 of the cost reporting period (see instruct						
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er		oom days) arter	0	11. 00		
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI)		e room days)	0	12. 00		
	through December 31 of the cost reporting period	3 .	<b>3</b> ,				
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI)			0	13. 00		
14. 00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra			o	14. 00		
15. 00	Total nursery days (title V or XIX only)	am (exertaining swring beart	adyo)	0			
16. 00	Nursery days (title V or XIX only)			0			
47.00	SWING BED ADJUSTMENT				47.00		
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 of	f the cost	0.00	17. 00		
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00		
	reporting period						
19. 00	Medicaid rate for swing-bed NF services applicable to services	0. 00	19. 00				
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	0.00	20. 00				
20.00	reporting period	0.00	20.00				
21. 00	Total general inpatient routine service cost (see instructions	15, 445, 602	1				
22. 00	Swing-bed cost applicable to SNF type services through December 17)	er 31 of the cost reporti	ng period (line	0	22. 00		
23. 00	5 x line 17)   Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	period (line 6	o	23. 00		
20.00	x line 18)	or or the east reperting	, por rou ( o		20.00		
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24. 00		
25. 00	7 x line 19)	21 of the cost reporting	poriod (line 0	0	25. 00		
23.00	Swing-bed cost applicable to NF type services after December 3 x line 20)	of the cost reporting	perrou (Trie 6	١	25.00		
26. 00	Total swing-bed cost (see instructions)			0	26. 00		
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		15, 445, 602	27. 00		
20 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  General inpatient routine service charges (excluding swing-bed	d and observation had sh	argos)	0	20 00		
29. 00	Private room charges (excluding swing-bed charges)	a and observation bed cha	ai ges)	0			
30.00	Semi -pri vate room charges (excluding swing-bed charges)			Ö	30.00		
31. 00	General inpatient routine service cost/charge ratio (line 27	: line 28)		0. 000000			
32. 00	Average private room per diem charge (line 29 ÷ line 3)	==,		0.00			
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	1		
34. 00	Average per diem private room charge differential (line 32 mir	nus line 33)(see instruc	tions)	0.00			
35. 00	Average per diem private room cost differential (line 34 x lin	, ,	· ··· <del>-</del> /	0.00			
36. 00	Private room cost differential adjustment (line 3 x line 35)	/		0.00	36.00		
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	15, 445, 602			
	27 minus line 36)	· · · · · · · · · · · · · · · · · · ·					
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ICTMENTS			1		
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			1 070 (1	20.00		
38. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			1, 072. 61			
39. 00 40. 00	Medically necessary private room cost applicable to the Program	•		0			
	Total Program general inpatient routine service cost (line 39)	,			41.00		
	1 3 3 3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			٥١			

COMPLIT	Financial Systems ATION OF INPATIENT OPERATING COST	RH OF NORTHWEST I	Provi der C	CN: 15-2024	Peri od:	Worksheet D-1	·2552-1 I
COMI UI	ATTOM OF THEATTERS OF ENAMENO COOT		Trovider C	011. 10 2024	From 02/01/2021 To 01/31/2022	Date/Time Pre 6/1/2022 10:5	epared:
			Ti tl	e XIX	Hospi tal	PPS	o alli
	Cost Center Description	Total Inpatient Costli	Total npatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
	Investory (11.11 by a vivy	1.00	2. 00	3.00	4. 00	5. 00	10.0
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units						42. 0
43. 00	INTENSIVE CARE UNIT						43. 0
44. 00	CORONARY CARE UNIT						44. 0
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)						47. 0
	Cost Center Description					1 00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3,	line 200)			1. 00 0	48.00
49. 00	Total Program inpatient costs (sum of lines			ins)		О	49. 0
50. 00	PASS THROUGH COST ADJUSTMENTS  Pass through costs applicable to Program inp	atient routine s	ervices (from	ı Wkst D sui	m of Parts L and	0	50. 0
			•	•		-	
51. 00	Pass through costs applicable to Program inpland IV)	atient ancillary	services (fr	om Wkst. D,	sum of Parts II	0	51. 0
52. 00	Total Program excludable cost (sum of lines	50 and 51)				O	52.0
53. 00	Total Program inpatient operating cost exclu		ated, non-phy	sician anest	netist, and	O	53.00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
	Program di scharges					C	
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	55. 0 56. 0
57. 00	, ,	ing cost and tar	get amount (I	ine 56 minus	line 53)	0	1
58. 00	Bonus payment (see instructions)	0					
59. 00	DO Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						59.0
60. 00	Lesser of lines 53/54 or 55 from prior year						60.0
61. 00	If line 53/54 is less than the lower of line				,	0	61. 0
	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						
62.00							62.0
63.00	B. 00   Allowable Inpatient cost plus incentive payment (see instructions)   PROGRAM INPATIENT ROUTINE SWING BED COST						63.0
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Decem	ber 31 of the	cost report	ng period (See	C	64. 0
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after Decembe	r 31 of the c	ost reportin	n period (See	0	65.0
	instructions)(title XVIII only)					-	
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line 6	4 plus line 6	5)(title XVI	II only). For	0	66. 0
67. 00	1 '	e costs through	December 31 c	of the cost r	eporting period	O	67.0
40 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	o costs often Do	combor 21 of	the cost ron	arting pariod	0	68.0
68. 00	(line 13 x line 20)	e costs after be	celliber 31 01	the cost rep	ortring period		00.0
69. 00	Total title V or XIX swing-bed NF inpatient					0	69.0
70. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil				)		70.0
71. 00	Adjusted general inpatient routine service c	ost per diem (li					71.0
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic		(line 14 v li	ne 35)			72. 0
74. 00	Total Program general inpatient routine serv						74. 0
75. 00	Capital-related cost allocated to inpatient 26. line 45)	routine service	costs (from W	orksheet B, I	Part II, column		75. 0
76. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 0
77. 00	Program capital-related costs (line 9 x line	76)					77. 0
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		ovider record	ls)			78. 0 79. 0
80.00					nus line 79)		80.0
81.00	Inpatient routine service cost per diem limi						81.0
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (		)				82. 0 83. 0
84. 00	Program inpatient ancillary services (see in	structions)					84. 0
85.00	Utilization review - physician compensation	•	*				85.0
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS		Jugii 85)				86. 0
	Total observation bed days (see instructions					C	87. 0
87. 00 88. 00	· ·						88. 0

Health Financial Systems	RH OF NORTHWEST	INDIANA, LLC		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 02/01/2021 To 01/31/2022		
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	1, 102, 922	15, 445, 602	0. 07140	7 0	0	90. 00
91.00 Nursing Program cost	0	15, 445, 602	0.00000	0	0	91.00
92.00 Allied health cost	0	15, 445, 602	0.00000	0	0	92.00
93 00 All other Medical Education	0	15 445 602	0 00000	n n	0,	93 00

Health Fi	nancial Systems RH OF NORTHWEST IN	DIANA IIC		In lie	eu of Form CMS-2	2552_10
	T ANCILLARY SERVICE COST APPORTIONMENT	Provi der Co	CN: 15-2024	Peri od:	Worksheet D-3	
				From 02/01/2021 To 01/31/2022	Date/Time Pre 6/1/2022 10:5	
		Title	XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1. 00	2. 00	3. 00	
	PATIENT ROUTINE SERVICE COST CENTERS				1	
	000 ADULTS & PEDI ATRI CS			35, 357, 826		30. 00
	CILLARY SERVICE COST CENTERS					
	OOO OPERATING ROOM		0. 54190			
	400 RADI OLOGY-DI AGNOSTI C		0. 1322!			1
	000 LABORATORY		0. 1263			•
	500 RESPI RATORY THERAPY		0. 03889			1
66.00 06	600 PHYSI CAL THERAPY		0. 20443	1, 778, 914	363, 665	66. 00
67.00 06	0700 OCCUPATI ONAL THERAPY		0. 1363	70 1, 258, 409	171, 609	67. 00
68.00 06	800 SPEECH PATHOLOGY		0. 21334	487, 251	103, 952	68. 00
69.00 06	900 ELECTROCARDI OLOGY		0. 01014	15 3, 406, 949	34, 563	69. 00
71.00 07	100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 12668	9, 061, 686	1, 147, 989	71. 00
73. 00 07	300 DRUGS CHARGED TO PATIENTS		0. 17290	58 7, 647, 957	1, 322, 852	73. 00
74. 00 07	400 RENAL DIALYSIS		0. 15713	38 2, 590, 541	407, 072	74. 00
76. 00   03	950 WOUND CARE		0. 00000	00	0	76. 00
200.00	Total (sum of lines 50 through 94 and 96 through 98)			60, 316, 794	5, 976, 328	200. 00
201.00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201. 00
202. 00	Net charges (line 200 minus line 201)			60, 316, 794		202. 00

Heal th	Financial Systems RH OF NORTHWEST IN	IDI ANA, LLC		In Lie	eu of Form CMS-2	2552-10
INPATIE	NT ANCILLARY SERVICE COST APPORTIONMENT	Provi der Co	CN: 15-2024	Peri od:	Worksheet D-3	
				From 02/01/2021 To 01/31/2022	Date/Ti me Pre 6/1/2022 10:5	
		Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges		Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1. 00	2. 00	3. 00	
	NPATIENT ROUTINE SERVICE COST CENTERS					
H-	3000 ADULTS & PEDIATRICS			0		30. 00
	NCILLARY SERVICE COST CENTERS					
	05000 OPERATING ROOM		0. 5419		0	
	D5400 RADI OLOGY-DI AGNOSTI C		0. 1322!		0	54. 00
	06000 LABORATORY		0. 1263!		0	60. 00
	06500 RESPI RATORY THERAPY		0. 0388		0	65. 00
66.00	06600 PHYSI CAL THERAPY		0. 2044:	31 0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY		0. 1363	70 0	0	67. 00
68.00	06800 SPEECH PATHOLOGY		0. 2133	43 0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY		0. 0101	45 0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 1266	36 0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 1729	58 0	0	73. 00
74.00	07400 RENAL DIALYSIS		0. 1571:	38 0	0	74. 00
76.00	03950 WOUND CARE		0. 00000	00 0	0	76. 00
200.00	Total (sum of lines 50 through 94 and 96 through 98)			0	0	200. 00
201.00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201. 00
202. 00	Net charges (line 200 minus line 201)			0	l	202. 00

Health Financial Systems RH 0F
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Peri od: | Worksheet E-1 | From 02/01/2021 | Part | To 01/31/2022 | Date/Time Prepared: Provider CCN: 15-2024

			'	0 01/31/2022	6/1/2022 10: 5	
		Ti tl e	e XVIII	Hospi tal	PPS	
		I npati er	nt Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1. 00	Total interim payments paid to provider	11.00	13, 943, 092		0	1, 00
2. 00	Interim payments payable on individual bills, either		10, 710, 072		0	
2.00	submitted or to be submitted to the contractor for				Ĭ	2.00
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider	<u>'</u>	•			1
3. 01	ADJUSTMENTS TO PROVIDER		C		0	3. 01
3. 02				)	0	3. 02
3. 03				1	0	
3. 04					l o	
3. 05					l o	
0.00	Provider to Program			1		1 0.00
3.50	ADJUSTMENTS TO PROGRAM	10/28/2021	183, 483		0	3.50
3. 51		01/04/2022	282, 417		0	
3. 52		0170172022	202,		0	
3. 53				1	0	
3. 54				1	l o	
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		-465, 900	1	0	
0. , ,	3. 50-3. 98)		100,700			0. , ,
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		13, 477, 192		0	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR		•		•	1
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		C		0	5. 01
5.02			0	)	0	5. 02
5.03			C		0	5. 03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM		C	)	0	5. 50
5. 51			C	)	0	5. 51
5. 52			C	)	0	
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		C	)	0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		0	1	0	
6. 02	SETTLEMENT TO PROGRAM		548, 406		0	
7.00	Total Medicare program liability (see instructions)		12, 928, 786		0	7. 00
				Contractor	NPR Date	
			_	Number	(Mo/Day/Yr)	
0.00	Tu		0	1. 00	2. 00	0.55
8.00	Name of Contractor	1				8.00

Heal th	Financial Systems RH OF NORTHWEST I	NDLANA LLC	Inlie	u of Form CMS-	2552-10
	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT  Provider CCN: 15-2024   Period: From 02/01/2021   To 01/31/2022				epared:
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				4
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				4
1. 00	Total hospital discharges as defined in AARA §4102 from Wkst.				1. 00
2. 00	2.00 Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and 8 through 12, and plus for cost				2. 00
reporting periods beginning on or after 10/01/2013, line 32)					
3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2					3. 00
4. 00	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines	1, and 8 through 12, and	plus for cost		4. 00
	reporting periods beginning on or after 10/01/2013, line 32)				
5. 00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00
6. 00	Total hospital charity care charges from Wkst. S-10, col. 3 I				6. 00
7. 00	CAH only - The reasonable cost incurred for the purchase of c line 168	ertified HIT technology	Wkst. S-2, Pt. I		7. 00
8. 00	Calculation of the HIT incentive payment (see instructions)				8.00
9. 00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
10.00	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH	(See That detroils)			1 10.00
30. 00	Initial/interim HIT payment adjustment (see instructions)				30.00
	Other Adjustment (specify)				31.00
	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	s)		32. 00
					•

Health Financial Systems	RH OF NORTHWEST INDIANA, LLC	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-2024	Peri od: From 02/01/2021 To 01/31/2022	Worksheet E-3 Part IV Date/Time Prepared: 6/1/2022 10:58 am

PART IV - MEDICARE PART A SERVICES - LTCH PPS   1.00					6/1/2022 10: 5	8 am
PART I I - MEDICARE PART A SERVICES - LTCH PPS			Title XVIII	Hospi tal	PPS	
PART I I - MEDICARE PART A SERVICES - LTCH PPS						
1.00   Net Federal PPS Payments (see instructions)   12, 282, 185   1, 00   10, 111   11					1.00	
Full standard payment amount   10,178,338   1,01						
1.02   Short stay outilier standard payment amount   0.03   0.04   0.05   0.0						1
1.03   Site neutral payment amount - Cost   0   1.03   0   0   1.04   0.04						•
1.04   Site neutral payment amount - IPPS comparable   0   1.04						•
2.00		1 3				•
Total PPS Payments (sum of lines 1 and 2)						•
A. 0.0						
5.00						
6.00         Cost of physicians' services in a teaching hospital (see instructions)         0         6.00           7.00         Subtotal (see instructions)         13,392,559         7.00           8.00         Primary payer payments         0         8.00           9.00         Subtotal (line 7 less line 8).         13,392,559         9.00           11.00         Deductibles         18,001         10.00           12.00         Coinsurance         772,284         11.00           12.00         Coinsurance         12,602,274         13.00           14.00         Allowable bad debts (exclude bad debts for professional services) (see instructions)         502,326         14.00           15.00         Allowable bad debts (exclude bad debts (see instructions)         326,512         15.00           16.00         Allowable bad debts for dual eligible beneficiaries (see instructions)         316,644         16.00           17.00         Subtotal (sum of lines 13 and 15)         12,928,786         17.00           19.00         Other pass through costs (see instructions)         12,928,786         17.00           19.00         Other pass through costs (see instructions)         0         18.00           10.00         Other pass through costs (see instructions)         0         19.00     <			ons)		0	1
1.0						
S. 00   O. 00   Subtotal (line 7 less line 8).   13, 392,559   0. 00   13, 392,559   0. 00   13, 392,559   0. 00   13, 392,559   0. 00   13, 392,559   0. 00   13, 392,559   0. 00   13, 374,558   11. 00   13, 374,558   11. 00   13, 374,558   11. 00   13, 374,558   11. 00   13, 374,558   12. 00   13, 374,558   12. 00   13, 374,558   13. 00   14. 00   1		Cost of physicians' services in a teaching hospital (see inst	ructions)			
0.00		Subtotal (see instructions)			13, 392, 559	7. 00
10. 00     10. 00   10. 00     10. 00     10. 00     10. 00     10. 00     10. 00   10. 00     10. 00     10. 00     10. 00     10. 00     10. 00   10. 00     10. 00     10. 00     10. 00     10. 00     10. 00   10. 00     10. 00     10. 00     10. 00     10. 00     10. 00   10. 00     10. 00   10. 00   10. 00   10. 00   10. 00   10. 00   10. 00   10. 00   10. 00   10. 00   10. 00   10. 00   10. 00   1					1	
11.00   Subtotal (line 9 minus line 10)   13,374,558   11.00   12.00   Coinsurance   772, 284   12.00   Coinsurance   772,	9.00				13, 392, 559	9. 00
12.00   Coinsurance   772, 284   12.00   Subtotal (line 11 minus line 12)   12.602, 274   13.00   14.00   Allowable bad debts (exclude bad debts for professional services) (see instructions)   502, 326   14.00   15.00   Adjusted reimbursable bad debts (see instructions)   326, 512   15.00   16.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   316, 644   16.00   17.00   Subtotal (sum of lines 13 and 15)   12, 928, 786   17.00   18.00   Direct graduate medical education payments (from Wkst. E-4, line 49)   18.00   19.00   Other pass through costs (see instructions)   18.00   19.00   Other pass through costs (see instructions)   19.00   Other pass through costs (see instructions)   19.00	10.00				18, 001	10. 00
13.00   Subtotal (line 11 minus line 12)   12,602,274   13.00   14.00   All owable bad debts (exclude bad debts for professional services) (see instructions)   502,326   14.00   15.00   Adjusted reimbursable bad debts (see instructions)   326,512   15.00   16.00   All owable bad debts for dual eligible beneficiaries (see instructions)   316,644   16.00   17.00   Subtotal (sum of lines 13 and 15)   12,928,786   17.00   12,928,786   1	11.00	Subtotal (line 9 minus line 10)			13, 374, 558	11. 00
14. 00	12.00	Coinsurance			772, 284	12. 00
15.00	13.00				12, 602, 274	13. 00
16.00       Allowable bad debts for dual eligible beneficiaries (see instructions)       316,644       16.00         17.00       Subtotal (sum of lines 13 and 15)       12,928,786       17.00         18.00       Direct graduate medical education payments (from Wkst. E-4, line 49)       0       18.00         19.00       Other pass through costs (see instructions)       0       19.00         20.00       Outlier payments reconciliation       0       20.00         21.00       The ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       21.00         21.50       Pioneer ACO demonstration payment adjustment (see instructions)       0       21.50         21.98       Recovery of accelerated depreciation.       0       21.98         22.00       Demonstration payment adjustment amount before sequestration       0       21.98         22.01       Sequestration adjustment (see instructions)       12,928,786       22.00         22.01       Demonstration payment adjustment amount after sequestration       0       22.01         22.02       Demonstration payment adjustment amount after sequestration       0       22.02         23.00       Interim payments       13,477,192       23.00         24.00       Tentative settlement (for contractor use only)       -548,406       25.00 <t< td=""><td>14.00</td><td>Allowable bad debts (exclude bad debts for professional service</td><td>ces) (see instructions)</td><td></td><td>502, 326</td><td>14. 00</td></t<>	14.00	Allowable bad debts (exclude bad debts for professional service	ces) (see instructions)		502, 326	14. 00
17. 00       Subtotal (sum of lines 13 and 15)       12, 928, 786       17. 00         18. 00       Direct graduate medical education payments (from Wkst. E-4, line 49)       0 18. 00         19. 00       Other pass through costs (see instructions)       0 19. 00         20. 00       Outlier payments reconciliation       0 20. 00         21. 00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0 21. 00         21. 90       Pioneer ACO demonstration payment adjustment (see instructions)       0 21. 50         21. 98       Recovery of accelerated depreciation.       0 21. 99         22. 00       Demonstration payment adjustment amount before sequestration       0 21. 99         22. 01       Sequestration adjustment (see instructions)       12, 928, 786       22. 00         22. 02       Demonstration payment adjustment amount after sequestration       0 22. 01         22. 02       Demonstration payment adjustment (see instructions)       12, 928, 786       22. 00         22. 01       Sequestration adjustment (see instructions)       12, 928, 786       22. 00         23. 00       Interim payments       13, 477, 192       23. 00         24. 00       Tentative settlement (for contractor use only)       -548, 406       25. 00         25. 00       Bal ance due provi der/program (line 22 minus lines 22.01, 22.02, 2	15.00	Adjusted reimbursable bad debts (see instructions)			326, 512	15. 00
18.00 Direct graduate medical education payments (from Wkst. E-4, line 49)  19.00 Other pass through costs (see instructions)  20.00 Outlier payments reconciliation  20.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  21.50 Pioneer ACO demonstration payment adjustment (see instructions)  21.98 Recovery of accelerated depreciation.  21.99 Demonstration payment adjustment amount before sequestration  22.00 Total amount payable to the provider (see instructions)  22.01 Sequestration adjustment (see instructions)  22.02 Sequestration adjustment (see instructions)  22.03 Demonstration payment adjustment amount after sequestration  22.01 Interim payments  23.00 Interim payments  24.00 Total aive settlement (for contractor use only)  25.00 Balance due provider/program (line 22 minus lines 22.01, 22.02, 23 and 24)  26.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 39, 784 50.00 Sills. 2  TO BE COMPLETED BY CONTRACTOR  50.00 Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions)  51.00 Outlier reconciliation adjustment amount (see instructions)  The rate used to calculate the Time Value of Money (see instructions)  52.00 The rate used to calculate the Time Value of Money (see instructions)  52.00 Time Interval used to calculate the Time Value of Money (see instructions)  53.00 Time Interval used to calculate the Time Value of Money (see instructions)  54.00 Time Interval used to calculate the Time Value of Money (see instructions)  55.00 Time Interval used to calculate the Time Value of Money (see instructions)	16.00	Allowable bad debts for dual eligible beneficiaries (see insti	ructions)		316, 644	16. 00
19.00   Other pass through costs (see instructions)   0   19.00   20.00   20.00   Outlier payments reconciliation   0   20.0	17.00	Subtotal (sum of lines 13 and 15)			12, 928, 786	17. 00
20. 00       Outlier payments reconciliation       0       20. 00         21. 00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       21. 00         21. 50       Pioneer ACO demonstration payment adjustment (see instructions)       0       21. 50         21. 98       Recovery of accelerated depreciation.       0       21. 98         21. 99       Demonstration payment adjustment amount before sequestration       0       21. 99         22. 00       Total amount payable to the provider (see instructions)       12, 928, 786       22. 00         22. 01       Sequestration adjustment (see instructions)       0       22. 01         22. 02       Demonstration payment adjustment amount after sequestration       0       22. 01         23. 00       Interim payments       13, 477, 192       23. 00         24. 00       Tentative settlement (for contractor use only)       13, 477, 192       23. 00         25. 00       Balance due provider/program (line 22 minus lines 22.01, 22.02, 23 and 24)       -548, 406       25. 00         26. 00       Fortested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 39, 784       39, 784       26. 00         51. 00       Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions)       1, 110, 374       50. 00         52. 0	18.00	Direct graduate medical education payments (from Wkst. E-4, Li	ne 49)		0	18. 00
21.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   21.00	19.00	Other pass through costs (see instructions)			0	19. 00
21. 50	20.00	Outlier payments reconciliation			0	20. 00
21. 98   Recovery of accel erated depreciation.	21.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	21. 00
21.99   Demonstration payment adjustment amount before sequestration   0   21.99   22.00   Total amount payable to the provider (see instructions)   12,928,786   22.00   22.01   Sequestration adjustment (see instructions)   0   22.01   22.02   Demonstration payment adjustment amount after sequestration   0   22.01   22.02   23.00   Interim payments   13,477,192   23.00   24.00   Tentative settlement (for contractor use only)   0   24.00   25.00   Balance due provider/program (line 22 minus lines 22.01, 22.02, 23 and 24)   -548,406   25.00   26.00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 39,784   26.00   25.00   Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions)   1,110,374   50.00   51.00   Outlier reconciliation adjustment amount (see instructions)   0   51.00   52.00   The rate used to calculate the Time Value of Money (see instructions)   0.00   52.00	21. 50	Pioneer ACO demonstration payment adjustment (see instructions	s)		0	21. 50
22.00 Total amount payable to the provider (see instructions)  22.01 Sequestration adjustment (see instructions)  22.02 Demonstration payment adjustment amount after sequestration  23.00 Interim payments  24.00 Tentative settlement (for contractor use only)  25.00 Balance due provider/program (line 22 minus lines 22.01, 22.02, 23 and 24)  26.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 39, 784 26.00 25.00  26.00 Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions)  50.00 Outlier reconciliation adjustment amount (see instructions)  50.00 The rate used to calculate the Time Value of Money (see instructions)  50.00 The rate used to calculate the Time Value of Money (see instructions)  50.00 The rate used to calculate the Time Value of Money (see instructions)  50.00 The rate used to calculate the Time Value of Money (see instructions)  50.00 The rate used to calculate the Time Value of Money (see instructions)  50.00 The rate used to calculate the Time Value of Money (see instructions)	21. 98	Recovery of accelerated depreciation.			0	21. 98
22. 01   Sequestration adjustment (see instructions)   0   22. 01	21. 99	Demonstration payment adjustment amount before sequestration			0	21. 99
22. 02   Demonstration payment adjustment amount after sequestration   0   22. 02   23. 00   Interim payments   13, 477, 192   23. 00   24. 00   Tentative settlement (for contractor use only)   0   24. 00   25. 00   Balance due provider/program (line 22 minus lines 22. 01, 22. 02, 23 and 24)   -548, 406   25. 00   26. 00   Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 39, 784   26. 00   39. 15. 2   10   10   10   10   10   10   10	22.00	Total amount payable to the provider (see instructions)			12, 928, 786	22. 00
23.00 Interim payments  13, 477, 192 23.00  24.00 Tentative settlement (for contractor use only)  25.00 Balance due provider/program (line 22 minus lines 22.01, 22.02, 23 and 24)  26.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 39, 784 26.00  25.00 Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions)  50.00 Outlier reconciliation adjustment amount (see instructions)  13, 477, 192 23.00  24.00  25.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 39, 784 26.00  26.00 Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions)  50.00 Outlier reconciliation adjustment amount (see instructions)  70.00 The rate used to calculate the Time Value of Money (see instructions)  70.00 S2.00	22. 01	Sequestration adjustment (see instructions)			0	22. 01
24.00 Tentative settlement (for contractor use only)  25.00 Balance due provider/program (line 22 minus lines 22.01, 22.02, 23 and 24)  26.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 39, 784 26.00    26.00 Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions)  50.00 Outlier reconciliation adjustment amount (see instructions)  1,110,374 50.00 51.00 The rate used to calculate the Time Value of Money (see instructions)  0 24.00 24.00 25.00 25.00	22. 02	Demonstration payment adjustment amount after sequestration			0	22. 02
25.00 Balance due provider/program (line 22 minus lines 22.01, 22.02, 23 and 24)  26.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 39, 784 26.00 \$\frac{\$115.2}{\$10.80}\$ COMPLETED BY CONTRACTOR  50.00 Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions)  51.00 Outlier reconciliation adjustment amount (see instructions)  52.00 The rate used to calculate the Time Value of Money (see instructions)  53.00 October 1, 39, 784 26.00 11, 110, 374 50.00 11, 1	23.00	Interim payments			13, 477, 192	23. 00
26.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 39,784 26.00 \$\frac{\text{\$115.2}}{\text{\$10.00}}\$  TO BE COMPLETED BY CONTRACTOR  50.00 Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions)  1,110,374 50.00 0utlier reconciliation adjustment amount (see instructions)  1,110,374 50.00 51.00 The rate used to calculate the Time Value of Money (see instructions)  26.00 Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions)  1,110,374 50.00 51.00 52.00	24.00	Tentative settlement (for contractor use only)			0	24. 00
\$115.2 TO BE COMPLETED BY CONTRACTOR  50.00 Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions) 1,110,374 50.00 51.00 Outlier reconciliation adjustment amount (see instructions) 0 51.00 The rate used to calculate the Time Value of Money (see instructions) 0.00 52.00	25.00	Balance due provider/program (line 22 minus lines 22.01, 22.0)	2, 23 and 24)		-548, 406	25. 00
TO BE COMPLETED BY CONTRACTOR  50.00 Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions)  51.00 Outlier reconciliation adjustment amount (see instructions)  52.00 The rate used to calculate the Time Value of Money (see instructions)  52.00 The rate used to calculate the Time Value of Money (see instructions)  53.00 The rate used to calculate the Time Value of Money (see instructions)  54.00 The rate used to calculate the Time Value of Money (see instructions)	26.00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2, o	chapter 1,	39, 784	26. 00
50.00 Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions) 1,110,374 50.00 51.00 Outlier reconciliation adjustment amount (see instructions) 51.00 The rate used to calculate the Time Value of Money (see instructions) 0.00 52.00		§115. 2		·		
51.00 Outlier reconciliation adjustment amount (see instructions)  0 51.00  The rate used to calculate the Time Value of Money (see instructions)  0 52.00		TO BE COMPLETED BY CONTRACTOR				
52.00 The rate used to calculate the Time Value of Money (see instructions) 0.00 52.00	50.00	Original outlier amount from Wkst. E-3, Pt IV, line 2 (see in	structions)		1, 110, 374	50.00
	51.00	Outlier reconciliation adjustment amount (see instructions)			0	51.00
53.00 Time Value of Money (see instructions) 0 53.00	52.00	The rate used to calculate the Time Value of Money (see instru	uctions)		0.00	52.00
	53.00	Time Value of Money (see instructions)			0	53.00

Health Financial Systems	RH OF NORTHWEST INDIANA, LLC	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-2024	From 02/01/2021	Worksheet E-3 Part VII Date/Time Prepared:

Mode   Mode				10 01/31/2022	6/1/2022 10:5	
Input   Inpu			Title XIX	Hospi tal		
PART VII - CALCULATION OF RETINBUSSIMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES   1.00   Inpati ent hospit alf /SMF/MF services   0   1.00   2.00   Act of cold and other services   0   3.00   Act of cold and other services   0   4.00   Act of cold and other services   0   0.00   Act of cold and other services					Outpati ent	
COMPUTATION OF NET COST OF COVERED SERVICES   1.00   1.0				1. 00	2. 00	
Inpati ent hospit al /SMF/MF services	-	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SEF	RVICES FOR TITLES V OR XI	X SERVICES		
Medical and other services   0   2.00		COMPUTATION OF NET COST OF COVERED SERVICES				
3.00   Organ acquisition (certified transplant centers only)	1.00	Inpatient hospital/SNF/NF services		0		1.00
Subtotal (sum of lines 1, 2 and 3)	2.00	Medical and other services			0	2. 00
	3.00	Organ acquisition (certified transplant centers only)		0		3. 00
0.00		Subtotal (sum of lines 1, 2 and 3)		0	0	4. 00
Subtotal (line 4 less sum of lines 5 and 6)		, , , , , , , , , , , , , , , , , , , ,		0		1
COMPUTATION OF LESSER OF COST OR CHARGES						
Reasonable Charges   8.00   8.00   8.00   8.00   9.00   10.0	7. 00			0	0	7.00
Routine service charges						1
9.00   Ancillary service charges   0   0   9.00	0.00					
10.00   Organ acquisition charges, net of revenue   0   10.0				١	0	1
11.00   Incentive from target amount computation   0   0   11.00   COSTOMARY CHARGES   0   0   0   12.00   COSTOMARY CHARGES   0   0   0   12.00   COSTOMARY CHARGES   0   0   0   12.00   0   13.00   0   14.00   0   14.00   0   0   14.00   0   0   14.00   0   0   0   14.00   0   0   0   0   0   0   0   0   0				-	Ü	
12.00   Total reasonable charges (sum of lines 8 through 11)   13.00   12.00   13.00   13.00   14.00   14.00   14.00   14.00   14.00   14.00   14.00   14.00   14.00   14.00   14.00   14.00   14.00   14.00   14.00   15.00				-		1
CUSTOMARY CHARGES   1.00   13.00   13.00   14.00   15.00   1				- 1	0	
13.00   Amount actually collected from patients liable for payment for services on a charge basis   14.00   Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)   15.00   Ratio of line 13 to line 14 (not to exceed 1.000000)   0.0000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.00000000	12.00			ı o	0	12.00
basis   14.00   Anounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)   0.000000   0.000000   15.00   15.00   Ratio of line 13 to line 14 (not to exceed 1.000000)   0.000000   0.000000   15.00   16.00   1	13 00		r services on a charge		0	13 00
14.00   Amounts that would have been realized from patients Liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)   0.000000   0.000000   15.00   16.00   16.00   17.00	10.00		services on a enarge		Ü	10.00
a charge basis had such payment been made in accordance with 42 CFR \$413.13(e) 15.00 Ratio of line 13 to line 14 (not to exceed 1.000000) 16.00 Total customary charges (see instructions) 17.00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 11ne 4) (see instructions) 18.00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16 (see instructions) 19.00 Interns and Residents (see instructions) 19.00 Interns and Residents (see instructions) 19.00 Cost of physicians' services in a teaching hospital (see instructions) 10.00 Cost of physicians' services in a teaching hospital (see instructions) 10.00 Cost of physicians' services (enter the lesser of line 4 or line 16) 10.00 PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers. 10.00 Outlier payments 10.00 Outlie	14.00		r payment for services on	o	0	14.00
16. 00   Total customary charges (see instructions)   0   0   16. 00   17. 00   Excess of customary charges over reasonable cost (complete only if line 16 exceeds   0   0   17. 00						
17.00   Excess of Customary Charges over reasonable cost (complete only if line 16 exceeds   0	15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15. 00
				0		1
18.00   Excess of reasonable cost over customary charges (complete only if line 4 exceeds line   16) (see instructions)   19.00   19	17. 00		y if line 16 exceeds	0	0	17. 00
16) (see instructions)	40.00					40.00
19.00   Interns and Residents (see instructions)   0   0   19.00   20.00   2	18.00		y if line 4 exceeds line	0	0	18.00
20.00   Cost of physicians' services in a teaching hospital (see instructions)   0   0   20.00     21.00   Cost of covered services (enter the lesser of line 4 or line 16)   0   0   21.00     PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.	10.00				0	10.00
21.00			cuctions)	-	-	
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.   22. 00   22. 00   23. 00   0utlier payments   0   0   23. 00   0utlier payments   0   0   23. 00   24. 00   25. 00   26. 00   26. 00   26. 00   26. 00   26. 00   27. 00   28. 00   29. 00   27. 00   28. 00   29. 00				-	_	
22.00   Other than outlier payments   0   0   22.00	21.00					21.00
23. 00 Outlier payments	22. 00		omproted for the provide		0	22. 00
25.00 Capital exception payments (see instructions) 26.00 Routine and Ancillary service other pass through costs 27.00 Subtotal (sum of lines 22 through 26) 28.00 Customary charges (title V or XIX PPS covered services only) 29.00 Titles V or XIX (sum of lines 21 and 27) 29.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT  30.00 Excess of reasonable cost (from line 18) 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 31.00 Deductibles 30.00 Allowable bad debts (see instructions) 31.00 Allowable bad debts (see instructions) 35.00 Utilization review 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Bal ance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  25.00 26.00 27.00 28.00 0 0 28.00 0 0 28.00 0 0 28.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		, ,		o	0	
26. 00 Routine and Ancillary service other pass through costs  27. 00 Subtotal (sum of lines 22 through 26)  28. 00 Customary charges (title V or XIX PPS covered services only)  29. 00 Titles V or XIX (sum of lines 21 and 27)  COMPUTATION OF REIMBURSEMENT SETTLEMENT  30. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)  29. 00 Deductibles  30. 00 Jal. 00  31. 00 Ocinsurance  30. 01 Jal. 00 Ocinsurance  30. 02 Allowable bad debts (see instructions)  31. 00 Jutilization review  32. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  33. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  34. 00 Jirect graduate medical education payments (from Wkst. E-4)  40. 00 Total amount payable to the provider (sum of lines 38 and 39)  41. 00 Interim payments  42. 00 Balance due provider/program (line 40 minus line 41)  43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,	24.00	Program capital payments		O		24. 00
27. 00 Subtotal (sum of lines 22 through 26) 0 0 27. 00 28. 00 Customary charges (title V or XIX PPS covered services only) 0 0 28. 00 29. 00 Titles V or XIX (sum of lines 21 and 27) 0 0 0  20. 00 COMPUTATION OF REI MBURSEMENT SETTLEMENT  30. 00 Excess of reasonable cost (from line 18) 0 0 31. 00 31. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 0 0 31. 00 32. 00 Deductibles 0 0 0 32. 00 33. 00 Coinsurance 0 0 0 33. 00 34. 00 Allowable bad debts (see instructions) 0 0 34. 00 35. 00 Utilization review 0 0 35. 00 36. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 0 0 36. 00 37. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 37. 00 38. 00 Subtotal (line 36 ± line 37) 0 0 38. 00 39. 00 Direct graduate medical education payments (from Wkst. E-4) 0 0 39. 00 40. 00 Total amount payable to the provider (sum of lines 38 and 39) 0 0 40. 00 41. 00 Interim payments 0 0 41. 00 43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43. 00	25.00	Capital exception payments (see instructions)		O		25. 00
28. 00 Customary charges (title V or XIX PPS covered services only)  Titles V or XIX (sum of lines 21 and 27)  COMPUTATION OF REIMBURSEMENT SETTLEMENT  30. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)  Deductibles  Coinsurance  31. 00 O 32. 00  32. 00  34. 00 Allowable bad debts (see instructions)  Utilization review  Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)  Therefore The Adjustments (SEE INSTRUCTIONS) (SPECIFY)  Subtotal (line 36 ± line 37)  Direct graduate medical education payments (from Wkst. E-4)  Total amount payable to the provider (sum of lines 38 and 39)  10 O 42. 00  43. 00  Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,	26.00	Routine and Ancillary service other pass through costs		0	0	26. 00
29.00   Titles V or XIX (sum of lines 21 and 27)   0   0   29.00				0		
COMPUTATION OF REIMBURSEMENT SETTLEMENT   30.00   Excess of reasonable cost (from line 18)   0   0   30.00   31.00   Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)   0   0   31.00   32.00   23.00						
30.00 Excess of reasonable cost (from line 18) 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32.00 Deductibles 32.00 Coi nsurance 34.00 Allowable bad debts (see instructions) 35.00 Utilization review 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,	29. 00			0	0	29. 00
31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)  32.00 Deductibles  33.00 Coi nsurance  34.00 Allowable bad debts (see instructions)  35.00 Utilization review  36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)  37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  38.00 Subtotal (line 36 ± line 37)  39.00 Direct graduate medical education payments (from Wkst. E-4)  40.00 Total amount payable to the provider (sum of lines 38 and 39)  41.00 Interim payments  42.00 Balance due provider/program (line 40 minus line 41)  43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,						
32.00 Deductibles 33.00 Coinsurance 33.00 Allowable bad debts (see instructions) 35.00 Utilization review 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,		, ,				
33.00       Coinsurance       0       0       33.00         34.00       Allowable bad debts (see instructions)       0       0       34.00         35.00       Utilization review       0       35.00         36.00       Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)       0       0       36.00         37.00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       0       37.00         38.00       Subtotal (line 36 ± line 37)       0       0       38.00         39.00       Direct graduate medical education payments (from Wkst. E-4)       0       0       39.00         40.00       Total amount payable to the provider (sum of lines 38 and 39)       0       0       40.00         41.00       Interim payments       0       0       41.00         42.00       Balance due provider/program (line 40 minus line 41)       0       0       42.00         43.00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,       0       43.00			)			
34.00       Allowable bad debts (see instructions)       0       34.00         35.00       Utilization review       0       35.00         36.00       Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)       0       0       36.00         37.00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       0       37.00         38.00       Subtotal (line 36 ± line 37)       0       0       38.00         39.00       Direct graduate medical education payments (from Wkst. E-4)       0       39.00         40.00       Total amount payable to the provider (sum of lines 38 and 39)       0       0       40.00         41.00       Interim payments       0       0       41.00         42.00       Balance due provider/program (line 40 minus line 41)       0       0       42.00         43.00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,       0       43.00						
35.00 Utilization review 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,				-		
36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)  37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  38.00 Subtotal (line 36 ± line 37)  39.00 Direct graduate medical education payments (from Wkst. E-4)  40.00 Total amount payable to the provider (sum of lines 38 and 39)  41.00 Interim payments  42.00 Balance due provider/program (line 40 minus line 41)  43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,				-	U	
37.00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       0       37.00         38.00       Subtotal (line 36 ± line 37)       0       0       38.00         39.00       Direct graduate medical education payments (from Wkst. E-4)       0       39.00         40.00       Total amount payable to the provider (sum of lines 38 and 39)       0       0       40.00         41.00       Interim payments       0       0       41.00         42.00       Balance due provider/program (line 40 minus line 41)       0       0       42.00         43.00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,       0       0       43.00			4 33)	-	0	
38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  0 38.00 39.00 0 40.00 0 41.00 0 42.00			3 30)	-		
39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  39.00 0 40.00 0 41.00 0 42.00 0 43.00				-		
40.00 Total amount payable to the provider (sum of lines 38 and 39)  41.00 Interim payments  42.00 Balance due provider/program (line 40 minus line 41)  43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  0 40.00  41.00  0 40.00  42.00  43.00					ŭ	
41.00 Interim payments  42.00 Balance due provider/program (line 40 minus line 41)  43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  0 41.00  0 41.00  42.00  43.00					0	
42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 42.00 43.00				o		1
				0	0	1
chapter 1, §115.2	43.00		nce with CMS Pub 15-2,	0	0	43.00
		chapter 1, §115.2				I

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

Provider CCN: 15-2024

Peri od: Worksheet G From 02/01/2021 To 01/31/2022 Date/Time Prepared: 6/1/2022 10:58 am

——————————————————————————————————————					6/1/2022 10:5	8 am
		General Fund		Endowment Fund	Plant Fund	
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS	1.00	2.00	0.00	1.00	
1.00	Cash on hand in banks	0	0	0		1. 00
2.00	Temporary investments	0	1	_		2. 00
3.00	Notes recei vabl e	0	0	0	0	3.00
4.00	Accounts receivable	5, 044, 660	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6. 00 7. 00	Allowances for uncollectible notes and accounts receivable Inventory	0	0	0	0	6. 00 7. 00
8.00	Prepai d expenses			0	0	8.00
9. 00	Other current assets	156, 632	0	0	Ö	9. 00
10.00	Due from other funds	0	Ö	_	Ö	10.00
11. 00	Total current assets (sum of lines 1-10)	5, 201, 292	0	0	l	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12. 00
13.00	Land improvements	0	0	0	0	13. 00
14.00	Accumulated depreciation	0	0	0	0	14. 00
15. 00	Bui I di ngs	284, 766	0	0	0	15. 00
16. 00	Accumulated depreciation	-275, 141	0	0	0	16. 00
17. 00	Leasehold improvements	0	0	_	0	17. 00
18.00	Accumulated depreciation	0	0	_	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20. 00 21. 00	Accumulated depreciation Automobiles and trucks	0	0	0	0	20.00
21.00	Accumulated depreciation	0	0	0		21.00
23. 00	Major movable equipment	3, 785, 686	1	0	0	23. 00
24. 00	Accumulated depreciation	-2, 269, 907	0	0	0	24. 00
25. 00	Mi nor equi pment depreci abl e	2,207,707	0	0	Ö	25. 00
26. 00	Accumulated depreciation	Ö	Ö	0	Ō	26. 00
27. 00	HIT designated Assets	0	0	0	0	27. 00
28.00	Accumulated depreciation	0	0	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	0	0	0	29. 00
30.00	Total fixed assets (sum of lines 12-29)	1, 525, 404	0	0	0	30. 00
	OTHER ASSETS					
31. 00	Investments	0	0	_		31.00
32. 00	Deposits on Leases	1, 092, 807		_		32.00
33. 00	Due from owners/officers	16, 854, 128		_	0	33.00
34.00	Other assets	16, 538, 105			0	34.00
35. 00 36. 00	Total other assets (sum of lines 31-34) Total assets (sum of lines 11, 30, and 35)	34, 485, 040 41, 211, 736		_		35. 00 36. 00
30.00	CURRENT LIABILITIES	41, 211, 730	0		0	30.00
37. 00	Accounts payable	2, 825, 076	0	0	0	37. 00
38. 00	Salaries, wages, and fees payable	1, 332, 848		0	1	38.00
39. 00	Payrol I taxes payable	0	Ö	Ö	o o	39. 00
40.00	Notes and Loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accel erated payments	0				42.00
43.00	Due to other funds	852, 624	0	0	0	43. 00
44. 00	Other current liabilities	0		_	0	44. 00
45. 00	Total current liabilities (sum of lines 37 thru 44)	5, 010, 548	0	0	0	45. 00
	LONG TERM LIABILITIES	1	1			
46. 00	Mortgage payable	0	0	_	1	46. 00
47. 00	Notes payable	0	0	_	1	47. 00
48. 00	Unsecured Loans Other Long term Liabilities	244 021	0	_		48. 00
49. 00 50. 00	Total long term Habilities (sum of lines 46 thru 49)	266, 921 266, 921	0 0	_	l	49. 00 50. 00
51.00	Total liabilities (sum of lines 45 and 50)	5, 277, 469			l	51.00
31.00	CAPITAL ACCOUNTS	3, 277, 407	0	0	0	31.00
52. 00	General fund balance	35, 934, 267				52. 00
53. 00	Specific purpose fund		l 0			53. 00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55. 00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57. 00
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
	repl acement, and expansi on					
59. 00	Total fund balances (sum of lines 52 thru 58)	35, 934, 267		0	0	59. 00
60. 00	Total liabilities and fund balances (sum of lines 51 and	41, 211, 736	0	0	0	60. 00
	[59]	I	I	I	I	l

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES

					To 01/31/2022	Date/Time Prep 6/1/2022 10:58	
		General	Fund	Special F	urpose Fund	Endowment Fund	, c
		1.00	2. 00	3. 00	4. 00	5. 00	
1.00	Fund balances at beginning of period		36, 426, 924		0		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)		55, 803				2.00
3.00	Total (sum of line 1 and line 2)	_	36, 482, 727		0		3. 00
4.00	Additions (credit adjustments) (specify)	0			0	0	4. 00
5. 00 6. 00	FUND BALANCE RECON	0			0	0	5. 00 6. 00
7. 00					0		7. 00
8. 00					0		8. 00
9. 00					0	0	9. 00
10.00	Total additions (sum of line 4-9)		o		0		10.00
11. 00	Subtotal (line 3 plus line 10)		36, 482, 727		0		11.00
12.00	Deductions (debit adjustments) (specify)	0			0	0	12.00
13.00	ACCOUNT 62101 BAD DEBT REV DED	0			0	0	13.00
14.00		0			0	0	14.00
15. 00		0			0	0	15. 00
16.00		0			0	0	16.00
17. 00	T-t-1 d-du-ti (6 li 12 17)	0			0	0	17. 00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance		36, 482, 727		0		18. 00 19. 00
19.00	sheet (line 11 minus line 18)		30, 402, 727				19.00
	Tenest (Trine Tr ill flue Trine Te)	Endowment Fund	PI ant	Fund			
1.00	TE	6.00	7. 00	8. 00			1.00
1. 00 2. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)	0			0		1. 00 2. 00
3. 00	Total (sum of line 1 and line 2)				0		3. 00
4. 00	Additions (credit adjustments) (specify)		0				4. 00
5. 00	FUND BALANCE RECON		0				5. 00
6. 00			Ö				6. 00
7.00			О				7. 00
8.00			O				8.00
9.00			0				9. 00
10. 00	Total additions (sum of line 4-9)	0			0		10.00
11. 00	Subtotal (line 3 plus line 10)	0			0		11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13. 00 14. 00	ACCOUNT 62101 BAD DEBT REV DED		U				13. 00 14. 00
15. 00			0				15. 00
16. 00			0				16. 00
17. 00			0				17. 00
						I	17.00
18. 00	Total deductions (sum of lines 12-17)	o			o		18. 00
	Total deductions (sum of lines 12-17) Fund balance at end of period per balance	0			0		

 
 Heal th Financial Systems
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 STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES
 Provider CCN: 15-2024

			T	01/31/2022	Date/Time Prep 6/1/2022 10:58	
	Cost Center Description		Inpati ent	Outpati ent	Total	
	'		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Services					
1.00	Hospi tal		66, 164, 627		66, 164, 627	1. 00
2.00	SUBPROVI DER - I PF					2.00
3.00	SUBPROVI DER - I RF					3. 00
4.00	SUBPROVI DER					4. 00
5. 00	Swing bed - SNF		0		0	5. 00
6.00	Swing bed - NF		0		0	6. 00
7. 00	SKILLED NURSING FACILITY					7. 00
8.00	NURSING FACILITY					8. 00
9.00	OTHER LONG TERM CARE					9. 00
10. 00	Total general inpatient care services (sum of lines 1-9)		66, 164, 627		66, 164, 627	10. 00
11 00	Intensive Care Type Inpatient Hospital Services					11 00
11. 00 12. 00	INTENSIVE CARE UNIT					11. 00 12. 00
12.00	BURN INTENSIVE CARE UNIT					12.00
14. 00	SURGICAL INTENSIVE CARE UNIT					14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)					15. 00
16. 00	Total intensive care type inpatient hospital services (sum of	Lines	0		0	16. 00
10.00	11-15)	111163	O		O	10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)		66, 164, 627		66, 164, 627	17. 00
18. 00	Ancillary services		123, 495, 743	o	123, 495, 743	18. 00
19. 00	Outpatient services		.20, .70, 7.0	0	0	19. 00
20. 00	RURAL HEALTH CLINIC		0	o	0	20. 00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	o	0	21. 00
22. 00	HOME HEALTH AGENCY					22. 00
23.00	AMBULANCE SERVICES					23. 00
24.00	CMHC					24. 00
25.00	AMBULATORY SURGICAL CENTER (D. P. )					25. 00
26.00	HOSPI CE					26.00
27.00	OTHER (SPECIFY)		0	0	0	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	189, 660, 370	0	189, 660, 370	28. 00
	G-3, line 1)					
	PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			25, 316, 326		29. 00
30. 00	BAD DEBT ADDED INTO EXPENSE		596, 101			30. 00
31. 00	ROUNDING		1			31. 00
32. 00			0			32. 00
33.00			0			33. 00
34. 00			0			34. 00
35. 00 36. 00	Total additions (sum of lines 30-35)		0	596, 102		35. 00 36. 00
37.00	**DEDUCT**		0	390, 102		37. 00
38. 00	DEDUCT		0			38. 00
39. 00			0			39. 00
40. 00			0			40. 00
41. 00			0			41. 00
42. 00	Total deductions (sum of lines 37-41)		J	O		42. 00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42	)(transfer		25, 912, 428		43. 00
<del>-</del>	to Wkst. G-3, line 4)	, , , , , , , ,		., , , .=-		

Heal th	Financial Systems RH OF NORTHWEST I	I NDI ANA, LLC	In Lie	u of Form CMS-2	2552-10
STATEM	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-2024	Period: From 02/01/2021 To 01/31/2022	Worksheet G-3 Date/Time Pre 6/1/2022 10:5	pared:
				1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, li	ne 28)		189, 660, 370	1. 00
2. 00	Less contractual allowances and discounts on patients' accou			161, 246, 760	2. 00
3. 00	<b>'</b>			28, 413, 610	
4. 00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		25, 912, 428	4. 00
5. 00	Net income from service to patients (line 3 minus line 4)	/		2, 501, 182	5. 00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			0	6. 00
7.00	Income from investments			0	7. 00
8.00	Revenues from telephone and other miscellaneous communication	n services		0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			0	10. 00
11. 00	Rebates and refunds of expenses			0	11. 00
	Parking Lot receipts			0	12. 00
	Revenue from laundry and linen service			0	13. 00
14.00	Revenue from meals sold to employees and quests			0	14. 00