near til i manci	ai bystellis	Renabili tati on nospi tai	or Northern mar	III LI C	J 01 101111 CW3-2332-10
This report is	required by law (42 USC 1395)	g; 42 CFR 413.20(b)). Fai	lure to report can res	sult in all interim	FORM APPROVED
payments made	since the beginning of the cos	st reporting period being	deemed overpayments (	(42 USC 1395g).	OMB NO. 0938-0050
					EXPIRES 03-31-2022
HOSPITAL AND F	IOSPITAL HEALTH CARE COMPLEX CO	OST REPORT CERTIFICATION	Provider CCN: 15-3047		Worksheet S
AND SETTLEMENT	SUMMARY			From 05/01/2021	Parts I-III
				To 04/30/2022	Date/Time Prepared: 9/15/2022 11:43 am
PART I - COST	REPORT STATUS				77 137 2022 11. 43 dill
Provi der	1. [ X ] Electronically prepar	ed cost report		Date: 9/15/202	22 Time: 11:43 am
use only	2. [ ] Manually prepared cos	t report			
	3. [ 0 ] If this is an amended			resubmitted this co	ost report
	4. [ F ] Medicare Utilization.	Enter "F" for full or "L	." for low.		
Contractor		6. Date Received:		). NPR Date:	
use only	(1) As Submitted			. Contractor's Vendo	
	(2) Settled without Audit	8. [ N ] Initial Report fo	or this Provider CCN 12		
	(3) Settled with Audit	9. [ N ] Final Report for	this Provider CCN	number of tim	es reopened = 0-9.
	(4) Reopened				
	(5) Amended				

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by Rehabilitation Hospital of Northern Indiana (15-3047) for the cost reporting period beginning 05/01/2021 and ending 04/30/2022 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 FINANCIAL OFFICER OR ADMINISTRATOR			ELECTRONI C				
	1			SI GNATURE STATEMENT				
1	Trish	na Niemuth	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	Trisha Niemuth			2			
3	Signatory Title	CF0			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 Hosp	oi tal	0	205, 327	0	0	0	1.00
2. 00 Subp	rovider - IPF	0	0	0		0	2.00
3. 00 Subp	provider - IRF	0	0	0		0	3. 00
5. 00 Swi n	ng Bed - SNF	0	0	0		0	5. 00
6. 00 Swi n	ng Bed - NF	0				0	6.00
7. 00 SKI L	LED NURSING FACILITY	0	0	0		0	7. 00
9.00 HOME	HEALTH AGENCY I	0	0	0		0	9. 00
200. 00 Total		0	205, 327	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 Rehabilitation Hospital of Northern Indi In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-3047 Peri od: Worksheet S-2 From 05/01/2021 Part I Date/Time Prepared: 04/30/2022 9/15/2022 11:43 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 4807 Edison Lakes Parkway 1.00 PO Box: 1.00 State: IN 2.00 City: Mishawaka Zip Code: 46545 County: ST. **JOSEPH** 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N)
V XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Rehabilitation Hospital 153047 43780 5 05/28/2020 Ν 3.00 of Northern Indiana Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 6.00 Subprovider - (Other) 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: 2.00 1.00 20.00 Cost Reporting Period (mm/dd/yyyy) 05/01/2021 04/30/2022 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.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-3047 Peri od: Worksheet S-2 From 05/01/2021 Part I 04/30/2022 Date/Time Prepared: 9/15/2022 11:43 am In-State In-State Out-of Out-of Medi cai d 0ther Medi cai d Medi cai d State State HMO days Medi cai d paid days el i gi bl e Medi cai d Medi cai d days unpai d paid days eligible days unpai d 1.00 2. 00 3. 00 4. 00 5. 00 6.00 24.00 If this provider is an IPPS hospital, enter the 0 24.00  $\cap$ n in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state 18 41 0 0 689 25.00 Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5. Urban/Rural S Date of Geogr 1. 00 2.00 26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural. 26.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, 27.00 enter the effective date of the geographic reclassification in column 2. If this is a sole community hospital (SCH), enter the number of periods SCH status in 35.00 effect in the cost reporting period. Endi ng: Begi nni ng: 1.00 2.00 36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number 36, 00 of periods in excess of one and enter subsequent dates. If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 37.00 0 is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see 37.01 37.01 instructions) If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is 38.00 greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. Y/N Y/N 1.00 2.00 39. 00 39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions) 40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or Ν Ν 40.00 "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions) XVIII XIX 1.00 2.00 3.00 Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance Ν 45.00 with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment exception for extraordinary circumstances Ν N Ν 46.00 pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through 47.00 | Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. 47.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. Ν Ν Ν 48.00 Teaching Hospitals Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital Ν 56.00 was involved in training residents in approved GME programs in the prior year or penultimate 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. 57.00 | If line 56 is yes, is this the first cost reporting period during which residents in approved 57 00 GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. 58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. 58 00 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I. 59.00

OSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provi der Co		Period: From 05/01/2021 To 04/30/2022	Worksheet S-2 Part I Date/Time Pre 9/15/2022 11:	pared:
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
				1.00	2.00	3.00	
0. 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. CR) NAHE	ee If column 1	N			60.0
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2. 00	3. 00	4. 00	5. 00	-
	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in				0.00	0.00	61.0
1. 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						61.0
	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. 0
1. 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)						61.0
	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. 0
	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)						
. 06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary						61.0
	care or general surgery. (see instructions)	Pro	gram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2. 00	3.00	4. 00	
	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				0.00	0.00	61. 1
	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, the direct GME FTE unweighted count.				0.00	0. 00	61. 2
						1.00	
	ACA Provisions Affecting the Health Resources and Ser				sind for which		42.0
	Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instructions that rotated from a during in this cost reporting period of HRSA THC programmers.	ctions) n Teachi ŋram. (s	ng Health Cen ee instructio	ter (THC) into			62.0
. 00	Teaching Hospitals that Claim Residents in Nonprovide Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ettings	during this c	67. (see insti	ructions)	N	63. 0
				Unwei ghted FTEs Nonprovi der	Unwei ghted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	

	The year of the for the fire condition is the year, comprete firmes of this eaging	or. (See Thistia	Cti ons)		
		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	
Se	ection 5504 of the ACA Base Year FTE Residents in Nonprovider Settings	This base year	is your cost r	eporting	
ре	eriod that begins on or after July 1, 2009 and before June 30, 2010.				
64. 00 Er	inter in column 1, if line 63 is yes, or your facility trained residents	0.00	0.00	0. 000000	64.00
i r	n the base year period, the number of unweighted non-primary care				
re	esident FTEs attributable to rotations occurring in all nonprovider				
se	ettings. Enter in column 2 the number of unweighted non-primary care				
re	resident FTEs that trained in your hospital. Enter in column 3 the ratio				
of	of (column 1 divided by (column 1 + column 2)). (see instructions)				

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-3047 Peri od: Worksheet S-2 From 05/01/2021 Part I Date/Time Prepared: 04/30/2022 9/15/2022 11:43 am Program Name Program Code Unwei ghted Unwei ghted 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 0. 00 0. 00 0.000000 65.00 65.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) 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 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 Ν Ν 0 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)

Health Financial Systems Rehabilitation Hospital o	of Northern Indi	In Lie	u of Form CM	S-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CCN: 15-3047	Peri od: From 05/01/2021 To 04/30/2022	Worksheet S Part I Date/Time F 9/15/2022 1	Prepared:
			1.00	
Long Term Care Hospital PPS				
80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes ar 81.00 Is this a LTCH co-located within another hospital for part or a "Y" for yes and "N" for no.  TEFRA Providers		g period? Enter	N N	80. 00 81. 00
85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TE 66.00 Did this facility establish a new Other subprovider (excluded u §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			N	85. 00 86. 00
87.00 Is this hospital an extended neoplastic disease care hospital of	classified under section	ı	N	87. 00
1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		V	XIX	
		1. 00	2. 00	
Title V and XIX Services				
90.00 Does this facility have title V and/or XIX inpatient hospital s yes or "N" for no in the applicable column.	services? Enter "Y" for	N	N	90.00
91.00 Is this hospital reimbursed for title V and/or XIX through the full or in part? Enter "Y" for yes or "N" for no in the applica	able column.	N	N	91.00
92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual instructions) Enter "Y" for yes or "N" for no in the applicable			N	92. 0
93.00 Does this facility operate an ICF/IID facility for purposes of "Y" for yes or "N" for no in the applicable column.	title V and XIX? Enter	N	N	93. 0
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and applicable column.	d "N" for no in the	N	N	94. 0
95.00 If line 94 is "Y", enter the reduction percentage in the applic	cable column.	0. 00	0.00	95. 0
96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or applicable column.	"N" for no in the	N	N	96. 0
97.00 If line 96 is "Y", enter the reduction percentage in the applic 98.00 Does title V or XIX follow Medicare (title XVIII) for the inter stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for column 1 for title V, and in column 2 for title XIX.	rns and residents post	0. 00 Y	0. 00 Y	97. 0 98. 0
98.01 Does title V or XIX follow Medicare (title XVIII) for the repor C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title title XIX.			Y	98. 0
98.02 Does title V or XIX follow Medicare (title XVIII) for the calcubed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "		Y	Y	98. 0
for title V, and in column 2 for title XIX.  98.03 Does title V or XIX follow Medicare (title XVIII) for a critical reimbursed 101% of inpatient services cost? Enter "Y" for yes contact the contact and the contact are incompared to the contact and the contact are incompared to the contact and the contact are incompared to the contact are incompared to the contact and the contact are incompared to the contact are incompared			N	98. 0
for title V, and in column 2 for title XIX.  98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH rei outpatient services cost? Enter "Y" for yes or "N" for no in co		N	N	98. 0
in column 2 for title XIX.  98.05 Does title V or XIX follow Medicare (title XVIII) and add back Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in colu	the RCE disallowance or umn 1 for title V, and i	Y n	Y	98. 0
column 2 for title XIX.  98.06  Pts. I through IV? Enter "Y" for yes or "N" for no in column 1		Y	Y	98. 0
column 2 for title XIX.  Rural Providers				
105.00 Does this hospital qualify as a CAH? 106.00 If this facility qualifies as a CAH, has it elected the all-inc	clusive method of paymer	N N		105. 00 106. 00
for outpatient services? (see instructions)  107.00 Column 1: If line 105 is Y, is this facility eligible for cost training programs? Enter "Y" for yes or "N" for no in column 1. Column 2: If column 1 is Y and line 70 or line 75 is Y, do you approved medical education program in the CAH's excluded IPF a	(see instructions) u train I&Rs in an			107. 0
approved medical education program in the CAH's excluded TPF a Enter "Y" for yes or "N" for no in column 2. (see instructions 108.00Ls this a rural hospital qualifying for an exception to the CRN	s)	N N		108. 0

108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108. 00			
	Physi cal	Occupati onal	Speech	Respi ratory		
	1.00 2.00 3.00					
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					109. 00	
				1.00		

110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.

Health Financial Systems Rehabilitation Hospital of HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Pro		I ndi CN: 15-3047	Period: From 05/01/202 To 04/30/202		S-2
			10 017 007 202	9/15/2022	
			1. 00	2.00	
111.00 If this facility qualifies as a CAH, did it participate in the From Health Integration Project (FCHIP) demonstration for this cost report in the property of the FCHIP demonstration for the FCHIP demonstration property integration prong of the FCHIP demonstration which this CAH is participated in the property of the FCHIP demonstration in the participate in the property of the FCHIP demonstration in the participate in the property of the property of the participate in the participa	porting p 1 is Y, e ating in	period? Enter enter the column 2.	N		111. 00
		1. 00	2. 00	3.00	_
112.00 Did this hospital participate in the Pennsylvania Rural Health Modemonstration for any portion of the current cost reporting period Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.  Miscellaneous Cost Reporting Information	d?	N			112. 00
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" in column 1. If column 1 is yes, enter the method used (A, B, or in column 2. If column 2 is "E", enter in column 3 either "93" per for short term hospital or "98" percent for long term care (inclumn psychiatric, rehabilitation and long term hospitals providers) based on the same column and long term hospitals providers.	E only) rcent des	N			0 115. 00
the definition in CMS Pub. 15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y" for years.	es or	N N			116. 00
"N" for no. 117.00 s this facility legally-required to carry malpractice insurance?	Enter	N N			117. 00
"Y" for yes or "N" for no.  118.00 Is the malpractice insurance a claims-made or occurrence policy? I	Enter 1		0		118. 00
if the policy is claim-made. Enter 2 if the policy is occurrence.		Premi ums	Losses	Insurance	<i>j</i>
		1.00	2.00	3.00	
118.01 List amounts of malpractice premiums and paid losses:		1.00	0	0	0 118. 01
			1. 00	2.00	
118.02 Are mal practice premiums and paid losses reported in a cost center Administrative and General? If yes, submit supporting schedule liand amounts contained therein.  119.00 DO NOT USE THIS LINE			N	2.00	118. 02
120.00 s this a SCH or EACH that qualifies for the Outpatient Hold Harml §3121 and applicable amendments? (see instructions) Enter in colum "N" for no. Is this a rural hospital with < 100 beds that qualified Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	mn 1, "Y" es for th	' for yes or ne Outpatient		N	120.00
121.00 Did this facility incur and report costs for high cost implantable patients? Enter "Y" for yes or "N" for no.	e devi ces	s charged to	N		121. 00
122.00 Does the cost report contain healthcare related taxes as defined a Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Yethe Worksheet A line number where these taxes are included.  Transplant Center Information					122. 00
irransprant Center Information	and "N"	for no. If	N		125. 00
125.00 Does this facility operate a transplant center? Enter "Y" for yes					126. 00
	he certif	ication date			
125.00 Does this facility operate a transplant center? Enter "Y" for yes yes, enter certification date(s) (mm/dd/yyyy) below.					127. 00
<ul> <li>125.00 Does this facility operate a transplant center? Enter "Y" for yes yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>126.00 If this is a Medicare certified kidney transplant center, enter the in column 1 and termination date, if applicable, in column 2.</li> <li>127.00 If this is a Medicare certified heart transplant center, enter the in column 1 and termination date, if applicable, in column 2.</li> </ul>	e certifi	cation date			
<ul> <li>125.00 Does this facility operate a transplant center? Enter "Y" for yes yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>126.00 If this is a Medicare certified kidney transplant center, enter the in column 1 and termination date, if applicable, in column 2.</li> <li>127.00 If this is a Medicare certified heart transplant center, enter the</li> </ul>	e certifi e certifi	cation date			127. 00
<ul> <li>125.00 Does this facility operate a transplant center? Enter "Y" for yes yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>126.00 If this is a Medicare certified kidney transplant center, enter the in column 1 and termination date, if applicable, in column 2.</li> <li>127.00 If this is a Medicare certified heart transplant center, enter the in column 1 and termination date, if applicable, in column 2.</li> <li>128.00 If this is a Medicare certified liver transplant center, enter the in column 1 and termination date, if applicable, in column 2.</li> </ul>	e certifi e certifi certific	cation date cation date cation date i			127. 00 128. 00
<ul> <li>125.00 Does this facility operate a transplant center? Enter "Y" for yes yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>126.00 If this is a Medicare certified kidney transplant center, enter the in column 1 and termination date, if applicable, in column 2.</li> <li>127.00 If this is a Medicare certified heart transplant center, enter the in column 1 and termination date, if applicable, in column 2.</li> <li>128.00 If this is a Medicare certified liver transplant center, enter the in column 1 and termination date, if applicable, in column 2.</li> <li>129.00 If this is a Medicare certified lung transplant center, enter the column 1 and termination date, if applicable, in column 2.</li> <li>130.00 If this is a Medicare certified pancreas transplant center, enter date in column 1 and termination date, if applicable, in column 2.</li> </ul>	e certifi e certifi certific the cert	cation date cation date cation date i			127. 00 128. 00 129. 00 130. 00
<ul> <li>125.00 Does this facility operate a transplant center? Enter "Y" for yes yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>126.00 If this is a Medicare certified kidney transplant center, enter the in column 1 and termination date, if applicable, in column 2.</li> <li>127.00 If this is a Medicare certified heart transplant center, enter the in column 1 and termination date, if applicable, in column 2.</li> <li>128.00 If this is a Medicare certified liver transplant center, enter the in column 1 and termination date, if applicable, in column 2.</li> <li>129.00 If this is a Medicare certified lung transplant center, enter the column 1 and termination date, if applicable, in column 2.</li> <li>130.00 If this is a Medicare certified pancreas transplant center, enter date in column 1 and termination date, if applicable, in column 2.</li> <li>131.00 If this is a Medicare certified intestinal transplant center, enter date in column 1 and termination date, if applicable, in column 2.</li> </ul>	e certifice certifice certifice the certifice certification certif	cation date cation date itification			127. 00 128. 00 129. 00 130. 00 131. 00
<ul> <li>125.00 Does this facility operate a transplant center? Enter "Y" for yes yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>126.00 If this is a Medicare certified kidney transplant center, enter the in column 1 and termination date, if applicable, in column 2.</li> <li>127.00 If this is a Medicare certified heart transplant center, enter the in column 1 and termination date, if applicable, in column 2.</li> <li>128.00 If this is a Medicare certified liver transplant center, enter the in column 1 and termination date, if applicable, in column 2.</li> <li>129.00 If this is a Medicare certified lung transplant center, enter the column 1 and termination date, if applicable, in column 2.</li> <li>130.00 If this is a Medicare certified pancreas transplant center, enter date in column 1 and termination date, if applicable, in column 2.</li> <li>131.00 If this is a Medicare certified intestinal transplant center, enter</li> </ul>	e certifice certifice certifice the certifice certification certif	cation date cation date itification			127. 00 128. 00 129. 00 130. 00

134. 00

140. 00

HB1609

134.00 of this is an organ procurement organization (0P0), enter the OPO number in column 1

and termination date, if applicable, in column 2.

All Providers

140.00 Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)

Rehabilitation Hospital of Northern Indi Health Financial Systems In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 15-3047 Peri od: Worksheet S-2 From 05/01/2021 Part I 04/30/2022 Date/Time Prepared: To 9/15/2022 11:43 am 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number 141 00 Name: FRNEST HEALTH LNC. Contractor's Name: NOVITAS SOLUTIONS Contractor's Number: 04011 141 00 142.00 Street: 4600 LENA DRIVE PO Box: 142.00 143.00 Ci ty: MECHANI CSBURG 17055 143. 00 State: Zip Code: 1.00 144.00 Are provider based physicians' costs included in Worksheet A? N 144. 00 1. 00 2.00 145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for 145 00 inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? 146.00 Ν Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. 147. 00 Ν N 148 00 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no Ν 149.00 Part A Part B Title V Title XIX 1.00 2.00 3.00 4.00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal 155.00 Ν N 156.00 Subprovi der - IPF Ν Ν Ν Ν 156.00 157.00 Subprovi der - IRF 157 00 N Ν Ν N 158. 00 SUBPROVI DER 158. 00 159.00 SNF Ν Ν Ν 159. 00 Ν 160.00 HOME HEALTH AGENCY 160.00 Ν Ν Ν Ν 161.00 CMHC Ν Ν N 161. 00 1.00 Multicampus 165.00 s this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 Enter "Y" for yes or "N" for no. Name County State Zip Code CBSA FTE/Campus 0 1.00 2.00 3.00 4.00 5.00 166.00 If line 165 is yes, for each 0.00 166.00 campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) 1.00 Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00 is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no. 167 00 168.00 of this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the 168.00 reasonable cost incurred for the HIT assets (see instructions) 168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions) 168.01 169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the 0.00169.00 transition factor. (see instructions) Begi nni ng Endi ng 1.00 2.00 170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting 170. 00 period respectively (mm/dd/yyyy) 1.00 2.00 171.00|If line 167 is "Y", does this provider have any days for individuals enrolled in 0171.00 N section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)

	n Financial Systems Rehabilitation Hospit TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CCN: 15-3047	Peri od: From 05/01/2021 To 04/30/2022		epared:
				Y/N	Date	43 alli
				1. 00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format.  COMPLETED BY ALL HOSPITALS	for all NO re	esponses. Ente	er all dates in t	the	
	Provider Organization and Operation			_		
1.00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in c		instructions)			1.00
			Y/N	Date	V/I	
2. 00	Has the provider terminated participation in the Medicare F	rogram2 If	1.00 N	2. 00	3. 00	2.00
2.00	yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.		IN IN			2.00
3. 00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home confidered supply companies) that are related to the provide officers, medical staff, management personnel, or members of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug ler or its of the board	Y			3.00
			Y/N	Туре	Date	
	F:		1.00	2. 00	3. 00	
4. 00	Financial Data and Reports  Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date available.	or Compiled,	Y	A		4. 00
5.00	column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues different those on the filed financial statements? If yes, submit recommendations are considered to the cost report total expenses and total revenues different total expenses.		N			5. 00
				Y/N	Legal Oper.	
	Approved Educational Activities			1. 00	2. 00	_
6. 00	Approved Educational Activities  Column 1: Are costs claimed for a nursing program? Column	2. If you is	s the provider	- N		
5. 50	lis the legal operator of the program?	z. II yes, Is				6. 00
7. 00 8. 00	is the legal operator of the program?  Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve	structions.	·	N N		7. 00 8. 00
7. 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions.  Are costs claimed for Interns and Residents in an approved	structions.  d and/or renew	wed during the			7. 00
7. 00 8. 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated of	estructions.  Indicate and/or renew  Indicate graduate medicals.	wed during the	e N		7. 00 8. 00
7. 00 8. 00 9. 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.	istructions.  Indicate and/or renew  Indicate medical  Indicate me	wed during the cal education the current	N N		7. 00 8. 00 9. 00
7. 00 8. 00 9. 00 10. 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	istructions.  Indicate and/or renew  Indicate medical  Indicate me	wed during the cal education the current	N N N	Y/N 1.00	7. 00 8. 00 9. 00 10. 00
7. 00 8. 00 9. 00 10. 00 11. 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions.  Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.  Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.  Bad Debts	ustructions.  Indicate and/or renew graduate medicus.  Indicate and	wed during the cal education the current proved	N N N	1. 00	7. 00 8. 00 9. 00 10. 00 11. 00
7. 00 8. 00 9. 00 10. 00 11. 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions.  Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.  Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.  Bad Debts Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection provider.	structions.  d and/or renew graduate medic s.  r renewed in t & R in an App	wed during the cal education the current proved	N N N N		7. 00 8. 00 9. 00 10. 00
7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions.  Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.  Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.  Bad Debts  Is the provider seeking reimbursement for bad debts? If yes	sstructions.  d and/or renew graduate medicus.  r renewed in to  & R in an App  , see instruct oolicy change of	wed during the cal education the current proved	N N N N N N N N N N N N N N N N N N N	1. 00 Y	7. 00 8. 00 9. 00 10. 00 11. 00
7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions.  Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instructions was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.  Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.  Bad Debts Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.  If line 12 is yes, were patient deductibles and/or co-payments.	structions. d and/or renew graduate medic s. r renewed in 1 & R in an App , see instruct olicy change conts waived? If	wed during the cal education the current proved tions. during this caf yes, see ins	N N N N N N N Structions.	1. 00 Y N	7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.  Bad Debts Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-paymed Bed Complement	structions. d and/or renew graduate medic s. r renewed in t & R in an App  , see instruct olicy change c ents waived? If  ng period? If Par	wed during the cal education the current proved tions. during this configurations that the current seek instance in the current seek in the curre	N N N N N N N N N N N N N N N N N N N	1.00  Y N N T B Date	7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions.  Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.  Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.  Bad Debts Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.  If line 12 is yes, were patient deductibles and/or co-paymed Bed Complement  Did total beds available change from the prior cost reportions.	structions. d and/or renew graduate medic s. r renewed in t & R in an App  , see instruct olicy change c ents waived? If  ng period? If Pan	wed during the cal education the current proved tions. during this configurations, see instance.	N N N N N N N N Structions.	1.00 Y N N	7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions.  Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.  Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.  Bad Debts  Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.  If line 12 is yes, were patient deductibles and/or co-paymed Bed Complement  Did total beds available change from the prior cost reportions.  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	structions. d and/or renew graduate medic s. r renewed in t & R in an App  , see instruct olicy change c ents waived? If  ng period? If Par	wed during the cal education the current proved tions. during this configurations that the current seek instance in the current seek in the curre	N N N N N N N N N N N N N N N N N N N	1.00  Y N N T B Date	7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions.  Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.  Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.  Bad Debts  Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.  If line 12 is yes, were patient deductibles and/or co-paymed Bed Complement  Did total beds available change from the prior cost reportion to total beds available change from the prior cost reportion of the PS&R Report used in columns 2 and 4. (see instructions)	sstructions. d and/or renew graduate medicus. or renewed in to a R in an App  a, see instruct colicy change counts waived? If  par  Y/N  1.00	wed during the cal education the current proved tions. during this confusion that the current proved to the cu	ost reporting structions.  Par Y/N 3.00	1.00  Y N N  T B Date 4.00	7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00

Ν

19.00

19.00

Report data for additional claims that have been billed but are not included on the PS&R Report used to file this

cost report? If yes, see instructions.

If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.

HOSPI T	Financial Systems Rehabilitation Hospit AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-3047	Period: From 05/01/2021 To 04/30/2022	u of Form CM: Worksheet S Part II Date/Time P 9/15/2022 1	-2 repared:
		Descri	ipti on	Y/N	Y/N	
		(	)	1. 00	3. 00	
20. 00				N	N	20.00
	Report data for Other? Describe the other adjustments:	Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4. 00	
21. 00	Was the cost report prepared only using the provider's	1.00 N	2.00	3. 00 N	4.00	21.00
21.00	records? If yes, see instructions.	"		.,		21.00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS H	OSPI TALS)			
22.00	Capital Related Cost	a i natruati ana				
22. 00 23. 00	Have assets been relifed for Medicare purposes? If yes, see Have changes occurred in the Medicare depreciation expense		ale mada du	ring the cost		22. 0
23.00	reporting period? If yes, see instructions.	due to apprais	ars made du	iring the cost		23.0
24. 00	Were new leases and/or amendments to existing leases entere	ed into durina	this cost re	eportina period?		24. 00
	If yes, see instructions	3		7 3 1		
25. 00	Have there been new capitalized leases entered into during	the cost repor	ting period	? If yes, see		25. 0
2/ 22	instructions.		10	16		0, 0
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.	he cost reporti	ng period?	If yes, see		26. 0
27. 00	Has the provider's capitalization policy changed during the	e cost renortin	na neriod? I	f ves submit		27. 0
27.00	copy.	c cost reportin	ig period. I	yes, sabiii t		27.0
	Interest Expense					
28. 00	Were new Loans, mortgage agreements or Letters of credit er	ntered into dur	ing the cos	t reporting		28. 0
	period? If yes, see instructions.					
29. 00	Did the provider have a funded depreciation account and/or		bt Service	Reserve Fund)		29. 0
30. 00	treated as a funded depreciation account? If yes, see instr Has existing debt been replaced prior to its scheduled matu		dob+2 Lf vo	5 500		30.0
30. 00	instructions.	uiity with new	debt? IT ye:	s, see		30.0
31. 00	Has debt been recalled before scheduled maturity without is	ssuance of new	debt? If ve	s. see		31. 0
	instructions.					
	Purchased Services					
32. 00			d through c	ontractual		32. 0
33. 00	arrangements with suppliers of services? If yes, see instruit line 32 is yes, were the requirements of Sec. 2135.2 app		a to compot	itivo bidding2 lf		33. 0
33.00	no, see instructions.	pireu pertainin	ig to competi	itive brading: ii		33.0
	Provi der-Based Physi ci ans					
34. 00	Are services furnished at the provider facility under an ar	rrangement with	provi der-b	ased physicians?		34. 0
	If yes, see instructions.	Ü	•	. ,		
35. 00			its with the	provi der-based		35. 0
	physicians during the cost reporting period? If yes, see in	nstructions.		V /N	Doto	
				Y/N 1. 00	Date 2.00	
	Home Office Costs			1.00	2.00	
36. 00	Were home office costs claimed on the cost report?					36. 0
	If line 36 is yes, has a home office cost statement been pr	repared by the	home office	?		37. 0
	If yes, see instructions.	-				
38. 00	If line 36 is yes, was the fiscal year end of the home off			f		38. 0
39. 00	the provider? If yes, enter in column 2 the fiscal year end			6		39. 0
J7. UU	If line 36 is yes, did the provider render services to other see instructions.	ei chain compon	ients: II ye:	٥,		39.0
40. 00		home office?	If yes, see			40. 0
	instructions.					
		1.	00	2.	00	
'	Cost Report Preparer Contact Information	h.		D: 1		44.00
11.00	Enter the first name, last name and the title/position	Mary		Pi tcock		41.00
11. 00	held by the cost report preparer in columns 1 2 and 2	i .				II.
41. 00	held by the cost report preparer in columns 1, 2, and 3, respectively					
	respecti vel y.	ERNEST HEALTH	I NC			42. 00
		ERNEST HEALTH	I NC			42. 00
41. 00 42. 00 43. 00	respectively. Enter the employer/company name of the cost report preparer.	ERNEST HEALTH 903-588-0077	I NC	marykay@ernest	nealth.com	42. 0 43. 0

Health Financial Systems Rehabili	tation Hospital of Northern Indi	In Lieu of Form CMS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUES	TONNALRE Provider CCN: 15	
		From 05/01/2021   Part II To 04/30/2022   Date/Time Prepared: 9/15/2022 11:43 am
	3.00	
Cost Report Preparer Contact Information		
41.00 Enter the first name, last name and the title.		Anal yst 41.00
held by the cost report preparer in columns 1	2, and 3,	
respecti vel y.		
42.00 Enter the employer/company name of the cost re	port	42. 00
preparer.		
43.00 Enter the telephone number and email address		43.00
report preparer in columns 1 and 2, respective	ly.	

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

| Peri od: | Worksheet S-3 | From 05/01/2021 | Part I | To 04/30/2022 | Date/Time Prepared:

					10	04/30/2022	9/15/2022 11:	
							I/P Days / 0/P	75 dili
							Visits / Trips	
	Component	Worksheet A	No. of	Beds	Bed Davs	CAH Hours	Title V	
		Line Number			Avai I abl e			
		1. 00	2. (	00	3.00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		40	14, 600	0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2. 00
3.00	HMO IPF Subprovider							3. 00
4.00	HMO IRF Subprovider							4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						0	6. 00
7.00	Total Adults and Peds. (exclude observation			40	14, 600	0. 00	0	7. 00
	beds) (see instructions)							
8. 00	INTENSIVE CARE UNIT							8. 00
9. 00	CORONARY CARE UNIT							9. 00
10.00	BURN INTENSIVE CARE UNIT							10.00
11. 00	SURGI CAL INTENSI VE CARE UNI T							11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)							12.00
13. 00	NURSERY				4.4.00			13.00
14.00	Total (see instructions)			40	14, 600	0. 00	0	14.00
15.00	CAH visits						0	15.00
16.00	SUBPROVIDER - I PF							16. 00 17. 00
17. 00 18. 00	SUBPROVIDER - I RF							18.00
19. 00	SUBPROVIDER SKILLED NURSING FACILITY	44. 00	•	0	0		0	19.00
20. 00	NURSING FACILITY	44.00		U	U		U	20.00
21. 00	OTHER LONG TERM CARE							21. 00
22. 00	HOME HEALTH AGENCY	101. 00					0	22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )	101.00	•				U	23. 00
24. 00	HOSPI CE							24. 00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25. 00	CMHC - CMHC	55. 55						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)	07.00		40				27. 00
28. 00	Observation Bed Days						0	28. 00
29. 00	Ambul ance Trips						_	29. 00
30. 00	Employee discount days (see instruction)							30.00
31. 00	Employee discount days - IRF							31. 00
32. 00	Labor & delivery days (see instructions)			0	0			32. 00
32. 01	Total ancillary labor & delivery room			1	آ ا			32. 01
	outpatient days (see instructions)							
33.00	LTCH non-covered days							33. 00
33. 01	LTCH site neutral days and discharges							33. 01
	•		•		'	·		

In Lieu of Form CMS-2552-10

| Period: | Worksheet S-3 |
| From 05/01/2021 | Part |
| To 04/30/2022 | Date/Time Prepared: | 9/15/2022 | 11: 43 am

						9/15/2022 11:	43 am
		I/P Days	o/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		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)	3, 294	18	7, 760			1. 00
2.00	HMO and other (see instructions)	1, 805	730				2. 00
3.00	HMO IPF Subprovider	0	0				3. 00
4.00	HMO IRF Subprovider	0	0				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	C	)		5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0	C	)		6. 00
7.00	Total Adults and Peds. (exclude observation	3, 294	18	7, 760	)		7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13.00	NURSERY						13. 00
14.00	Total (see instructions)	3, 294	18	7, 760	0.00	80. 87	14. 00
15.00	CAH visits	o	0	(	)		15. 00
16.00	SUBPROVI DER - I PF						16. 00
17.00	SUBPROVI DER - I RF						17. 00
18.00	SUBPROVI DER						18. 00
19.00	SKILLED NURSING FACILITY	o	0		0.00	0.00	19. 00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY	o	0		0.00	0.00	22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25.00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	o	0		0.00	0.00	26. 25
27. 00	Total (sum of lines 14-26)				0.00	80. 87	27. 00
28. 00	Observation Bed Days		0	C			28. 00
29. 00		o					29. 00
30.00	Employee discount days (see instruction)			C			30.00
31.00	1						31. 00
32.00	1 . 3	o	0	C			32. 00
32. 01	Total ancillary labor & delivery room			d			32. 01
	outpatient days (see instructions)						
33.00		o					33. 00
33. 01	LTCH site neutral days and discharges	o					33. 01
		. '		•	•	•	•

33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-3047

Peri od: Worksheet S-3 From 05/01/2021 Part I To 04/30/2022 Date/Time Prepared:

9/15/2022 11:43 am Full Time Di scharges Equi val ents Title XVIII Total All Component Nonpai d Title V Title XIX Workers Pati ents 15.00 12.00 13.00 14.00 11.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 235 525 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 00 118 49 3.00 HMO IPF Subprovider 3.00 HMO IRF Subprovider 4.00 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 5.00 Hospital Adults & Peds. Swing Bed NF 6.00 6.00 7.00 Total Adults and Peds. (exclude observation 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 8.00 CORONARY CARE UNIT 9.00 9.00 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 13.00 525 14.00 Total (see instructions) 0.00 0 235 14.00 CAH visits 15.00 15.00 SUBPROVIDER - IPF 16.00 16.00 SUBPROVIDER - IRF 17.00 17.00 18.00 SUBPROVI DER 18.00 19.00 SKILLED NURSING FACILITY 0.00 19.00 20 00 NURSING FACILITY 20 00 21.00 OTHER LONG TERM CARE 21.00 22.00 HOME HEALTH AGENCY 0.00 22.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 23.00 HOSPI CE 24.00 24 00 HOSPICE (non-distinct part) 24. 10 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 29.00 Ambul ance Trips 30 00 Employee discount days (see instruction) 30.00 31.00 Employee discount days - IRF 31.00 32.00 Labor & delivery days (see instructions) Total ancillary labor & delivery room 32.00 32.01 32.01 outpatient days (see instructions) 33.00 LTCH non-covered days 33.00

33.01 LTCH site neutral days and discharges

Heal th	Financial Systems Rehabil	itation Hospital	of Northern	l ndi	In Lie	u of Form CMS-2	2552-10
	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O		Provi der Co	CN: 15-3047 F	Peri od:	Worksheet A	
					rom 05/01/2021		
					Γo 04/30/2022		
	Coat Cantar Dagarintian	Colorios	O+bon	Total (sol 1	Dool oooi fi ooti	9/15/2022 11:	43 am
	Cost Center Description	Sal ari es	0ther	,	Reclassifications (See A-6)	Reclassified Trial Balance	
				+ col . 2)	ons (see A-6)	(col. 3 +-	
						col . 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
1.00	00100 CAP REL COSTS-BLDG & FLXT		3, 013, 676	3, 013, 676	349, 748	3, 363, 424	1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP		679, 174			728, 420	
3.00	00300 OTHER CAP REL COSTS		398, 994			720, 420	3.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	427, 041	705, 654			1, 132, 695	4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	1, 483, 397	1, 274, 569			2, 757, 966	5.00
7. 00	00700 OPERATION OF PLANT	57, 284	368, 766			426, 050	
8. 00	00800 LAUNDRY & LINEN SERVICE	37, 204	45, 794			45, 794	
9. 00	00900 HOUSEKEEPING	99, 542	29, 708			129, 250	1
10. 00	01000 DI ETARY	264, 470	115, 476			379, 946	
13. 00	01300 NURSI NG ADMI NI STRATI ON	260, 535	23, 799			284, 334	
16. 00	01600 MEDICAL RECORDS & LIBRARY	81, 805	23, 799 16, 932			98, 737	
16.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	01,000	10, 932	90, 73	0	90, 131	10.00
30. 00	03000 ADULTS & PEDIATRICS	1 047 200	400 012	2 427 200	0	2 427 200	30.00
44. 00	04400 SKI LLED NURSI NG FACI LI TY	1, 947, 388	689, 812 0				44. 00
44.00	ANCI LLARY SERVICE COST CENTERS	l ol	0		<u>)                                    </u>	0	44.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	10 (24	10.72	-4, 490	15 144	F4 00
	05700 CT SCAN	0	19, 634			15, 144	
57. 00	1 1	0	0		3, 646	3, 646	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	22.745	22.74	844	844	
60.00	06000 LABORATORY	(0.040	23, 765			23, 765	
65. 00	06500 RESPIRATORY THERAPY	62, 240	21, 885			84, 125	l
66.00	06600 PHYSI CAL THERAPY	462, 962	60, 738			479, 159	
67.00	06700 OCCUPATI ONAL THERAPY	329, 999	31, 413			391, 622	
68. 00	06800 SPEECH PATHOLOGY	186, 515	15, 808			216, 654	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	53, 629	80, 204			133, 833	
73. 00	07300 DRUGS CHARGED TO PATIENTS	194, 961	212, 357			407, 318	
74. 00	07400 RENAL DIALYSIS	0	207, 046			207, 046	
76. 00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	84, 358	84, 358	3 0	84, 358	76.00
	OUTPATIENT SERVICE COST CENTERS						
91. 00		0	0		0	0	
91. 01	04951 OUTPATIENT THERAPY	0	0		0	0	
93. 00	04950 OUTPATIENT WOUND CENTER	0	0	(	0	0	93. 00
	OTHER REIMBURSABLE COST CENTERS	T		Т			
	09500 AMBULANCE SERVICES	0	0		0	0	, , , , , ,
101.00	10100 HOME HEALTH AGENCY	0	0	(	0	0	101. 00
	SPECIAL PURPOSE COST CENTERS	T		Т			
	06950 OTHER SPECIAL PURPOSE COST CENTERS	0	0		0		117. 00
118.00		5, 911, 768	8, 119, 562	14, 031, 330	0	14, 031, 330	118.00
	NONREI MBURSABLE COST CENTERS						
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	•	0		192. 00
	07950 MARKETI NG	0	0		0		194. 00
	07951 OTHER NONREIMBURSABLE COST CENTERS	0	0		0		194. 01
200.00	TOTAL (SUM OF LINES 118 through 199)	5, 911, 768	8, 119, 562	14, 031, 330	0	14, 031, 330	200. 00

Peri od: Worksheet A From 05/01/2021 To 04/30/2022 Date/Time Prepared:

				9/15/2022 11:	43 am
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For Allocation		
		6. 00	7. 00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FIXT	106, 104	3, 469, 528		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	45, 148	773, 568		2.00
3.00	00300 OTHER CAP REL COSTS	0	0		3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-2, 027	1, 130, 668		4.00
5.00	00500 ADMINISTRATIVE & GENERAL	899, 087	3, 657, 053		5.00
7. 00	00700 OPERATION OF PLANT	-10, 386		l .	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0		l .	8.00
9. 00	00900 HOUSEKEEPI NG	0		l .	9.00
10.00	01000 DI ETARY	-4, 982		l .	10.00
13. 00	01300 NURSING ADMINISTRATION	0		l .	13. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	-214			16. 00
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	-214	70, 323		10.00
30. 00	03000 ADULTS & PEDIATRICS	0	2, 637, 200		30.00
	04400 SKILLED NURSING FACILITY				44. 00
44.00	ANCILLARY SERVICE COST CENTERS				44.00
54. 00	05400 RADI OLOGY - DI AGNOSTI C		15, 144		54.00
		0			57. 00
	05800 MAGNETIC RESONANCE IMAGING (MRI)				
		0			58.00
60.00	06000 LABORATORY	0	23, 765	·	60.00
65. 00	06500 RESPI RATORY THERAPY	0	84, 125		65. 00
		0	479, 159		66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	,	·	67. 00
68. 00		0			68. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-502			71.00
	07300 DRUGS CHARGED TO PATIENTS	-917			73. 00
	07400 RENAL DIALYSIS	0		l control of the cont	74. 00
76. 00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	84, 358		76. 00
	OUTPATIENT SERVICE COST CENTERS	T	1		4
	09100 EMERGENCY	0		l .	91. 00
	04951 OUTPATI ENT THERAPY	0			91. 01
93. 00		0	0		93. 00
	OTHER REIMBURSABLE COST CENTERS				4
	09500 AMBULANCE SERVICES	0			95. 00
101.00	10100 HOME HEALTH AGENCY	0	0		101. 00
	SPECIAL PURPOSE COST CENTERS				
	06950 OTHER SPECIAL PURPOSE COST CENTERS	0		l .	117. 00
118.00		1, 031, 311	15, 062, 641		118. 00
	NONREI MBURSABLE COST CENTERS				
	19200 PHYSICIANS' PRIVATE OFFICES	0	0		192. 00
	07950 MARKETI NG	0	0		194. 00
194.01	1 07951 OTHER NONREIMBURSABLE COST CENTERS	0	0		194. 01
200.00	TOTAL (SUM OF LINES 118 through 199)	1, 031, 311	15, 062, 641		200.00

Health Financial Systems Rehabilitation Hospital of Northern Indi In Lieu of Form CMS-2552-10
RECLASSIFICATIONS Provider CCN: 15-3047 Period: From 05/01/2021 To 04/30/2022 Date/Time Prepared:

						04/30/2022	9/15/2022 11	epareu: : 43 am
		Increases						
	Cost Center	Li ne #	Sal ary	0ther				
	2. 00	3. 00	4.00	5. 00				
	A - RCLS PCT THERAPY							
1.00	OCCUPATI ONAL THERAPY	67.00	27, 345	2, 865	i			1. 00
2.00	SPEECH PATHOLOGY	6800	12, 972	<u>1, 3</u> 59				2. 00
	TOTALS		40, 317	4, 224				
	B - RCLS CT & MRI FROM RADIOL	_OGY						
1.00	CT SCAN	57.00	0	3, 646	)			1. 00
2.00	MAGNETIC RESONANCE IMAGING	58.00	0	844				2. 00
	(MRI )							
	TOTALS		0	4, 490				
500.00	Grand Total: Increases		40, 317	8, 714				500.00

Health Financial Systems Rehabilitation Hospital of Northern Indi In Lieu of Form CMS-2552-10

RECLASSIFICATIONS Provider CCN: 15-3047 Period: From 05/01/2021 To 04/30/2022 Date/Time Prepared:

						10 04/30/2022	9/15/2022 11	
		Decreases					77 107 2022 11	10 4111
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.			
	6. 00	7.00	8. 00	9. 00	10. 00			
	A - RCLS PCT THERAPY							
1.00	PHYSI CAL THERAPY	66.00	40, 317	4, 224	· C			1. 00
2.00		0.00	0	C	O			2. 00
	TOTALS		40, 317	4, 224				
	B - RCLS CT & MRI FROM RADIOL	_OGY						
1.00	RADI OLOGY-DI AGNOSTI C	54.00	0	4, 490	0			1. 00
2.00		0.00	0	C	0			2. 00
	TOTALS			4, 490	)			
500.00	Grand Total: Decreases		40, 317	8, 714		1		500.00

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS

				1	To 04/30/2022	Date/Time Pre 9/15/2022 11:	pared: 43 am
	·			Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	T BALANCES					
1.00	Land	0	0	C	0	0	1. 00
2.00	Land Improvements	0	0	C	0	0	2.00
3.00	Buildings and Fixtures	5, 414	19, 901, 180	C	19, 901, 180	0	3. 00
4.00	Building Improvements	104, 469	-104, 469	C	-104, 469	0	4.00
5.00	Fixed Equipment	0	108, 230	C	108, 230	0	5. 00
6.00	Movable Equipment	2, 114, 646	703, 574	C	703, 574	0	6. 00
7.00	HIT designated Assets	0	0	C	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	2, 224, 529	20, 608, 515	C	20, 608, 515	0	8. 00
9.00	Reconciling Items	0	0	C	0	0	9. 00
10.00	Total (line 8 minus line 9)	2, 224, 529	20, 608, 515	C	20, 608, 515	0	10. 00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6.00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES					
1.00	Land	0	0				1.00
2.00	Land Improvements	0	0				2. 00
3.00	Buildings and Fixtures	19, 906, 594	0				3. 00
4.00	Building Improvements	0	0				4. 00
5.00	Fixed Equipment	108, 230	0				5. 00
6.00	Movable Equipment	2, 818, 220	0				6. 00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	22, 833, 044	0				8. 00
9.00	Reconciling Items	0	0				9. 00
10. 00	Total (line 8 minus line 9)	22, 833, 044	0				10. 00

Health Financial Systems Rehabilitation I		of Northern Indi	In Lie	u of Form CMS-2552-10
DECONCLUATION OF CADITAL CO	OCTC CENTEDS	Drovi don CCN, 1E 2017	Dori od:	Workshoot A 7

10 Peri od: Worksheet A-7 From 05/01/2021 Part II To 04/30/2022 Date/Time Prepared: 9/15/2022 11: 43 am SUMMARY OF CAPITAL Insurance (see Taxes (see Cost Center Description Depreciation Interest Lease instructions) instructions) 9.00 10.00 11.00 12.00 13.00 PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 CAP REL COSTS-BLDG & FLXT 277, 435 2, 696, 509 39, 732 1.00 CAP REL COSTS-MVBLE EQUIP 0 2.00 315, 673 363, 501 0 0 2.00 3, 060, 010 3.00 Total (sum of lines 1-2) 593, 108 39, 732 0 3.00 SUMMARY OF CAPITAL Total (1) (sum Cost Center Description 0ther Capital-Relate of cols. 9 through 14) d Costs (see instructions) 14.00 15.00 PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2

0

0

3, 013, 676

679, 174

3, 692, 850

1.00

2.00

3.00

1.00

2.00

3.00

CAP REL COSTS-BLDG & FIXT

CAP REL COSTS-MVBLE EQUIP

Total (sum of lines 1-2)

Health Financial System	ns	Rehabilitation Hospital	of Northern Indi	In Lie	u of Form CMS-2552-10
RECONCILIATION OF CAPI	TAL COSTS CENTERS		Provider CCN: 15-304	7 Peri od:	Worksheet A-7
				From 05/01/2021	

RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provider CO	F	reniod: from 05/01/2021 fo 04/30/2022	Worksheet A-7 Part III Date/Time Prep 9/15/2022 11:4	
		COME	PUTATION OF RAT	108	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio	instructions)		
				(col. 1 - col.			
				2)			
	DADT III DECONCILIATION OF CARLTAL COCTO OF	1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS CE	20, 014, 824		20, 014, 824	0. 876573	17, 310	1. 00
2. 00	CAP REL COSTS-BLDG & FIXT	2, 818, 220		2, 818, 220		, , , , , , , , , , , , , , , , , , , ,	2. 00
3. 00	Total (sum of lines 1-2)	22, 833, 044		22, 833, 044		·	3. 00
3.00	Total (Suil of Titles 1-2)		TION OF OTHER O		SUMMARY 0		3.00
		ALLOCA	TION OF OTHER C	ALL TAL	SolviiviAit1	ONITIAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Capi tal -Relate				
			d Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	ENTERS					
1.00	CAP REL COSTS-BLDG & FLXT	332, 438		349, 748	•		1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	46, 809	0	49, 246	•		2. 00
3.00	Total (sum of lines 1-2)	379, 247	0	398, 994		3, 033, 584	3. 00
			Sl	JMMARY OF CAPIT	AL		
	Cost Center Description	Interest	Insurance (see			Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate		
					d Costs (see	through 14)	
		11.00	10.00	10.00	instructions)	45.00	
	DADT III DECONCILIATION OF CADITAL COCTO OF	11. 00	12. 00	13. 00	14. 00	15. 00	
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS CE		17 210	222 420		2 440 520	1 00
2.00	CAP REL COSTS-BLDG & FLXT CAP REL COSTS-MVBLE EQUIP	39, 732	17, 310 2, 437			3, 469, 528 773, 568	1. 00 2. 00
3.00	Total (sum of lines 1-2)	39, 732				· ·	3. 00
3.00	Tiotal (Suill of Titles 1-2)	39, /32	19, 747	3/9, 24/	ı V	4, 243, 096	3.00

Description   Sept   Account   Description   Sept   Account   Description   Descript						Го 04/30/2022	Date/Time Prep 9/15/2022 11:4	
Cost Center Description   Basis/Code   (2)   Annunt   Cost Center   Line 2   Wist. A.7 Ber							77 107 2022 11.	10 4
1.00   Investment Income					To/From Which the Amount is	to be Adjusted		
1.00   Investment Income								
1.00   Investment Income								
1.00   Investment Income		Cost Contor Description	Pacis/Codo (2)	Amount	Cost Contor	line#	Wkst A 7 Dof	
Trivestment income - CAP REL		cost center bescription						
1.000   1.00	1. 00	Investment income - CAP REL	1.00					1. 00
COSTS MARIE FOUR (chapter 2)   0				_			_	
Investment income - other   0	2.00			O	CAP REL COSTS-MVBLE EQUIP	2.00	O	2.00
1.7   1.7	3.00			0		0.00	0	3.00
discounts (chapter 8)								
Refunds and rebates or	4.00			0		0.00	0	4.00
Rental of provider space by   0   0.00   0	5.00			О		0.00	0	5. 00
Suppliers (chapter 8)   A   -1,092ADMINISTRATIVE & GENERAL   5,00   0   7,00   1,000	,							,
Telephone services (pay stations excluded) (chapter 2)   Station	6.00			O		0.00	O	6.00
8. 00   Television and radio service   A   -9,538@FRATION OF PLANT   7,00   0 8.00   0   0.00   0   0.00   0   0.00   0	7.00		A	-1, 092	ADMINISTRATIVE & GENERAL	5. 00	0	7. 00
8.00   Television and radio service (Chapter 21)   0   0   0   0   0   0   0   0   0								
Chapter 21)	8 00		Α	-9 538	OPERATION OF PLANT	7 00	0	8 00
10.00   Provider-based physician   adjustment   A-8-2   0   adjustment   11.00   Sale of scrap, waste, etc.   0   0.00   0.11.00   0.11.00   0.12.00   0.1		(chapter 21)		.,				
adjustment   adj			4.0.0	- 1		0.00		
11.00 Safe of scrap, waste, etc. (chapter 23) 12.00 Related organization (chapter 10) 13.00 Laundry and Ilinen service 0 0 0.00 0 13.00 13.00 Laundry and Ilinen service 0 0 0.00 0 13.00 15.00 Rental of quarters to employee and guests B -4.992 DIETARY 10.00 0 14.00 16.00 Sale of media and surgical part of the part of	10.00		A-8-2	٥			U	10.00
12.00   Related organization   transactions (chapter 10)   13.00   Laundry and linen service   0   0.00   0.13.00   13.00   14.00   Cafteria -employees and guests   B   -4.9820IETARY   10.00   0.10   0.15.00   15	11. 00	Sale of scrap, waste, etc.		0		0.00	0	11. 00
transactions (chapter 10)	12 00		A O 1	020 040			0	12 00
13.00   Laundry and I linen service   14.00   Cafferria -employees and guests   B   -4.9 per   10.00   0.00   0.13.00   15.00   15.00   16.00   15.00   16.00   15.00   16.00   15.00   16.00   15.00   16.00   15.0	12.00		A-0-1	920, 009			U	12.00
15.00   Rental of quarters to employee and others   0   0   0   0   0   0   0   15.00				O			-	
and others				-4, 982	DI ETARY		-	
Suppl   set to other than patients   17.00   Sale of drugs to other than patients   17.00   Sale of drugs to other than patients   18.00   Sale of modical records and abstracts   19.00   Nursing and allied health education (tuition, fees, books, etc.)   19.00   Nursing and allied health education (tuition, fees, books, etc.)   19.00   19.	13.00			ď		0.00	U	15.00
patients	16. 00			O		0.00	0	16. 00
17. 00   Sale of drugs to other than patients   0   0   0   0   17. 00   0   17. 00   0   18. 00   0   18. 00   0   18. 00   0   18. 00   0   18. 00   0   18. 00   0   18. 00   0   18. 00   0   18. 00   0   18. 00   0   18. 00   0   19. 00   19.								
patients	17. 00			o		0.00	0	17. 00
abstracts		1.	_				_	
19.00   Nursing and allied health eductation (tuition, fees, books, etc.)   20.00   Vending machines   8   -445 OPERATION OF PLANT   7.00   0.20.00   21.00   1nterest, finance or penalty charges (chapter 21)   22.00   1nterest expense on Medicare overpayments and borrowings to repay Medicare overpayments   4-8-3   0 RESPIRATORY THERAPY   65.00   23.00   24.00   24.00   25.00	18.00	II.	В	-2141	MEDICAL RECORDS & LIBRARY	16.00	O	18.00
Dooks, etc.)   Vending machines   B	19. 00	Nursing and allied health		0		0.00	0	19. 00
20. 00   Vending machines   B   -445   OPERATION OF PLANT   7. 00   0   20. 00								
21.00	20. 00		В	-445	OPERATION OF PLANT	7. 00	0	20.00
Charges (chapter 21)   Chapter 14)   Chapter 15)   Chapter 16)   Chapter 17)   Chapter 17)   Chapter 18)   Chapter 19)   Chapter 19)   Chapter 21)		Income from imposition of		0			0	21. 00
22.00   Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments and borrowings to repay Medicare overpayments   0   0   0   0   0   0   0   0   0								
overpayments and borrowings to repay Medicare overpayments Adjustment for respiratory therapy costs in excess of limitation (chapter 14)  23.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)  24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)  25.00 Utilization review – physicians' compensation (chapter 21)  26.00 Depreciation - CAP REL COSTS-BLDG & FIXT	22. 00			o		0.00	0	22. 00
23.00   Adjustment for respiratory therapy costs in excess of limitation (chapter 14)   24.00   Adjustment for physical therapy costs in excess of limitation (chapter 14)   A-8-3   OPHYSICAL THERAPY   66.00   24.00		overpayments and borrowings to						
therapy costs in excess of limitation (chapter 14)  24. 00 Adj ustment for physical therapy costs in excess of limitation (chapter 14)  25. 00 Utilization review - physicians' compensation (chapter 21)  26. 00 Depreciation - CAP REL COSTS-BLDG & FIXT	22 00		1 1 2		DESDIDATORY THERARY	45.00		22 00
24. 00 Adjustment for physical therapy costs in excess of limitation (chapter 14)  25. 00 Utilization review - physicians' compensation (chapter 21)  26. 00 Depreciation - CAP REL COSTS-BLDG & FIXT	23.00		A-0-3		RESPIRATORY HIERAFY	05.00		23.00
therapy costs in excess of limitation (chapter 14)  25. 00 Utilization review - physicians' compensation (chapter 21)  26. 00 Depreciation - CAP REL COSTS-BLDG & FIXT					DUNGLOSS, TUEDADY			
limitation (chapter 14)	24.00		A-8-3	O	PHYSICAL THERAPY	66.00		24.00
physicians' compensation (chapter 21)  26.00 Depreciation - CAP REL COSTS-BLDG & FIXT		limitation (chapter 14)						
Chapter 21)   Depreciation - CAP REL   OCAP REL COSTS-BLDG & FIXT   1.00   O 26.00	25. 00			0	*** Cost Center Deleted ***	114. 00		25. 00
26. 00 Depreciation - CAP REL COSTS-BLDG & FIXT 1.00 0 26. 00 COSTS-BLDG & FIXT 1.00 0 26. 00 COSTS-BLDG & FIXT 1.00 0 26. 00 CAP REL COSTS-BLDG & FIXT 1.00 0 26. 00 CAP REL COSTS-BLDG & FIXT 1.00 0 26. 00 CAP REL COSTS-BLDG & FIXT 1.00 0 26. 00 CAP REL COSTS-BLDG & FIXT 1.00 0 26. 00 CAP REL COSTS-BLDG & FIXT 1.00 0 26. 00 CAP REL COSTS-BLDG & FIXT 1.00 0 26. 00 CAP REL COSTS-BLDG & FIXT 1.00 0 26. 00 CAP REL COSTS-BLDG & FIXT 1.00 0 26. 00 CAP REL COSTS-BLDG & FIXT 1.00 0 26. 00 CAP REL COSTS-BLDG & FIXT 1.00 0 26. 00 CAP REL COSTS-BLDG & FIXT 1.00 0 27. 00 CAP REL COSTS-BLOG & FIXT 1.00 0 27. 00 CAP REL COSTS-BLOG & FIXT 1.00 0 27. 00 CAP REL COSTS-BLOG & FIXT 1.00 0 27. 00 CAP REL COSTS-BLOG & FIXT 1.00 CAP REL COSTS-BLOG & FIXT 1.00 CAP REL COSTS-BLOG & FIXT 1.00 CAP REL COSTS-BLOG & FIXT 1								
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP 28.00 Non-physician Anesthetist 29.00 Physicians' assistant 30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see instructions) 31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for Depreciation and Interest  OCAP REL COSTS-MVBLE EQUIP 2.00 0 *** Cost Center Deleted *** 19.00 0.00 0.00 0.00 0.27.00 0 0 *** Cost Center Deleted *** 19.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	26. 00			0	CAP REL COSTS-BLDG & FIXT	1.00	0	26. 00
28. 00   Non-physician Anesthetist   O *** Cost Center Deleted ***   19. 00   28. 00   29. 00   Physicians' assistant   O   0.00   O   30. 00   Adjustment for occupational therapy costs in excess of limitation (chapter 14)   30. 99   Hospice (non-distinct) (see instructions)   A-8-3   O SPEECH PATHOLOGY   O   O   31. 00   Adjustment for speech pathology costs in excess of limitation (chapter 14)   32. 00   CAH HIT Adjustment for Depreciation and Interest   O   O   O   32. 00   O   O   O   32. 00   O   O   34. 00   O   O   35. 00   O   O   36. 00   O   37. 00   O   38. 00   O   39. 00   O   30. 00	07.00				OAD DEL COCTO MUDI E FOILID	0.00		07.00
28. 00 Non-physician Anesthetist 0 *** Cost Center Deleted *** 19. 00 29. 00 29. 00 Physicians' assistant 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	27.00			O	CAP REL COSTS-MVBLE EQUIP	2.00	O	27.00
30. 00 Adj ustment for occupational therapy costs in excess of limitation (chapter 14) 30. 99 Hospice (non-distinct) (see instructions) 31. 00 Adj ustment for speech pathology costs in excess of limitation (chapter 14) 32. 00 CAH HIT Adj ustment for Depreciation and Interest  A-8-3  OCCUPATIONAL THERAPY  67. 00  30. 00  AA-8-3  OADULTS & PEDIATRICS  30. 00	28. 00			0	*** Cost Center Deleted ***	19. 00		28. 00
therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see instructions) 31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for Depreciation and Interest  OADULTS & PEDIATRICS 30.00 30.00 31.00 31.00 32.00			4.0.2	0	OCCUPATIONAL THEDADY		0	
limitation (chapter 14)  30. 99 Hospice (non-distinct) (see instructions)  31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14)  32. 00 CAH HIT Adjustment for Depreciation and Interest  OADULTS & PEDIATRICS  30. 00  31. 00  30. 99  0 SPEECH PATHOLOGY  68. 00  0 0 0 0 0 32. 00	3U. UU		A-8-3	O	JOCUPATI UNAL THEKAPY	67.00		30.00
instructions) 31.00 Adjustment for speech A-8-3 OSPEECH PATHOLOGY 68.00 31.00 pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for Depreciation and Interest 0 0 0.00 0 32.00		limitation (chapter 14)						
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)  32.00 CAH HIT Adjustment for Depreciation and Interest  A-8-3 OSPEECH PATHOLOGY  68.00 31.00  0.00 0 32.00	30. 99			O	ADULTS & PEDIATRICS	30.00		30. 99
pathology costs in excess of limitation (chapter 14)  32.00 CAH HIT Adjustment for Depreciation and Interest  0 0.00 0 32.00	31. 00		A-8-3	O.	SPEECH PATHOLOGY	68. 00		31.00
32.00 CAH HIT Adjustment for 0 0.00 0 32.00 Depreciation and Interest		pathology costs in excess of						
Depreciation and Interest	32 00					0.00	0	32 00
	JZ. 00			٥		0.00	U	32.00
	33. 00		В	-3, 660	ADMINISTRATIVE & GENERAL	5. 00	0	33.00

50.00

ADJUSTMENTS TO EXPENSES Provider CCN: 15-3047 Peri od: Worksheet A-8 From 05/01/2021 04/30/2022 Date/Time Prepared: 9/15/2022 11:43 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Amount Cost Center Line # Wkst. A-7 Ref. 1.00 2.00 3.00 4.00 5.00 33. 02 MISC INCOME -7, 577 ADMINISTRATIVE & GENERAL 33. 02 В 5.00 -917 DRUGS CHARGED TO PATIENTS 33.03 MISC INCOME В 73.00 0 33.03 33.04 PRE-OPENING AMORTIZATION - CAP Α 81, 895 CAP REL COSTS-BLDG & FIXT 1.00 33.04 33.05 PRE-OPENING AMORTIZATION - A&G 260, 734 ADMI NI STRATI VE & GENERAL 33.05 Α 5.00 -287 ADMI NI STRATI VE & GENERAL OTHER ol 33.11 5.00 33.11 Α EXPENSE-ADVERTI SI NG/MARKETI NG-33.13 OTHER Α -26, 655 ADMINI STRATI VE & GENERAL 5.00 33.13 EXPENSE-ADVERTI SI NG/MARKETI NG -126, 017 ADMI NI STRATI VE & GENERAL 33, 29 BAD DEBT EXPENSE-BAD DEBT--5.00 33. 29 33. 93 OTHER EXPENSE-FLOWERS & -49 ADMINISTRATIVE & GENERAL Α 5.00 0 33.93 GLFTS-TAXES-FRANCHI SE FEES/BUSI NESS 34.18 Α -150 ADMINISTRATIVE & GENERAL 5.00 34.18 TAX--OTHER EXPENSE-GIVEAWAYS---192 ADMINISTRATIVE & GENERAL 34.21 Α 5.00 34.21 OTHER EXPENSE-GI VEAWAYS---3, 614 ADMI NI STRATI VE & GENERAL 34. 22 5.00 0 34. 22 Α OTHER EXPENSE-GLVFAWAYS---176 ADMINISTRATIVE & GENERAL 34.38 Α 5.00 0 34 38 OTHER FEES-LATE FEES---14 ADMINISTRATIVE & GENERAL 5.00 34.48 34.48 Α -5 ADMINISTRATIVE & GENERAL 34.50 OTHER FEES-LATE FEES--Α 5.00 0 34.50 OTHER FEES-LATE FEES---403 OPERATION OF PLANT 7.00 0 34.65 34, 65 Α -502 MEDICAL SUPPLIES CHARGED TO 34.77 OTHER FEES-LATE FEES--Α 71.00 34.77 PATI ENTS OTHER EXPENSE-MARKETING -2, 166 ADMI NI STRATI VE & GENERAL 5.00 0 34.86 34.86 Α COLLATERAL --TAXES-SALES TAX---4, 490 ADMINI STRATI VE & GENERAL 34.93 5.00 34.93 0 Α TELEPHONE OPERATOR EXPENSE -17, 193 ADMI NI STRATI VE & GENERAL 35 25 Α 5.00 ol 35 25 35. 26 TELEPHONE BENEFIT EXPENSE Α -2, 027 EMPLOYEE BENEFITS DEPARTMENT 4.00 35. 26 35 27 TELEVISION LEASE -26, 426 CAP REL COSTS-MVBLE EQUIP 2.00 10 35. 27 Α -1, 396 ADMI NI STRATI VE & GENERAL UNALLOWABLE LOBBYING % OF 5.00 35.28 35.28 Α

1,031,311

TOTAL (sum of lines 1 thru 49)

(Transfer to Worksheet A,

ASSOC DUES

50.00

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

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

B. Amount Received - if cost cannot be determined.

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

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

OFFICE COSTS

				Го 04/30/2022	Date/Time Pre 9/15/2022 11:	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HO Alloc - Cap Rel Bldg	18, 451	0	1. 00
2.00	2. 00	CAP REL COSTS-MVBLE EQUIP	HO Alloc - Cap Rel Equipment	71, 574	0	2.00
3.00	5. 00	ADMINISTRATIVE & GENERAL	HO Alloc - Cap Rel A&G	1, 297, 722	0	3.00
4.00	5. 00	ADMINISTRATIVE & GENERAL	Intercompany Management Fees	0	497, 647	4.00
4.01	5. 00	ADMINISTRATIVE & GENERAL	PRE-OPENING AMORTIZATION - H	33, 011	0	4. 01
4.03	1.00	CAP REL COSTS-BLDG & FIXT	PRE-OPENING AMORTIZATION - H	5, 758	0	4. 03
5. 00	0		0	1, 426, 516	497, 647	5. 00

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

				Related Organization(s) and	I/or Home Office			
	Symbol (1)	Name	Percentage of	Name	Percentage of			
	, , ,		Ownershi p		Ownershi p			
	1. 00	2. 00	3. 00	4. 00	5. 00			
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:								

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

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

6. 00	В		O. OO ERNEST HEALTH	100.00	6. 00
7.00			0.00	0.00	7. 00
8. 00			0.00	0.00	8. 00
9. 00			0.00	0.00	9. 00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or	FI NANCI AL			100.00
	non-financial) specify:				

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

Heal	th Financial Syst	ems	R	Rehabilitation	n Hospital	of Northe	rn In	di		In Lie	u of Form CMS-	2552-10
STAT	EMENT OF COSTS OF	SERVICES FROM	RELATED OF	RGANI ZATI ONS	AND HOME	Provi der	CCN:	15-3047	Peri o		Worksheet A-8	3-1
OFFI	CE COSTS									05/01/2021	D 1 /T' D	
									To (	34/30/2022	Date/Time Pre 9/15/2022 11:	eparea:
									L		9/15/2022 11:	43 8111
	Net	Wkst. A-7 Ref.										
	Adjustments											
	(col. 4 minus											
	col. 5)*											
	6. 00	7. 00										
	A. COSTS INCUR	RED AND ADJUST	MENTS REQUI	IRED AS A RES	SULT OF TRA	NSACTI ONS	WI TH	RELATED C	RGANI Z	ATIONS OR (	CLAI MED	
	HOME OFFICE CO	STS:										
1.00	18, 451	9										1.00

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

2.00

3.00

4.00

4.01

4 03

5.00

nas no	been posted to norksheet A,	cordinate transfer 2, the amount arrowable should be mareated in cordinate of this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	6. 00		
	B. INTERRELATIONSHIP TO RELAT	FED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

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

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

2.00

3.00

4.00

4.01

4 03

5.00

71, 574

1, 297, 722

-497, 647

33, 011

928, 869

5.758

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0

0

Rehabilitation Hospital of Northern Indi In Lieu of Form CMS-2552-10

Provider CCN: 15-3047 | Period: | Worksheet B | From 05/01/2021 | Part I

0001 71220071	62.12.11.12 62.11.162 666.16				From 05/01/2021 From 04/30/2022	Part I Date/Time Pre	pared:
						9/15/2022 11:	
			CAPI TAL REI	LATED COSTS			
			BUBB & FLVT	I 10/01 5 50/11 5			
	Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
		for Cost			BENEFITS		
		Allocation			DEPARTMENT		
		(from Wkst A					
		col . 7)	1 00	2.00	4.00	4.0	
GENER	RAL SERVICE COST CENTERS	0	1. 00	2. 00	4. 00	4A	
	CAP REL COSTS-BLDG & FIXT	3, 469, 528	3, 469, 528				1.00
	CAP REL COSTS-MVBLE EQUIP	773, 568	-,,	773, 56	3		2. 00
- 1	EMPLOYEE BENEFITS DEPARTMENT	1, 130, 668	12, 478				4. 00
- 1	ADMINISTRATIVE & GENERAL	3, 657, 053	228, 492			4, 246, 418	5. 00
	OPERATION OF PLANT	415, 664	1, 031, 302			1, 688, 874	7. 00
	LAUNDRY & LINEN SERVICE	45, 794	1,031,302	227, 74		45, 794	8.00
	HOUSEKEEPI NG	129, 250	76, 206		·   •	243, 244	9. 00
	DIETARY	374, 964	238, 360			721, 725	10.00
	NURSING ADMINISTRATION	284, 334	119, 435			484, 832	13. 00
	MEDICAL RECORDS & LIBRARY	98, 523	13, 497			132, 121	16. 00
	TIENT ROUTINE SERVICE COST CENTERS	70, 523	13, 477	3,00	7 17,092	132, 121	10.00
	ADULTS & PEDIATRICS	2, 637, 200	1, 224, 206	272, 94	406, 868	4, 541, 223	30.00
	SKILLED NURSING FACILITY	0	0, 221, 200		0	0	44. 00
	LARY SERVICE COST CENTERS	٩			91 91		11.00
	RADI OLOGY-DI AGNOSTI C	15, 144	0		ol ol	15, 144	54.00
	CT SCAN	3, 646	0			3, 646	57. 00
	MAGNETIC RESONANCE IMAGING (MRI)	844	0			844	58. 00
	LABORATORY	23, 765	12, 351	2, 75	ا ا	38, 870	60.00
	RESPI RATORY THERAPY	84, 125	.2,001	1	13, 004	97, 129	65. 00
	PHYSI CAL THERAPY	479, 159	299, 796	66, 84		934, 102	66.00
	OCCUPATIONAL THERAPY	391, 622	52, 078			529, 971	67. 00
	SPEECH PATHOLOGY	216, 654	21, 328			284, 416	68. 00
	MEDICAL SUPPLIES CHARGED TO PATIENTS	133, 331	74, 424	16, 59		235, 554	71.00
	DRUGS CHARGED TO PATIENTS	406, 401	65, 575			527, 330	73.00
	RENAL DIALYSIS	207, 046	03, 373		0 40, 733	207, 046	74.00
	OTHER ANCILLARY SERVICE COST CENTERS	84, 358	0			84, 358	76.00
	ATIENT SERVICE COST CENTERS	04, 330			<u> </u>	04, 330	70.00
	EMERGENCY	O	0		ol lo	0	91.00
	OUTPATIENT THERAPY		0	•		0	91.00
	OUTPATIENT WOUND CENTER		0			0	93. 00
	R REIMBURSABLE COST CENTERS	<u> </u>			<u> </u>	0	73.00
	AMBULANCE SERVICES	O	0		ol	0	95. 00
	HOME HEALTH AGENCY	l ol	0		ol ol		101. 00
	AL PURPOSE COST CENTERS	-1			-1		
	OTHER SPECIAL PURPOSE COST CENTERS	0	0	(	o o	0	117. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	15, 062, 641	3, 469, 528	773, 56	1, 145, 928	15, 062, 641	118. 00
NONRE	IMBURSABLE COST CENTERS						
192. 00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	(	0	0	192. 00
194. 00 07950	MARKETI NG	0	0		o  o	0	194. 00
194. 01 07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	(	o  o	0	194. 01
200. 00	Cross Foot Adjustments					0	200. 00
201. 00	Negative Cost Centers		0	(	o  o	0	201. 00
202. 00	TOTAL (sum lines 118 through 201)	15, 062, 641	3, 469, 528	773, 56	1, 145, 928	15, 062, 641	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

In Lieu of Form CMS-2552-10

| Period: | Worksheet B |
| From 05/01/2021 | Part |
| To 04/30/2022 | Date/Time Prepared: | 9/15/2022 | 11: 43 am

						9/15/2022 11:	43 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 & 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	4, 246, 418					5. 00
7.00	00700 OPERATION OF PLANT	663, 047	2, 351, 921				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	17, 979	2,001,721	63, 773			8.00
9. 00	00900 HOUSEKEEPI NG	95, 497	81, 571		420, 312		9. 00
10.00	01000 DI ETARY	283, 347	255, 138	1		1, 307, 444	
13. 00	01300 NURSI NG ADMI NI STRATI ON	190, 344	127, 842	l .		1, 307, 444	13. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	51, 870	14, 447			0	16. 00
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	31,670	14, 447		2,073	U	10.00
20.00		1 702 071	1 210 270	(2.772	242 502	1 207 444	20.00
30.00	03000 ADULTS & PEDIATRICS	1, 782, 871	1, 310, 379	1		1, 307, 444	
44. 00		0	0	0	0	0	44. 00
	ANCILLARY SERVICE COST CENTERS			_	_	_	
54. 00	1 1	5, 945	0	0	0	0	54. 00
57. 00	05700 CT SCAN	1, 431	0	0	0	0	57. 00
58. 00		331	0	0	0	0	58. 00
60.00	06000 LABORATORY	15, 260	13, 220	0	2, 447	0	60.00
65.00	06500 RESPI RATORY THERAPY	38, 133	0	0	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	366, 726	320, 899	0	59, 408	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	208, 065	55, 743	0	10, 320	0	67.00
68.00	06800 SPEECH PATHOLOGY	111, 661	22, 829	0	4, 226	0	68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	92, 478	79, 663	0	14, 748	0	71. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	207, 028	70, 190	0	12, 994	0	73. 00
74.00	07400 RENAL DIALYSIS	81, 286	. 0	0		0	74.00
76. 00	03950 OTHER ANCILLARY SERVICE COST CENTERS	33, 119	0	0	0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS		<u> </u>		- 1		
91. 00		0	0	0	0	0	91.00
91. 01	04951 OUTPATIENT THERAPY	ol	0	_	_	0	
93. 00	1	Ö	0	_	_	0	
70.00	OTHER REIMBURSABLE COST CENTERS	<u> </u>		· · · ·	J	U	70.00
95 00	09500 AMBULANCE SERVICES	O	0	0	0	0	95. 00
	10100 HOME HEALTH AGENCY		0		0	_	101. 00
101.0	SPECIAL PURPOSE COST CENTERS	<u> </u>		1	U	U	101.00
117 0	0 06950 OTHER SPECIAL PURPOSE COST CENTERS	O	0	0	0	0	117. 00
	1 1		ŭ	_	_		
118. 0		4, 246, 418	2, 351, 921	63, 773	420, 312	1, 307, 444	1118.00
	NONREI MBURSABLE COST CENTERS	_1		_	_	_	
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192. 00
	07950 MARKETI NG	0	0	0	0		194. 00
	1 07951 OTHER NONREIMBURSABLE COST CENTERS	0	0	1 0	0	0	194. 01
200.0	-						200. 00
201. 0		0	0	0	0		201. 00
202. 0	TOTAL (sum lines 118 through 201)	4, 246, 418	2, 351, 921	63, 773	420, 312	1, 307, 444	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-3047

Peri od: Worksheet B From 05/01/2021 Part I

04/30/2022 Date/Time Prepared: 9/15/2022 11:43 am Cost Center Description NURSI NG MEDI CAL Subtotal Intern & Total RECORDS & ADMI NI STRATI ON Residents Cost LI BRARY & Post Stepdown Adjustments 13.00 16.00 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01300 NURSING ADMINISTRATION 13.00 13 00 826, 685 01600 MEDICAL RECORDS & LIBRARY 16.00 201, 113 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 826, 685 96, 776 10, 171, 744 10, 171, 744 30.00 0 04400 SKILLED NURSING FACILITY 44 00 44.00 0 0 ANCILLARY SERVICE COST CENTERS 05400 RADI OLOGY-DI AGNOSTI C 54.00 0 917 22, 006 22, 006 54.00 0 0 05700 CT SCAN 5, 298 57.00 57 00 221 5 298 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 51 1, 226 1, 226 58.00 60.00 06000 LABORATORY 5, 850 75, 647 0 75, 647 60.00 0000000 06500 RESPIRATORY THERAPY 65.00 3, 363 138, 625 0 0 0 138, 625 65.00 06600 PHYSI CAL THERAPY 1, 704, 195 1, 704, 195 66.00 23, 060 66 00 06700 OCCUPATIONAL THERAPY 67.00 22, 325 826, 424 826, 424 67.00 06800 SPEECH PATHOLOGY 10, 590 433, 722 433, 722 68.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 7, 339 71.00 429, 782 429, 782 71.00 07300 DRUGS CHARGED TO PATIENTS 26, 291 843.833 843, 833 73 00 73 00 0 74.00 07400 RENAL DIALYSIS 2,870 291, 202 291, 202 74.00 03950 OTHER ANCILLARY SERVICE COST CENTERS 118, 937 118, 937 76.00 76.00 1,460 OUTPATIENT SERVICE COST CENTERS 91.00 91 00 09100 EMERGENCY 0 0 0 0 91.01 04951 OUTPATIENT THERAPY 0 0 0 0 0 91.01 04950 OUTPATIENT WOUND CENTER 93.00 93.00 0 0 0 0 0 OTHER REIMBURSABLE COST CENTERS 95 00 95 00 09500 AMBULANCE SERVICES 0 0 0 0 0 101.00 10100 HOME HEALTH AGENCY 0 0 101.00 SPECIAL PURPOSE COST CENTERS 117. 00 06950 OTHER SPECIAL PURPOSE COST CENTERS 0 117, 00 15, 062, 641 826, 685 201, 113 15, 062, 641 118. 00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 192. 00 0 0 194. 00 194. 00 07950 MARKETI NG 0 Λ 0 194. 01 07951 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 0 194. 01 200.00 Cross Foot Adjustments 0 0 200. 00 0 201.00 201.00 Negative Cost Centers 0 202.00 TOTAL (sum lines 118 through 201) 826, 685 201, 113 15, 062, 641 15, 062, 641 202. 00 Health Financial Systems Rehabilitation Hospital of Northern Indi In Lieu of Form CMS-2552-10 ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-3047 Peri od: Worksheet B From 05/01/2021 Part II 04/30/2022 Date/Time Prepared: 9/15/2022 11:43 am CAPITAL RELATED COSTS **EMPLOYEE** Cost Center Description Directly BLDG & FIXT MVBLE EQUIP Subtotal Assigned New **BENEFITS** DEPARTMENT Capi tal 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 12, 478 2, 782 15, 260 15, 260 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 0 0 0 228, 492 50, 945 279, 437 4, 127 5.00 00700 OPERATION OF PLANT 1, 031, 302 229, 940 159 7 00 1, 261, 242 7 00 00800 LAUNDRY & LINEN SERVICE 8.00 C 0 8.00 9.00 00900 HOUSEKEEPI NG 76, 206 16, 991 93, 197 277 9.00 0 01000 DI ETARY 238, 360 53. 145 291, 505 736 10.00 10 00 01300 NURSING ADMINISTRATION 13.00 119, 435 26, 629 146, 064 725 13.00 16.00 01600 MEDICAL RECORDS & LIBRARY 13, 497 3,009 16, <u>5</u>06 228 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 5, 419 30 00 03000 ADULTS & PEDIATRICS 0 1, 224, 206 272, 949 1, 497, 155 30 00 44.00 04400 SKILLED NURSING FACILITY 0 44.00 ANCILLARY SERVICE COST CENTERS 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 0 54.00 0 05700 CT SCAN O 57.00 Ω 0 0 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0 0 58.00 06000 LABORATORY 60.00 12, 351 2, 754 15, 105 60.00 65.00 06500 RESPIRATORY THERAPY 173 65.00 00000 06600 PHYSI CAL THERAPY 299, 796 66.00 66,843 366, 639 1, 176 66.00 67.00 06700 OCCUPATIONAL THERAPY 52,078 11, 611 63, 689 994 67.00 06800 SPEECH PATHOLOGY 21, 328 4, 755 26, 083 555 68.00 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 16, 594 91, 018 71.00 74.424 149 71.00 07300 DRUGS CHARGED TO PATIENTS 14, 621 80, 196 73.00 65, 575 542 73.00 74.00 07400 RENAL DIALYSIS 0 0 74.00 C 0 03950 OTHER ANCILLARY SERVICE COST CENTERS 0 76.00 0 0 0 76.00 OUTPATIENT SERVICE COST CENTERS 0 91.00 91.00 09100 EMERGENCY 0 0 0 0 04951 OUTPATIENT THERAPY 0 0 0 0 91.01 91.01 04950 OUTPATIENT WOUND CENTER 93.00 0 0 93.00 OTHER REIMBURSABLE COST CENTERS 95.00 95. 00 09500 AMBULANCE SERVICES 0 n 0 0 0 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 101.00 0 SPECIAL PURPOSE COST CENTERS

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15, 260 202. 00

200. 00

15, 260 118. 00

117.00 06950 OTHER SPECIAL PURPOSE COST CENTERS

194. 01 07951 OTHER NONREIMBURSABLE COST CENTERS

Cross Foot Adjustments

Negative Cost Centers

NONREI MBURSABLE COST CENTERS

192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES

194. 00 07950 MARKETI NG

200.00

201.00

202.00

SUBTOTALS (SUM OF LINES 1 through 117)

TOTAL (sum lines 118 through 201)

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 05/01/2021 Part II
To 04/30/2022 Date/Time Prepared:
9/15/2022 11: 43 am

						9/15/2022 11:	43 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 & 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	283, 564					5.00
7.00	00700 OPERATION OF PLANT	44, 277	1, 305, 678				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	1, 201	., 555, 5, 5	1, 201			8.00
9. 00	00900 HOUSEKEEPI NG	6, 377	45, 284	1	145, 135		9. 00
10.00	01000 DI ETARY	18, 921	141, 641	1		469, 113	
13. 00	01300 NURSING ADMINISTRATION	12, 711	70, 972	l .	8, 172	0	13. 00
16. 00		3, 464	8. 020			0	16. 00
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	3, 404	8,020	1	724	U	10.00
20.00		110.050	707 4/0	1 201	02.7/0	4/0 112	20.00
30.00		119, 052	727, 463	1	83, 768	469, 113	
44. 00		0	0	0	0	0	44. 00
	ANCILLARY SERVICE COST CENTERS						
54. 00		397	0	0	0	0	54. 00
57. 00		96	0	0	0	0	57. 00
58. 00		22	0	0	0	0	58. 00
60.00		1, 019	7, 339	1 0	845	0	60.00
65.00		2, 546	0	0	0	0	65.00
66. 00		24, 489	178, 148	1	20, 514	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	13, 894	30, 946	0	3, 563	0	67.00
68. 00		7, 457	12, 674	0	1, 459	0	68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	6, 176	44, 225	0	5, 093	0	71. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	13, 825	38, 966	0	4, 487	0	73. 00
74.00	07400 RENAL DIALYSIS	5, 428	0	0	0	0	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	2, 212	0	0	0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS						1
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
91. 01	04951 OUTPATI ENT THERAPY	ol	0	0	0	0	91. 01
93. 00	1 · · · · · · · · · · · · · · · · · · ·	o	0	0	0	0	93. 00
	OTHER REIMBURSABLE COST CENTERS	-1	-	-			
95 00	09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
	0 10100 HOME HEALTH AGENCY	0	0		0	_	101.00
101.0	SPECIAL PURPOSE COST CENTERS	<u> </u>		· · · · · ·		0	101.00
117 0	0 06950 OTHER SPECIAL PURPOSE COST CENTERS	O	0	0	0	0	117. 00
118. 0		283, 564	1, 305, 678	1	_		
110.0	NONREI MBURSABLE COST CENTERS	203, 304	1, 303, 070	1, 201	145, 155	407, 113	1110.00
102.0	0 19200 PHYSI CLANS' PRI VATE OFFI CES				0	0	192. 00
		0	0	0	0		
	0 07950 MARKETI NG		0	]	0		194.00
	1 07951 OTHER NONREIMBURSABLE COST CENTERS	0	0	'l O	0	0	194. 01
200.0		_	=	_	_	_	200.00
201.0		0	0	0	0		201. 00
202. 0	0 TOTAL (sum lines 118 through 201)	283, 564	1, 305, 678	1, 201	145, 135	469, 113	J202. 00

Health Financial Systems Rehabilitation Hospital of Northern Indi In Lieu of Form CMS-2552-10 ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-3047 Peri od: Worksheet B From 05/01/2021 Part II 04/30/2022 Date/Time Prepared: 9/15/2022 11:43 am Cost Center Description NURSI NG MEDI CAL Subtotal Intern & Total RECORDS & ADMI NI STRATI ON Residents Cost LI BRARY & Post Stepdown Adjustments 13.00 16.00 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01300 NURSING ADMINISTRATION 238, 644 13.00 13 00 01600 MEDICAL RECORDS & LIBRARY 16.00 29, 142 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 238, 644 14, 021 3, 155, 836 3, 155, 836 30.00 0 04400 SKILLED NURSING FACILITY 44.00 44.00 0 0 ANCILLARY SERVICE COST CENTERS 05400 RADI OLOGY-DI AGNOSTI C 54.00 0 133 530 530 54.00 0 0 05700 CT SCAN 57.00 57 00 32 128 128 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 29 29 58.00 60.00 06000 LABORATORY 848 25, 156 0 25, 156 60.00 0000000 06500 RESPIRATORY THERAPY 65.00 487 3, 206 0 0 0 3, 206 65.00 06600 PHYSI CAL THERAPY 594, 308 66.00 3 342 594, 308 66 00 06700 OCCUPATIONAL THERAPY 67.00 3, 235 116, 321 116, 321 67.00 1, 535 06800 SPEECH PATHOLOGY 49, 763 49, 763 68.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 1,064 147, 725 147, 725 71.00 07300 DRUGS CHARGED TO PATIENTS 141, 826 141.826 73.00 73 00 3,810 07400 RENAL DIALYSIS 0 74.00 416 5,844 5, 844 74.00 03950 OTHER ANCILLARY SERVICE COST CENTERS 212 2, 424 2, 424 76.00 76.00 OUTPATIENT SERVICE COST CENTERS 91.00 91 00 09100 EMERGENCY 0 Ω 0 0 0 91.01 04951 OUTPATIENT THERAPY 0 0 0 0 0 91.01 04950 OUTPATIENT WOUND CENTER 93.00 93.00 0 0 0 0 0 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95 00 95 00 0 0 0 0 0 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 117. 00 06950 OTHER SPECIAL PURPOSE COST CENTERS 0 117, 00 SUBTOTALS (SUM OF LINES 1 through 117) 238, 644 4, 243, 096 29, 142 4, 243, 096 118. 00 118.00 0 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 192. 00

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4, 243, 096 202. 00

194. 00 07950 MARKETI NG

200.00

201.00

202.00

194. 01 07951 OTHER NONREIMBURSABLE COST CENTERS

Cross Foot Adjustments

TOTAL (sum lines 118 through 201)

Negative Cost Centers

Provider CCN: 15-3047

Peri od:

COST ALLOCATION - STATISTICAL BASIS

From 05/01/2021 04/30/2022 Date/Time Prepared: 9/15/2022 11:43 am CAPITAL RELATED COSTS Cost Center Description BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Reconciliation ADMINISTRATIVE (SOUARE FEET) (SOUARE FEET) BENEFITS & GENERAL (ACCUM. COST) DEPARTMENT (GROSS SALARI ES) 1.00 2.00 5A 5. 00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 54 497 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 54, 497 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 196 196 5, 484, 725 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 3 589 3 589 1, 483, 397 10, 816, 223 5 00 -4, 246, 418 7.00 00700 OPERATION OF PLANT 16, 199 16, 199 57, 284 1, 688, 874 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 45, 794 8.00 9.00 00900 HOUSEKEEPI NG 1, 197 1, 197 99, 542 0 243, 244 9.00 01000 DI FTARY 721, 725 3 744 264, 470 0 10 00 10.00 3, 744 13.00 01300 NURSING ADMINISTRATION 1,876 1, 876 260, 535 0 484, 832 13.00 01600 MEDICAL RECORDS & LIBRARY 16.00 212 212 81,805 132, 121 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 4, 541, 223 30.00 03000 ADULTS & PEDIATRICS 19, 229 19, 229 1, 947, 385 0 30.00 04400 SKILLED NURSING FACILITY 44.00 44.00 0 ANCILLARY SERVICE COST CENTERS 05400 RADI OLOGY-DI AGNOSTI C 15. 144 54.00 0 0 54.00 57.00 05700 CT SCAN 0 Ω 0 0 3, 646 57 00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 844 58.00 60.00 06000 LABORATORY 194 194 O 38, 870 60.00 0 06500 RESPIRATORY THERAPY 97, 129 62, 240 65.00 Ω 65, 00 06600 PHYSI CAL THERAPY 934, 102 66.00 4.709 4,709 422, 645 66.00 06700 OCCUPATIONAL THERAPY 818 818 357, 345 529, 971 67.00 0 67.00 68.00 06800 SPEECH PATHOLOGY 199, 487 284, 416 68.00 335 335 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1, 169 1, 169 53, 629 235, 554 71.00 73.00 07300 DRUGS CHARGED TO PATIENTS 1,030 1,030 194, 961 0 527, 330 73.00 07400 RENAL DIALYSIS 207, 046 74.00 0 74.00 84, 358 76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 76.00 OUTPATIENT SERVICE COST CENTERS 09100 EMERGENCY 91.00 91.00 0 0 o 91.01 04951 OUTPATIENT THERAPY 0 0 0 0 91.01 04950 OUTPATIENT WOUND CENTER 0 93.00 0 0 0 93.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 C 0 101.00 10100 HOME HEALTH AGENCY 0 101.00 0 0 0 SPECIAL PURPOSE COST CENTERS 117. 00 06950 OTHER SPECIAL PURPOSE COST CENTERS 0 0 117.00 SUBTOTALS (SUM OF LINES 1 through 117) 54, 497 54, 497 5, 484, 725 -4, 246, 418 10, 816, 223 118. 00 118.00 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 192. 00 0 0 194. 00 07950 MARKETI NG 0 0 0 0 194. 00 0 194. 01 07951 OTHER NONREIMBURSABLE COST CENTERS 0 C 0 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, 3, 469, 528 773, 568 1, 145, 928 4, 246, 418 202. 00 Part I) 0. 392597 203. 00 203.00 Unit cost multiplier (Wkst. B, Part I) 14. 194690 0.208931 63.664569 204.00 Cost to be allocated (per Wkst. B, 15, 260 283, 564 204. 00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.002782 0. 026217 205. 00 II) 206, 00 NAHE adjustment amount to be allocated 206, 00 (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 Parts III and IV)

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

					0 04/30/2022	9/15/2022 11:	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	
		PLANT	LINEN SERVICE	(SQUARE FEET)	(TOTAL PATIENT	ADMI NI STRATI ON	
		(SQUARE FEET)	(TOTAL PATIENT		DAYS)	(1111001110	
			DAYS)			(NURSI NG SALARI ES)	
		7. 00	8.00	9. 00	10, 00	13. 00	
	GENERAL SERVICE COST CENTERS	7.00	0.00	7.00	10.00	10.00	
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	04 540					5. 00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	34, 513	l .				7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG	1, 197	1	33, 316			9. 00
10. 00	01000 DI ETARY	3, 744	1	3, 744			10.00
13. 00	01300 NURSI NG ADMINI STRATI ON	1, 876	1	1, 876			13. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	212	1	212		0	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	19, 229	1				30. 00
44. 00	04400 SKILLED NURSING FACILITY	0	0	C	0	0	44. 00
E 4 00	ANCI LLARY SERVI CE COST CENTERS			1			F 4 00
54. 00 57. 00	05400  RADI OLOGY-DI AGNOSTI C   05700  CT SCAN	0		0	-	0	54. 00 57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)		1			0	58.00
60.00	06000 LABORATORY	194	1	194		Ö	60.00
65. 00	06500 RESPIRATORY THERAPY	0	Ö	.,,		Ö	65. 00
66.00	06600 PHYSI CAL THERAPY	4, 709	0	4, 709	O	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	818	0	818	o	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	335	1	335		0	68. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 169	ł	1, 169		0	71. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 030	l	1, 030	1	0	73.00
74. 00	07400 RENAL DIALYSIS	0		C	1	0	74. 00 76. 00
76. 00	03950 OTHER ANCILLARY SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS	0	0		vj Uj	0	76.00
91. 00	09100 EMERGENCY	0	0		ol	0	91.00
91. 01	04951 OUTPATIENT THERAPY	0	ł .				91. 01
93. 00	04950 OUTPATIENT WOUND CENTER	0	•	C	O		93. 00
	OTHER REIMBURSABLE COST CENTERS						
95. 00		0					95. 00
101.00	10100 HOME HEALTH AGENCY	0	0	C	0	0	101. 00
117 0	SPECIAL PURPOSE COST CENTERS				ا	0	117 00
117.00	OCCUPIED OF THE SPECIAL PURPOSE COST CENTERS OF SUBTOTALS (SUM OF LINES 1 through 117)	0 34, 513	1	1	-		117.00
110.00	NONREI MBURSABLE COST CENTERS	34, 313	1,700	33, 310	7,700	1, 747, 303	1110.00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	C	0	0	192. 00
	07950 MARKETI NG	0	0	C	O	0	194. 00
194.01	1 07951 OTHER NONREIMBURSABLE COST CENTERS	0	0	C	0	0	194. 01
200.00	1						200. 00
201.00							201. 00
202.00		2, 351, 921	63, 773	420, 312	1, 307, 444	826, 685	202. 00
203. 00	Part I) Unit cost multiplier (Wkst. B, Part I)	40 145045	0 210170	12 415020	140 405053	0. 424510	202 00
203.00		68. 145945 1, 305, 678		12. 615920 145, 135		238, 644	
204.00	Part II)	1, 303, 070	1, 201	143, 133	407, 113	230, 044	204.00
205.00		37. 831484	0. 154768	4. 356315	60. 452706	0. 122546	205. 00
206.00							206. 00
207.04	(per Wkst. B-2)						207.00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00
	i dita iii did iv)	I	I	I	1	ı	ı

COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 15-3047 Peri od: Worksheet B-1 From 05/01/2021 To 04/30/2022 Date/Time Prepared: 9/15/2022 11:43 am Cost Center Description MEDI CAL RECORDS & LI BRARY (GROSS CHARGES) 16.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01300 NURSING ADMINISTRATION 13 00 13 00 01600 MEDICAL RECORDS & LIBRARY 16.00 16, 118, 346 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 7, 756, 000 30.00 04400 SKILLED NURSING FACILITY 44.00 44 00 ANCILLARY SERVICE COST CENTERS 05400 RADI OLOGY-DI AGNOSTI C 54.00 73, 476 54.00 05700 CT SCAN 57.00 57 00 17 693 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 4, 101 58.00 60.00 06000 LABORATORY 468, 838 60.00 65. 00 06500 RESPIRATORY THERAPY 269, 538 65.00 06600 PHYSI CAL THERAPY 1, 848, 200 66.00 66 00 06700 OCCUPATIONAL THERAPY 67.00 1, 789, 285 67.00 06800 SPEECH PATHOLOGY 848, 770 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 588, 238 71.00 07300 DRUGS CHARGED TO PATIENTS 2, 107, 157 73.00 73 00 74.00 07400 RENAL DIALYSIS 230, 050 74.00 03950 OTHER ANCILLARY SERVICE COST CENTERS 76.00 76.00 117,000 OUTPATIENT SERVICE COST CENTERS 91 00 09100 EMERGENCY 91.00 0 91.01 04951 OUTPATIENT THERAPY 0 91.01 04950 OUTPATIENT WOUND CENTER 93.00 93.00 0 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 0 95 00 101.00 10100 HOME HEALTH AGENCY 101.00 0 SPECIAL PURPOSE COST CENTERS 117. 00 06950 OTHER SPECIAL PURPOSE COST CENTERS 117.00 16, 118, 346 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 118. 00 NONREIMBURSABLE COST CENTERS 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 192.00 194. 00 194. 00 07950 MARKETI NG 0 194. 01 07951 OTHER NONREIMBURSABLE COST CENTERS 0 194.01 200.00 Cross Foot Adjustments 200.00 Negative Cost Centers 201.00 201.00 202.00 Cost to be allocated (per Wkst. B, 201, 113 202. 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 0.012477 203. 00 204.00 Cost to be allocated (per Wkst. B, 29, 142 204.00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.001808 205. 00 H) 206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207. 00 207.00 Parts III and IV)

Health Financial Systems		al Systems Rehab	Rehabilitation Hospital of Northern Inc			Indi In Lie		2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES			Provi der C		Period: From 05/01/2021 To 04/30/2022	Worksheet C Part I Date/Time Pre 9/15/2022 11:		
				Title	XVIII	Hospi tal	PPS	
						Costs		
	Со	st Center Description	Total Cost (from Wkst. B,	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
			Part I, col.	7.69		Di dai i diiando		
			1.00	2.00	3.00	4. 00	5. 00	
	I NPATI EN	NT ROUTINE SERVICE COST CENTERS					5, 55	
30.00		ULTS & PEDIATRICS	10, 171, 744		10, 171, 74	4 0	10, 171, 744	30.00
44.00	04400 SK	ILLED NURSING FACILITY	0		1	o o	0	44.00
	ANCI LLAR	RY SERVICE COST CENTERS						
54.00	05400 RA	DI OLOGY-DI AGNOSTI C	22, 006		22, 00	6 0	22, 006	54. 00
57.00	05700 CT	SCAN	5, 298		5, 29	8 0	5, 298	57. 00
58.00	05800 MA	GNETIC RESONANCE IMAGING (MRI)	1, 226		1, 22	6 0	1, 226	58. 00
60.00	06000 LA	BORATORY	75, 647		75, 64	7 0	75, 647	60.00
65.00	06500 RE	SPI RATORY THERAPY	138, 625	0	138, 62	5 0	138, 625	65. 00
66.00		IYSI CAL THERAPY	1, 704, 195	0	1, 704, 19	5 0	1, 704, 195	66. 00
67.00		CUPATIONAL THERAPY	826, 424	0	826, 42	4 0	826, 424	
68. 00		PEECH PATHOLOGY	433, 722	0	433, 72	2 0	433, 722	
71. 00		DICAL SUPPLIES CHARGED TO PATIENTS	429, 782		429, 78	2 0	429, 782	71. 00
73.00		RUGS CHARGED TO PATIENTS	843, 833		843, 83	3 0	843, 833	
		NAL DIALYSIS	291, 202		291, 20.	2 0	291, 202	
76. 00		HER ANCILLARY SERVICE COST CENTERS	118, 937		118, 93	7 0	118, 937	76. 00
		ENT SERVICE COST CENTERS						
			0		1	0	0	1
		ITPATI ENT THERAPY	0		1	0	0	1 /
93. 00		ITPATIENT WOUND CENTER	0			0 0	0	93. 00
		I MBURSABLE COST CENTERS						
95. 00		IBULANCE SERVI CES	0		1	0	0	
101.00		ME HEALTH AGENCY	0			0	0	101. 00
		PURPOSE COST CENTERS	_	1	1	_1	_	ļ <u>.</u>
	1 1	THER SPECIAL PURPOSE COST CENTERS	0	_	15.040	0		117. 00
200.00	1 1	btotal (see instructions)	15, 062, 641	0	15, 062, 64	1 0	15, 062, 641	
201.00		ess Observation Beds	0		45.046.44	0		201. 00
202.00	u <sub>l I</sub> Io	ital (see instructions)	15, 062, 641	0	15, 062, 64	1 0	15, 062, 641	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provi der CCN: 15-3047 Peri od: Worksheet C From 05/01/2021 Part I 04/30/2022 Date/Time Prepared: 9/15/2022 11:43 am Title XVIII Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA I npati ent + col . 7) Ratio Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 7, 756, 000 7, 756, 000 30.00 04400 SKILLED NURSING FACILITY 44.00 44.00 ANCILLARY SERVICE COST CENTERS 54.00 05400 RADI OLOGY-DI AGNOSTI C 73, 476 73, 476 0. 299499 0.000000 54.00 0. 299440 57.00 05700 CT SCAN 17,693 17, 693 0.000000 57.00 0 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 4, 101 4, 101 0. 298951 0.000000 58.00 60.00 06000 LABORATORY 468, 838 468, 838 0.161350 0.000000 60.00 06500 RESPIRATORY THERAPY 269, 538 269.538 0 0.514306 0.000000 65.00 65.00 06600 PHYSI CAL THERAPY 0 1, 848, 200 0. 922084 0.000000 66.00 1,848,200 66.00 67.00 06700 OCCUPATIONAL THERAPY 1, 789, 285 0 1, 789, 285 0.461874 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 848, 770 0 848, 770 0. 511001 0.000000 68.00 OI 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 588, 238 0.000000 71.00 588, 238 0.730626 71.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 2, 107, 157 2, 107, 157 0.400460 0.000000 73.00 74.00 07400 RENAL DIALYSIS 230,050 0 230, 050 1. 265820 0.000000 74.00 76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS 117,000 117,000 1.016556 0.000000 76.00 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 0 0 0.000000 0.000000 91.00 04951 OUTPATIENT THERAPY 0 0 0 0.000000 0.000000 91.01 91.01 04950 OUTPATIENT WOUND CENTER 0 0 0 0.000000 0.000000 93.00 93.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 0 0 0.000000 0.000000 95.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 117. 00 06950 OTHER SPECIAL PURPOSE COST CENTERS 0 117.00 200.00 Subtotal (see instructions) 16, 118, 346 0 16, 118, 346 200. 00 201.00 Less Observation Beds 201.00 0 202.00 Total (see instructions) 16, 118, 346 16, 118, 346 202.00

			10 04/30/2022	9/15/2022 11: 43 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
44.00 04400 SKILLED NURSING FACILITY				44. 00
ANCILLARY SERVICE COST CENTERS				
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 299499			54. 00
57. 00   05700   CT   SCAN	0. 299440			57. 00
58.00   05800   MAGNETIC RESONANCE IMAGING (MRI)	0. 298951			58. 00
60. 00   06000   LABORATORY	0. 161350			60.00
65. 00 06500 RESPI RATORY THERAPY	0. 514306			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 922084			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 461874			67. 00
68. 00   06800   SPEECH PATHOLOGY	0. 511001			68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 730626			71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 400460			73. 00
74. 00   07400   RENAL DI ALYSI S	1. 265820			74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	1. 016556			76. 00
OUTPATIENT SERVICE COST CENTERS				
91. 00  09100   EMERGENCY	0. 000000			91.00
91. 01  04951   OUTPATI ENT THERAPY	0. 000000			91. 01
93. 00 04950 OUTPATIENT WOUND CENTER	0. 000000			93. 00
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES	0. 000000			95. 00
101.00 10100 HOME HEALTH AGENCY				101. 00
SPECIAL PURPOSE COST CENTERS				
117.00 06950 OTHER SPECIAL PURPOSE COST CENTERS				117. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00   Total (see instructions)				202. 00

Health Financial Systems Renabi	iitation Hospit	<u>ai of Northern</u>	i nai	In Lie	u of form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der Co		Peri od:	Worksheet C	
			F	rom 05/01/2021	Part I	
			1	To 04/30/2022	Date/Time Pre	
					9/15/2022 11:	43 am_
		Ti tl	e XIX	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00   03000   ADULTS & PEDIATRICS	10, 171, 744		10, 171, 744	1 0	10, 171, 744	30.00
44.00   04400   SKILLED NURSING FACILITY	0		(	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
54. 00 05400 RADI OLOGY-DI AGNOSTI C	22, 006		22, 006	0	22, 006	54. 00
57. 00  05700 CT SCAN	5, 298		5, 298	0	5, 298	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 226		1, 226	0	1, 226	58. 00
60. 00   06000   LABORATORY	75, 647		75, 647		75, 647	60.00
65. 00 06500 RESPIRATORY THERAPY	138, 625	0	138, 625		138, 625	65.00
66. 00   06600 PHYSI CAL THERAPY	1, 704, 195	0	1, 704, 195		1, 704, 195	1
67. 00 06700 OCCUPATI ONAL THERAPY	826, 424	0	826, 424		826, 424	67. 00
68. 00 06800 SPEECH PATHOLOGY	433, 722	0	433, 722		433, 722	68.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	429, 782		429, 782		429, 782	71. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	843, 833		843, 833		843, 833	
74. 00 07400 RENAL DI ALYSI S	291, 202		291, 202		291, 202	74. 00
76. 00 03950 OTHER ANCILLARY SERVICE COST CENTERS	118, 937		118, 937		118, 937	76. 00
OUTPATIENT SERVICE COST CENTERS	110, 737		110, 737	· · · · · · · · · · · · · · · · · · ·	110, 737	70.00
91. 00 09100 EMERGENCY					0	91.00
91. 01 04951 OUTPATIENT THERAPY	0			-	1 0	91.00
93. 00 04950 OUTPATIENT WOUND CENTER	0				0	93. 00
OTHER REIMBURSABLE COST CENTERS	l o			) U	0	93.00
95. 00 09500 AMBULANCE SERVICES			1	0	0	95. 00
	0					101.00
101. 00 10100 HOME HEALTH AGENCY	<u> </u>			)	0	101.00
SPECIAL PURPOSE COST CENTERS			1	\	0	117. 00
117. 00 06950 OTHER SPECIAL PURPOSE COST CENTERS	45.000.044		45.000.00		_	
200.00 Subtotal (see instructions)	15, 062, 641	0	15, 062, 641	0		
201.00 Less Observation Beds	0	_	15.000			201. 00
202.00   Total (see instructions)	15, 062, 641	0	15, 062, 641	0	15, 062, 641	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provi der CCN: 15-3047 Peri od: Worksheet C From 05/01/2021 Part I 04/30/2022 Date/Time Prepared: 9/15/2022 11:43 am Title XIX Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA I npati ent + col . 7) Ratio Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 7, 756, 000 7, 756, 000 30.00 04400 SKILLED NURSING FACILITY 44.00 44.00 ANCILLARY SERVICE COST CENTERS 54.00 05400 RADI OLOGY-DI AGNOSTI C 73, 476 73, 476 0. 299499 0.000000 54.00 0. 299440 57.00 05700 CT SCAN 17,693 17, 693 0.000000 57.00 0 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 4, 101 4, 101 0. 298951 0.000000 58.00 60.00 06000 LABORATORY 468, 838 468, 838 0.161350 0.000000 60.00 06500 RESPIRATORY THERAPY 269, 538 269.538 0 0.514306 0.000000 65.00 65.00 06600 PHYSI CAL THERAPY 0 1, 848, 200 0. 922084 0.000000 66.00 1,848,200 66.00 67.00 06700 OCCUPATIONAL THERAPY 1, 789, 285 0 1, 789, 285 0.461874 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 848, 770 0 848, 770 0. 511001 0.000000 68.00 OI 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 588, 238 0.000000 71.00 588, 238 0.730626 71.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 2, 107, 157 2, 107, 157 0.400460 0.000000 73.00 74.00 07400 RENAL DIALYSIS 230,050 0 230, 050 1. 265820 0.000000 74.00 76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS 117,000 117,000 1.016556 0.000000 76.00 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 0 0 0.000000 0.000000 91.00 04951 OUTPATIENT THERAPY 0 0 0 0.000000 0.000000 91.01 91.01 04950 OUTPATIENT WOUND CENTER 0 0 0 0.000000 0.000000 93.00 93.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 0 0 0.000000 0.000000 95.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 117. 00 06950 OTHER SPECIAL PURPOSE COST CENTERS 0 117.00 200.00 Subtotal (see instructions) 16, 118, 346 0 16, 118, 346 200. 00 201.00 Less Observation Beds 201.00 0 202.00 Total (see instructions) 16, 118, 346 16, 118, 346 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-3047	From 05/01/2021 To 04/30/2022	Part I Date/Time Prepared: 9/15/2022 11:43 am
		Title XIX	Hospi tal	PPS
Cost Center Description	PPS Inpatient Ratio 11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
44.00 04400 SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS				
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 299499			54.00
57. 00  05700   CT   SCAN	0. 299440			57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 298951			58. 00
60. 00   06000   LABORATORY	0. 161350			60.00
65. 00 06500 RESPI RATORY THERAPY	0. 514306			65. 00
66. 00   06600 PHYSI CAL THERAPY	0. 922084			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 461874			67. 00
68. 00   06800   SPEECH PATHOLOGY	0. 511001			68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 730626			71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 400460			73. 00
74. 00   07400   RENAL DI ALYSI S	1. 265820			74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	1. 016556			76. 00
OUTPAȚI ENT SERVI CE COST CENTERS				
91. 00  09100 EMERGENCY	0. 000000			91.00
91. 01  04951 0UTPATI ENT THERAPY	0. 000000			91. 01
93. 00 04950 OUTPATIENT WOUND CENTER	0. 000000			93. 00
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES	0. 000000			95. 00
101.00 10100 HOME HEALTH AGENCY				101. 00
SPECIAL PURPOSE COST CENTERS	T			
117. 00 06950 OTHER SPECIAL PURPOSE COST CENTERS				117. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00   Total (see instructions)				202. 00

Health Financial Systems Rehabilitation Hospital of Northern Indi
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF Provider CCN: 15REDUCTIONS FOR MEDICALD ONLY | Peri od: | Worksheet C | From 05/01/2021 | Part II | To 04/30/2022 | Date/Time Prepared: Provider CCN: 15-3047

					10	04/30/2022	9/15/2022 11:	
				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	Reduction	
			I, col. 26)	II col. 26)	Cost (col. 1 -		Amount	
					col . 2)			
			1. 00	2. 00	3. 00	4. 00	5. 00	
		LARY SERVICE COST CENTERS						
54. 00		RADI OLOGY-DI AGNOSTI C	22, 006			0	0	0 00
57. 00		CT SCAN	5, 298			0	0	57. 00
58. 00		MAGNETIC RESONANCE IMAGING (MRI)	1, 226			0	0	58. 00
60.00		LABORATORY	75, 647	25, 156		0	0	60.00
65.00		RESPI RATORY THERAPY	138, 625	· ·		0	0	65. 00
66.00		PHYSI CAL THERAPY	1, 704, 195	· ·		0	0	66. 00
67. 00		OCCUPATI ONAL THERAPY	826, 424	· ·		0	0	67. 00
68.00	06800	SPEECH PATHOLOGY	433, 722	49, 763	383, 959	0	0	68. 00
71. 00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	429, 782	147, 725	282, 057	0	0	71. 00
73.00	07300	DRUGS CHARGED TO PATIENTS	843, 833	141, 826	702, 007	0	0	73. 00
74.00	07400	RENAL DIALYSIS	291, 202	5, 844	285, 358	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	118, 937	2, 424	116, 513	0	0	76. 00
		TIENT SERVICE COST CENTERS						
91.00		EMERGENCY	0	(	0	0	0	, , , , , , ,
		OUTPATI ENT THERAPY	0	(	0	0	0	91. 01
93.00		OUTPATIENT WOUND CENTER	0	(	0	0	0	93. 00
	-	REIMBURSABLE COST CENTERS						
		AMBULANCE SERVICES	0	C	0	0	0	, , , , , ,
101.00		HOME HEALTH AGENCY	0	C	0	0	0	101. 00
		AL PURPOSE COST CENTERS						
	1	OTHER SPECIAL PURPOSE COST CENTERS	0	(	0	0		117. 00
200.00	1	Subtotal (sum of lines 50 thru 199)	4, 890, 897	1, 087, 260	3, 803, 637	0		200. 00
201.00		Less Observation Beds	0	(	0	0		201. 00
202.00	)	Total (line 200 minus line 201)	4, 890, 897	1, 087, 260	3, 803, 637	0	0	202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 05/01/2021 | Part II | Date/Time Prepared: 9/15/2022 11:43 am

					9/15/2022 11: 4	3 am
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost Net of	Total Charges				
	Capital and		Cost to Charge			
	Operating Cost					
	Reduction	8)	/ col . 7)			
	6. 00	7. 00	8. 00			
ANCILLARY SERVICE COST CENTERS						
54. 00   05400   RADI OLOGY-DI AGNOSTI C	22, 006		1			54.00
57.00  05700 CT SCAN	5, 298		1			57.00
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)	1, 226		1			58.00
60. 00  06000  LABORATORY	75, 647	468, 838	0. 161350			60.00
65. 00   06500   RESPI RATORY THERAPY	138, 625	269, 538	0. 514306			65.00
66. 00   06600 PHYSI CAL THERAPY	1, 704, 195	1, 848, 200	0. 922084			66.00
67. 00  06700 OCCUPATI ONAL THERAPY	826, 424	1, 789, 285	0. 461874			67.00
68. 00   06800   SPEECH PATHOLOGY	433, 722	848, 770	0. 511001			68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	429, 782	588, 238	0. 730626			71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	843, 833	2, 107, 157	0. 400460			73.00
74.00   07400   RENAL DIALYSIS	291, 202	230, 050	1. 265820			74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	118, 937	117, 000	1. 016556			76.00
OUTPATIENT SERVICE COST CENTERS						
91. 00   09100   EMERGENCY	0	0	0.000000			91.00
91. 01  04951  OUTPATI ENT THERAPY	0	0	0.000000			91. 01
93. 00 O4950 OUTPATIENT WOUND CENTER	0	0	0.000000			93.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES	0	0	0.000000			95.00
101.00 10100 HOME HEALTH AGENCY	0	0	0.000000		1	101. 00
SPECIAL PURPOSE COST CENTERS						
117.00 06950 OTHER SPECIAL PURPOSE COST CENTERS	0	0	0.000000		1	117. 00
200.00 Subtotal (sum of lines 50 thru 199)	4, 890, 897	8, 362, 346			2	200.00
201.00 Less Observation Beds	0	0			2	201. 00
202.00   Total (line 200 minus line 201)	4, 890, 897	8, 362, 346			2	202. 00

Health Financial Systems Rehabi	litation Hospit	al of Northern	Indi	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Period: From 05/01/2021 To 04/30/2022		pared: 43 am
		Titl∈	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col . 1 - col			
	26)		2)			
	1.00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	3, 155, 836	0	3, 155, 83	6 7, 760	406. 68	30. 00
44.00 SKILLED NURSING FACILITY	0			0	0.00	44.00
200.00 Total (lines 30 through 199)	3, 155, 836		3, 155, 83	6 7, 760		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	3, 294	1, 339, 604				30. 00
44.00 SKILLED NURSING FACILITY	0	0	)			44.00
200.00 Total (lines 30 through 199)	3, 294	1, 339, 604				200. 00

Health Financial Systems	Rehabilitation Hospita	l of Northern Indi	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE	E CAPITAL COSTS	Provider CCN: 15-3047	Peri od: From 05/01/2021 To 04/30/2022	Worksheet D Part II Date/Time Prepared: 9/15/2022 11:43 am
		Title XVIII	Hospi tal	PPS
Cost Center Description	Cani tal	Total Charges Patio of Cos	t Innationt	Canital Costs

			T	04/30/2022	Date/Time Prep 9/15/2022 11:	
		Title	xVIII	Hospi tal	PPS	15 diii
Cost Center Description	Capi tal		Ratio of Cost	Inpati ent	Capital Costs	
· ·	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col.	Charges	column 4)	
	Part II, col.	8)	2)	-		
	26)					
	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
54. 00   05400   RADI OLOGY-DI AGNOSTI C	530				241	54.00
57. 00  05700 CT SCAN	128			8, 331	60	57. 00
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)	29	4, 101	0. 007071	0	0	58. 00
60. 00  06000 LABORATORY	25, 156				11, 874	60.00
65. 00   06500   RESPI RATORY THERAPY	3, 206	269, 538	0. 011894	141, 867	1, 687	65. 00
66. 00   06600 PHYSI CAL THERAPY	594, 308	1, 848, 200	0. 321560	778, 335	250, 281	66. 00
67. 00   06700   OCCUPATI ONAL THERAPY	116, 321	1, 789, 285	0. 065010	764, 825	49, 721	67. 00
68. 00   06800   SPEECH PATHOLOGY	49, 763	848, 770	0. 058630	368, 635	21, 613	68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	147, 725	588, 238	0. 251131	199, 701	50, 151	71. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	141, 826	2, 107, 157	0. 067307	837, 982	56, 402	73. 00
74. 00   07400   RENAL DI ALYSI S	5, 844	230, 050	0. 025403	120, 100	3, 051	74. 00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	2, 424	117, 000	0. 020718	20, 000	414	76. 00
OUTPATIENT SERVICE COST CENTERS						
91. 00   09100   EMERGENCY	0	0	0.000000	0	0	91. 00
91. 01   04951   OUTPATI ENT THERAPY	0	0	0.000000	0	0	91. 01
93.00 O4950 OUTPATIENT WOUND CENTER	0	0	0. 000000	0	0	93. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50 through 199)	1, 087, 260	8, 362, 346		3, 494, 459	445, 495	200. 00

Health Financial Systems	Rehabilitation Hospita	al of Northern	Indi	In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVIC	E OTHER PASS THROUGH COST	S Provider CC	F	Period: From 05/01/2021 To 04/30/2022		
		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 CENT	ERS					
30. 00 03000 ADULTS & PEDIATRICS	0	0	C	0	0	30.00
44.00 04400 SKILLED NURSING FACILITY	o	0		0		44.00
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,		ŕ		
	instructions)	minus col. 4)				
	4.00	5. 00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENT	ERS					
30. 00 03000 ADULTS & PEDIATRICS	0	0	7, 760	0.00	3, 294	30.00
44.00 04400 SKILLED NURSING FACILITY		0		0.00	0	44.00
200.00 Total (lines 30 through 199)		0	7, 760		3, 294	200.00
Cost Center Description	I npati ent			*		
·	Program Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENT	ERS					
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
44.00 04400 SKILLED NURSING FACILITY	o					44. 00
200.00 Total (lines 30 through 199)	o					200.00
, ,	1					

Health Financial Systems Rehabilitation Hospital of Northern Indi In Lieu of F						2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLA	RY SERVICE OTHER PASS	S Provi der C		Peri od:	Worksheet D	
THROUGH COSTS				From 05/01/2021	Part IV	
				To 04/30/2022	Date/Time Pre 9/15/2022 11:	
		Title	: XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anesthetist	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1.00	2A	2.00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54. 00
57. 00  05700 CT SCAN	0	0		0 0	0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	0	58. 00
60. 00   06000   LABORATORY	0	0		0	0	60.00
65. 00 06500 RESPIRATORY THERAPY	0	0		0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66. 00

0

0 0 0

0

0 0 0

0

0

67.00

68. 00

0 71.00

76.00

0 93.00

95.00

0 200.00

0 73.00

0 74.00

0 91.00

0 91.01

67. 00 06700 OCCUPATI ONAL THERAPY

07400 RENAL DIALYSIS

04951 OUTPATIENT THERAPY

OTHER REIMBURSABLE COST CENTERS
95. 00 09500 AMBULANCE SERVICES

93. 00 04950 OUTPATIENT WOUND CENTER

07100 MEDICAL SUPPLIES CHARGED TO PATIENTS

03950 OTHER ANCILLARY SERVICE COST CENTERS
OUTPATIENT SERVICE COST CENTERS

Total (lines 50 through 199)

07300 DRUGS CHARGED TO PATIENTS

68. 00 06800 SPEECH PATHOLOGY

09100 EMERGENCY

71.00

73. 00 74. 00

76.00

91.00

91.01

200.00

		itation Hospita			In Lie	u of Form CMS-	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	Provider Co			Worksheet D Part IV	
THROUG	H COSTS				From 05/01/2021 To 04/30/2022		enared.
					10 017 007 2022	9/15/2022 11:	43 am
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
		Education Cost		Cost (sum of		(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
						instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 73, 476		
57.00	05700  CT SCAN	0	0		0 17, 693	0. 000000	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 4, 101	0. 000000	
60.00	06000 LABORATORY	0	0		0 468, 838	0.000000	60.00
65.00	06500 RESPI RATORY THERAPY	0	0		0 269, 538	0. 000000	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0		0 1, 848, 200	0.000000	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	o	0		0 1, 789, 285	0. 000000	67. 00
68.00	06800 SPEECH PATHOLOGY	o	0		0 848, 770	0. 000000	68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	0		0 588, 238	0. 000000	71. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	o	0		0 2, 107, 157	0.000000	73. 00
74.00	07400 RENAL DIALYSIS	o	0		0 230, 050	0.000000	74. 00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	o	0		0 117, 000	0. 000000	76. 00
	OUTPATIENT SERVICE COST CENTERS						1
91.00	09100 EMERGENCY	0	0		0 0	0.000000	91. 00
91. 01	04951 OUTPATIENT THERAPY	o	0		0 0	0. 000000	91. 01
93.00	04950 OUTPATIENT WOUND CENTER	o	0		0 0	0. 000000	93. 00
	OTHER REIMBURSABLE COST CENTERS	'			•		1
95.00	09500 AMBULANCE SERVI CES						95. 00
200.00	Total (lines 50 through 199)	l ol	0		0 8, 362, 346		200.00

Heal th	Health Financial Systems Rehabilitation Hospital of Northern Indi In Lieu of Form CMS-2552-10							
	APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER' THROUGH COSTS		Provider CCN: 15-3		Period: From 05/01/2021 To 04/30/2022	Worksheet D Part IV Date/Time Prepared: 9/15/2022 11:43 am		
				XVIII	Hospi tal	PPS		
	Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent		
		Ratio of Cost	Program	Program	Program	Program		
		to Charges	Charges	Pass-Through		Pass-Through		
		(col. 6 ÷ col.		Costs (col.	3	Costs (col. 9		
		7)		x col. 10)		x col. 12)		
		9. 00	10.00	11. 00	12.00	13. 00		
	ANCILLARY SERVICE COST CENTERS	,				,		
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	33, 382		0	0	54.00	
57. 00	05700 CT SCAN	0. 000000	8, 331		0	0	57. 00	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0	0	58. 00	
60.00	06000 LABORATORY	0. 000000	221, 301		0	0	60.00	
65.00	06500 RESPI RATORY THERAPY	0. 000000	141, 867		0	0	65. 00	
66.00	06600 PHYSI CAL THERAPY	0. 000000	778, 335		0	0	66. 00	
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	764, 825		0	0	67.00	
68. 00	06800 SPEECH PATHOLOGY	0. 000000	368, 635		0 0	0	68. 00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	199, 701		0 0	0	71. 00	
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	837, 982		0 0	0	73. 00	
74.00	07400 RENAL DIALYSIS	0. 000000	120, 100		0 0	0	74. 00	
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	20, 000		0 0	0	76. 00	
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	0. 000000	0		0 0	0	91.00	
91.01	04951 OUTPATIENT THERAPY	0. 000000	0		0 0	0	91. 01	
93.00	04950 OUTPATIENT WOUND CENTER	0. 000000	0		0 0	0	93.00	
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95. 00	
200.00	Total (lines 50 through 199)		3, 494, 459		0 0	0	200. 00	

From 05/01/2021 To 04/30/2022 Part V Date/Time Prepared: 9/15/2022 11:43 am Title XVIII Hospi tal PPS Costs Cost Center Description Cost Cost Reimbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 ANCILLARY SERVICE COST CENTERS 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 57. 00 05700 CT SCAN 0 0 0 0 0 0 0 0 0 57.00 58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 58.00 60. 00 06000 LABORATORY 0 60.00 65. 00 06500 RESPIRATORY THERAPY 65.00 66. 00 |06600 PHYSI CAL THERAPY 0 66.00 06700 OCCUPATI ONAL THERAPY 0 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 0 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 71.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 74.00 07400 RENAL DIALYSIS 0 74.00 76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS 0 0 76.00 OUTPATIENT SERVICE COST CENTERS 91.00 0 91.00 09100 EMERGENCY 0 91.01 04951 OUTPATIENT THERAPY 0 0 91.01 93.00 04950 OUTPATIENT WOUND CENTER 0 0 93.00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 0 95.00 0 200.00 Subtotal (see instructions) 0 200.00 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges

0

202.00

202.00

Net Charges (line 200 - line 201)

Health Financial Systems Rehabi	litation Hospit	al of Northern	Indi	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Period: From 05/01/2021 To 04/30/2022		pared: 43 am
			e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col . 1 - col			
	26)		2)			
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	3, 155, 836	0	3, 155, 83	6 7, 760	406. 68	30.00
44.00 SKILLED NURSING FACILITY	0			0	0.00	44.00
200.00 Total (lines 30 through 199)	3, 155, 836		3, 155, 83	6 7, 760		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	18	7, 320				30.00
44.00 SKILLED NURSING FACILITY	0	0	)			44.00
200.00 Total (lines 30 through 199)	18	7, 320	)			200. 00

	5					6.5. 0110.6	
Health Financial Systems	Rehabilitation Hospit	al of	Northern	Indi	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE	CAPI TAL COSTS	Pi	rovider C	CN: 15-3047	Peri od:	Worksheet D	
					From 05/01/2021	Part II	
					To 04/30/2022	Date/Time Pre	pared:
						9/15/2022 11:4	
			Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total	Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from	Wkst. C.	to Charges	Program	(column 3 x	

			To	04/30/2022	Date/Time Prep 9/15/2022 11:4	pared:
		Ti +I	e XIX	Hospi tal	97 137 2022 11. 4 PPS	43 alli
Cost Center Description	Capi tal		Ratio of Cost	Inpatient	Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,		(col . 1 ÷ col .	Charges	column 4)	
	Part II, col.	8)	2)	3		
	26)	,	,			
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
54. 00   05400   RADI OLOGY-DI AGNOSTI C	530	73, 476	0. 007213	120	1	54.00
57. 00  05700 CT SCAN	128	17, 693	0.007234	0	0	57. 00
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)	29	4, 101	0. 007071	0	0	58. 00
60. 00   06000   LABORATORY	25, 156	468, 838	0. 053656	1, 608	86	60.00
65. 00   06500   RESPI RATORY THERAPY	3, 206	269, 538	0. 011894	21	0	65. 00
66. 00   06600 PHYSI CAL THERAPY	594, 308	1, 848, 200	0. 321560	4, 510	1, 450	66. 00
67. 00   06700 OCCUPATI ONAL THERAPY	116, 321	1, 789, 285	0. 065010	3, 620	235	67. 00
68. 00   06800   SPEECH PATHOLOGY	49, 763	848, 770	0. 058630	1, 800	106	68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	147, 725	588, 238	0. 251131	907	228	71. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	141, 826	2, 107, 157	0. 067307	6, 179	416	73. 00
74.00   07400   RENAL DI ALYSI S	5, 844	230, 050	0. 025403	0	0	74. 00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	2, 424	117, 000	0. 020718	0	0	76. 00
OUTPATIENT SERVICE COST CENTERS						
91. 00   09100   EMERGENCY	0	0	0.000000	0	0	91. 00
91. 01  04951 0UTPATI ENT THERAPY	0	0	0.000000	0	0	91. 01
93. 00 04950 OUTPATIENT WOUND CENTER	0	C	0.000000	0	0	93. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50 through 199)	1, 087, 260	8, 362, 346	)	18, 765	2, 522	200. 00

Health Financial Systems Rehabil	litation Hospita	al of Northern	I ndi	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COST		F	Period: From 05/01/2021 Fo 04/30/2022	Date/Time Pre 9/15/2022 11:	pared: 43 am
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng		Allied Health		
	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	(	0	0	30.00
44.00 04400 SKILLED NURSING FACILITY	0	0	(	0		44. 00
200.00 Total (lines 30 through 199)	0	0	(	0	0	200. 00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	I npati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
	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	7, 760	0.00	18	30.00
44.00  04400 SKILLED NURSING FACILITY		0	(	0.00	0	44. 00
200.00 Total (lines 30 through 199)		0	7, 760	D	18	200. 00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0					30. 00
44.00 04400 SKILLED NURSING FACILITY	O					44. 00
200.00 Total (lines 30 through 199)	o					200. 00
						•

Health Financial Systems	Rehabilitation Hospit	al of Northern	Indi	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCI THROUGH COSTS	LLARY SERVICE OTHER PASS	S Provider CO	Provi der CCN: 15-3047		Worksheet D Part IV Date/Time Prep 9/15/2022 11:4	oared: 43 am
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown	Nursi ng Program	Allied Health Post-Stepdown Adjustments		

			Title XIX		PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health		
	Anesthetist	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1. 00	2A	2. 00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0		0	0	54. 00
57. 00  05700   CT   SCAN	0	0		0	0	57. 00
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)	0	0		0	0	58. 00
60. 00  06000   LABORATORY	0	0		0	0	60.00
65. 00   06500   RESPI RATORY THERAPY	0	0		0	0	65. 00
66. 00   06600 PHYSI CAL THERAPY	0	0		0	0	66. 00
67. 00  06700 OCCUPATI ONAL THERAPY	0	0		0	0	67. 00
68. 00   06800   SPEECH PATHOLOGY	0	0		0	0	68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	71. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73. 00
74. 00   07400   RENAL DI ALYSI S	0	0		0 0	0	74. 00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0 0	0	76. 00
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	0	0		0 0	0	91. 00
91. 01   04951 OUTPATI ENT THERAPY	0	0		0 0	0	91. 01
93. 00 04950 OUTPATIENT WOUND CENTER	0	0		0 0	0	93. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES						95. 00
200.00 Total (lines 50 through 199)	0	0		0 0	0	200. 00

Health Financial Systems Rehabilitation Hospital of Northern Indi In Lieu of Form CMS-2552-1								
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	Provider Co		Peri od:	Worksheet D		
THROUG	H COSTS				From 05/01/2021 To 04/30/2022		narad.	
					10 04/30/2022	9/15/2022 11:		
			Titl	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	1					4	
	05400 RADI OLOGY-DI AGNOSTI C	0	0		73, 476	•		
	05700 CT SCAN	0	0		17, 693			
	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		4, 101			
	06000 LABORATORY	0	0		468, 838	l .	1	
	06500 RESPI RATORY THERAPY	0	0		269, 538	l .	1	
	06600 PHYSI CAL THERAPY	0	0		1, 848, 200	1	1	
	06700 OCCUPATI ONAL THERAPY	0	0		1, 789, 285	l		
	06800 SPEECH PATHOLOGY	0	0		848, 770	l .		
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		588, 238			
	07300 DRUGS CHARGED TO PATIENTS	0	0		2, 107, 157	l .	•	
	07400 RENAL DIALYSIS	0	0		230, 050	l .	•	
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0		117, 000	0. 000000	76. 00	
	OUTPATIENT SERVICE COST CENTERS							
	09100 EMERGENCY	0	0		0	0. 000000		
91. 01	04951 OUTPATI ENT THERAPY	0	0		0	0.000000	91. 01	
93.00	04950 OUTPATIENT WOUND CENTER	0	0		0	0.000000	93. 00	
	OTHER REIMBURSABLE COST CENTERS						4	
	09500 AMBULANCE SERVICES						95. 00	
200.00	Total (lines 50 through 199)	0	0		8, 362, 346		200. 00	

Health Financial Systems Rehabilitation Hospital of Northern Indi In Lieu of Form CMS-2552-10							
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER SH COSTS			CN: 15-3047 F	Period: From 05/01/2021 To 04/30/2022	Worksheet D Part IV Date/Time Pre 9/15/2022 11:	
			Titl	e XIX	Hospi tal	PPS	
	Cost Center Description	Outpati ent	Inpati ent	I npati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷ col.		Costs (col. 8		Costs (col. 9	
		7)		x col. 10)		x col. 12)	
	T	9. 00	10.00	11. 00	12.00	13.00	
	ANCILLARY SERVICE COST CENTERS			,	_		
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	120	[ C	0	0	54. 00
57. 00	05700  CT SCAN	0. 000000	0	[ C	0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0	[ C	0	0	58. 00
60.00	06000 LABORATORY	0. 000000	1, 608	[ C	0	0	60.00
65. 00	06500 RESPI RATORY THERAPY	0. 000000	21	[ C	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 000000	4, 510	C	0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	3, 620	C	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	1, 800	C	0	0	68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	907	C	0	0	71. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	6, 179	C	0	0	73. 00
74.00	07400 RENAL DIALYSIS	0. 000000	0	C	0	0	74. 00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0	C	0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	0. 000000	0	C	0	0	91.00
91. 01	04951 OUTPATI ENT THERAPY	0. 000000	0	C	0	0	91. 01
93.00	04950 OUTPATIENT WOUND CENTER	0. 000000	0	C	0	0	93. 00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES						95. 00
200.00	Total (lines 50 through 199)		18, 765	[ c	0	0	200. 00

Heal th	Fi nan	ncial Systems Rehabi	litation Hospit	al of Northern	Indi	In Lie	u of Form CMS-	2552-10
APPORT	TI ONMEN	NT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der C		Peri od:	Worksheet D	
						From 05/01/2021 To 04/30/2022	Part V Date/Time Pre	narod:
						10 04/30/2022	9/15/2022 11:	43 am
				Ti tl	e XIX	Hospi tal	PPS	
					Charges		Costs	
		Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
			Ratio From	Services (see		Rei mbursed	(see inst.)	
			Worksheet C,	inst.)	Servi ces	Services Not		
			Part I, col. 9		Subject To	Subject To		
					Ded. & Coins.			
					(see inst.)	(see inst.)		
			1.00	2. 00	3.00	4. 00	5. 00	
		LARY SERVICE COST CENTERS						
54.00		RADI OLOGY-DI AGNOSTI C	0. 299499	0	1	0	0	0 00
57.00	05700	CT SCAN	0. 299440	0		0 0	0	57. 00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0. 298951	0	)	0 0	0	58. 00
60.00	06000	LABORATORY	0. 161350	0	)	0 0	0	60.00
65.00	06500	RESPI RATORY THERAPY	0. 514306	0	)	0	0	65.00
66.00	06600	PHYSI CAL THERAPY	0. 922084	0	1	0 0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0. 461874	0	1	0 0	0	67. 00
68.00	06800	SPEECH PATHOLOGY	0. 511001	0	)	0 0	0	68. 00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 730626	0	)	0 0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0. 400460	l o	)	0	0	73.00
74.00	07400	RENAL DIALYSIS	1. 265820	l e	,	0	0	1
	1	OTHER ANCILLARY SERVICE COST CENTERS	1. 016556	l e	,	0	0	1
		TIENT SERVICE COST CENTERS			'			
91.00		EMERGENCY	0. 000000	0		0 0	0	91.00
91. 01	04951	OUTPATIENT THERAPY	0. 000000		,	0	0	91. 01
		OUTPATIENT WOUND CENTER	0. 000000		1	0	0	
		REIMBURSABLE COST CENTERS		-	I			1
95 00		AMBULANCE SERVICES	0. 000000	0		0		95. 00
200.00		Subtotal (see instructions)	3.00000	l n		o o	Ω	200.00
201.00	1	Less PBP Clinic Lab. Services-Program		Ĭ		0	Ü	201.00
201.00	1	Only Charges						
202.00		Net Charges (line 200 - line 201)		0		0 0	0	202. 00

| Period: | Worksheet D | From 05/01/2021 | Part V | To 04/30/2022 | Date/Time Prepared:

Title XIX   Hospital   PPS					То	04/30/2022	Date/Time Pro 9/15/2022 11:	
Cost Center Description			Titl	e XIX		Hospi tal		
Reimbursed   Services   Subject To   Ded. & Coins.   (See inst.)   Ded. & Coins.   Ded. & Coins.   (See inst.)   Ded. & Coins.   Ded. & Coin		Cos	sts					
Services	Cost Center Description	Cost	Cost					
Subject To   Ded. & Coin s.   Subject To   Ded. & Coin s.   (see inst.)	·	Rei mbursed	Rei mbursed					
Ded. & Coins. (see inst.)   Ded. & Coins. (see inst.)		Servi ces	Services Not					
See inst.   (see inst.   )		Subject To	Subject To					
ANCILLARY SERVICE COST CENTERS   54.00   05400   RADI OLOGY-DI AGNOSTI C   0   0   0   0   0   0   0   0   0		Ded. & Coins.	Ded. & Coins.					
ANCILLARY SERVICE COST CENTERS   54.00   05400 RADI OLOGY-DI AGNOSTI C   0   0   0   0   0   0   0   0   0								
54. 00		6.00	7. 00					
57. 00   05700   CT SCAN   0   0   0   0   58.00   MAGNETIC RESONANCE IMAGING (MRI ) 0   0   0   0   0   0   0   0   0   0								
58.00   05800   MAGNETIC RESONANCE IMAGING (MRI)   0 0 0   0 60.00   60.00		0	0					
60. 00 06000 LABORATORY 0 0 0 0 65. 00 65. 00 06500 RESPI RATORY THERAPY 0 0 0 0 65. 00 66. 0		0	0					
65. 00		0	0					
66. 00   06600   PHYSI CAL THERAPY   0   0   0   0   66. 00   67. 00   06700   0CCUPATI ONAL THERAPY   0   0   0   0   67. 00   68. 00   06800   SPECH PATHOLOGY   0   0   0   0   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   74. 00   07400   RENAL DI ALYSI S   0   0   0   76. 00   03950   OTHER ANCI LLARY SERVI CE COST CENTERS   0   0   76. 00   0017PATI ENT SERVI CE COST CENTERS   0   0   77. 00   09100   EMERGENCY   0   0   78. 00   04951   OUTPATI ENT THERAPY   0   0   791. 01   04951   OUTPATI ENT WOUND CENTER   0   0   795. 00   OTHER REI MBURSABLE COST CENTERS   0   795. 00   OTHER REI MBURSABLE COST CENTERS   0   795. 00   OUTPATI ENT SERVI CE S   0   796. 00   OUTPATI ENT WOUND CENTER   0   0   797. 00   OUTPATI ENT SUBJECT COST CENTERS   0   798. 00   OUTPATI ENT WOUND CENTER   0   0   799. 00   OUTPATI ENT WOUND CENTER   0   0   799. 00   OUTPATI ENT SUBJECT COST CENTERS   0   790. 00   OUTPATI ENT WOUND CENTER   0   0   790. 00   00   0   0   790. 00   00   00   0   790. 00   00   00   0   790		0	0					
67. 00		0	0					
68. 00		0	0					
71. 00		0	0					
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 74. 00 74. 00 74. 00 07400 RENAL DIALYSIS 0 0 0 74. 00 76. 00 03950 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	0					•
74. 00		0	0					
76. 00 03950 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	0					
OUTPATI ENT SERVI CE COST CENTERS   O		0	0					
91. 00		0	0					76. 00
91. 01								
93. 00		0	0					
OTHER REIMBURSABLE COST CENTERS   95.00		0	0					
95. 00		0	0					93. 00
200.00 Subtotal (see instructions) 0 0 200.00 Less PBP Clinic Lab. Services-Program 0 0 0 1 201.00								
201.00 Less PBP Clinic Lab. Services-Program 0 201.00 Only Charges		0						
Only Charges		0	0					
		0						201. 00
202.00   Net Charges (line 200 - line 201)   0  0   202.00								
	202.00   Net Charges (line 200 - line 201)	0	0					202. 00

Health Financial Systems	Rehabilitation Hospital	of Northern Indi	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-3047	Period: From 05/01/2021	Worksheet D-1
				Date/Time Prepared: 9/15/2022 11:43 am
		Title XVIII	Hosni tal	DDS

		Title XVIII	Hospi tal	9/15/2022 11: PPS	43 am_
	Cost Center Description	IT LITE AVITE	поѕрі таі	PPS	
	<u> </u>			1. 00	
	PART I - ALL PROVIDER COMPONENTS				
1. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days	excluding newborn)		7, 760	1. 00
2. 00	Inpatient days (including private room days, excluding swing-			7, 760	
3.00	Private room days (excluding swing-bed and observation bed day	ys). If you have only pr	ivate room days,	0	3. 00
	do not complete this line.			7.7/0	
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private roo		r 21 of the cost	7, 760 0	4. 00 5. 00
5.00	reporting period	on days) through becembe	i 31 or the cost	U	5.00
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)				
7. 00	Total swing-bed NF type inpatient days (including private roor reporting period	m days) through December	31 of the cost	0	7. 00
8. 00	Teporting period  Total swing-bed NF type inpatient days (including private room	m days) after December 3	1 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	44,5) 4. (5. 255525. 5	. 01 1110 0001	· ·	0.00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	3, 294	9. 00
10.00	newborn days) (see instructions)	alv. (i nalveli na priveto r	aam daya)	0	10.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII on through December 31 of the cost reporting period (see instruc-	tions)	Dolli days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, en				
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	only (including private	e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI)	Conty (including private	e room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar ye				
14. 00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed	days)	0	14. 00
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)	0	15. 00		
16.00	SWING BED ADJUSTMENT			U	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17. 00
	reporting period				
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	0.00	18. 00		
19. 00	Medicaid rate for swing-bed NF services applicable to services	0.00	19. 00		
	reporting period				
20. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s after December 31 of t	he cost	0.00	20. 00
21. 00	Total general inpatient routine service cost (see instructions	5)		10, 171, 744	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ing period (line	0	
22.00	5 x line 17)	21 -6			22.00
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24. 00
	7 x line 19)				05 00
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	31 of the cost reporting	period (line 8	0	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)		10, 171, 744	27. 00
20.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	d and abasevetion had ab	2222)	0	20.00
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	a and observation bed ch	ar ges)	0	28. 00 29. 00
30. 00	Semi -private room charges (excluding swing-bed charges)			0	30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27	: line 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 min	nus lino 22)(soo instrus	tions)	0. 00 0. 00	
35. 00	Average per diem private room cost differential (line 34 x line)		tions)	0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	.5 (1.)		0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	10, 171, 744	37. 00		
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 310. 79	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	•		4, 317, 742	
40.00	Medically necessary private room cost applicable to the Progra	•		0	
41.00	Total Program general inpatient routine service cost (line 39	+ IINE 40)	l	4, 317, 742	41.00

Heal th	Financial Systems Rehab	oilitation Hospital	of Norther	n Indi	In Lie	u of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST			CCN: 15-3047	Period: From 05/01/2021	Worksheet D-1	
					To 04/30/2022	Date/Time Pre	pared:
			Ti tl	e XVIII	Hospi tal	9/15/2022 11: PPS	<u>43 am</u>
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost In	patient Day	sDiem (col. 1 col. 2)	÷	(col. 3 x col. 4)	
		1.00	2.00	3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only)						42. 00
43. 00	Intensive Care Type Inpatient Hospital Unit INTENSIVE CARE UNIT	ts					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
	cost center bescription					1. 00	
48. 00	Program inpatient ancillary service cost (					2, 034, 320	48. 00
49. 00	Total Program inpatient costs (sum of lines	s 41 through 48)(se	e instructi	ons)		6, 352, 062	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS  Pass through costs applicable to Program in	nnationt routine se	rvices (fro	m Wket D su	m of Parts I and	1, 339, 604	50.00
30.00	III)	inpatrent routine se	ivices (iio	III WKSt. D, Sui	ii Oi Taits T and	1, 337, 004	30.00
51. 00	Pass through costs applicable to Program in and IV)	npatient ancillary	services (f	rom Wkst. D, s	sum of Parts II	445, 495	51. 00
52.00	Total Program excludable cost (sum of line	s 50 and 51)				1, 785, 099	52. 00
53. 00	Total Program inpatient operating cost exc medical education costs (line 49 minus line		ted, non-ph	ysi ci an anestl	netist, and	4, 566, 963	53. 00
F 4 00	TARGET AMOUNT AND LIMIT COMPUTATION						
54. 00 55. 00	Program discharges Target amount per discharge					0 0. 00	
56. 00	Target amount (line 54 x line 55)					0.00	1
57.00	Difference between adjusted inpatient opera	ating cost and targ	et amount (	line 56 minus	line 53)	0	
58. 00	Bonus payment (see instructions)	reporting period an	di na 100/	undated and a	ampaundad by tha	0	
59. 00	Lesser of lines 53/54 or 55 from the cost market basket	reporting period en	urng 1996,	updated and co	onipounded by the	0. 00	59. 00
60.00	Lesser of lines 53/54 or 55 from prior year					0. 00	
61. 00	If line 53/54 is less than the lower of line 53/54 is less than 53/54 is					0	61. 00
	which operating costs (line 53) are less the amount (line 56), otherwise enter zero (see		(II nes 54 x	60), or 1% of	r the target		
62.00	Relief payment (see instructions)	5 11.5tr <b>d</b> 5tr 51.5)				0	62. 00
63.00	Allowable Inpatient cost plus incentive page	yment (see instruct	i ons)			0	63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine co	osts through Decemb	er 31 of th	e cost report	ng period (See	0	64. 00
(F 00	instructions)(title XVIII only)	aata aftan Daaamban	21 of the	anat ranartin	a norted (Coo		45.00
65. 00	Medicare swing-bed SNF inpatient routine coinstructions)(title XVIII only)					0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient rou	tine costs (line 64	plus line	65)(title XVI	II only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient rout	ine costs through D	ecember 31	of the cost r	eporting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient rout	ine costs after Dec	ember 31 of	the cost rep	orting period	0	68. 00
(0.00	(line 13 x line 20)	++: /I:	/7	- (0)			(0.00
69. 00	Total title V or XIX swing-bed NF inpatien: PART III - SKILLED NURSING FACILITY, OTHER					0	69. 00
70. 00	Skilled nursing facility/other nursing facility				)		70. 00
71.00	Adjusted general inpatient routine service	•	e 70 ÷ line	2)			71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost appli		line 14 v l	ine 35)			72. 00 73. 00
74. 00	Total Program general inpatient routine se						74.00
75.00	Capital -related cost allocated to inpatien	•		•	Part II column		75. 00
75.00	·				ar c rry coranni		

Health Financial Systems Rehabi	litation Hospit	al of Northern	Indi	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 05/01/2021 To 04/30/2022	Date/Time Pre 9/15/2022 11:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	3, 155, 836	10, 171, 744	0. 31025	5 0	0	90. 00
91.00 Nursing Program cost	0	10, 171, 744	0.00000	0	0	91.00
92.00 Allied health cost	0	10, 171, 744	0.00000	0	0	92. 00
93.00 All other Medical Education	0	10, 171, 744	0. 00000	0	0	93. 00

Health Financial Systems	Rehabilitation Hospital	of Northern Indi	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-3047	Period: From 05/01/2021	Worksheet D-1
			To 04/30/2022	Date/Time Prepared: 9/15/2022 11:43 am
		Title XIX	Hosni tal	PDS

		Title XIX	Hospi tal	9/15/2022 11: PPS	43 am
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS				
1. 00 2. 00 3. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-bed and observation bed days).	ped and newborn days)	vate room days,	7, 760 7, 760 0	1. 00 2. 00 3. 00
4. 00 5. 00	do not complete this line.  Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private room reporting period	7, 760 0	4. 00 5. 00		
6. 00	Total swing-bed SNF type inpatient days (including private roof reporting period (if calendar year, enter 0 on this line)	om days) after December :	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private roor reporting period	m days) through December	31 of the cost	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)			0	8. 00
9. 00	Total inpatient days including private room days applicable to newborn days) (see instructions)	9 . 9		18	9. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII on through December 31 of the cost reporting period (see instructions).	tions)	,	0	10.00
11. 00 12. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er Swing-bed NF type inpatient days applicable to titles V or XI)	nter O on this line)		0	11. 00 12. 00
13. 00	through December 31 of the cost reporting period  Swing-bed NF type inpatient days applicable to titles V or XI)	3 ( 3 !	,	0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra	ear, enter O on this line	e)	0	14. 00
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)	, 3	3 /	0	15. 00 16. 00
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00
19. 00					19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services reporting period	s after December 31 of th	ne cost	0.00	20. 00
21. 00 22. 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through Decembe		ng period (line	10, 171, 744 0	21. 00 22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December $ 7 \times 1 $ ine 19)	r 31 of the cost reporti	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December (x line 20)	31 of the cost reporting	period (line 8	0	25. 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		0 10, 171, 744	26. 00 27. 00
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)		,	0	29. 00
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges)	· Lino 29)		0. 000000	30. 00 31. 00
32. 00	General inpatient routine service cost/charge ratio (line 27 - Average private room per diem charge (line 29 ÷ line 3)	- 111le 20)		0.00000	32.00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33. 00
34.00	Average per diem private room charge differential (line 32 mir	nus line 33)(see instruc	tions)	0.00	
35.00	Average per diem private room cost differential (line 34 x line		,	0.00	35. 00
36.00	Private room cost differential adjustment (line 3 x line 35)	•		0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	and private room cost di	fferential (line	10, 171, 744	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ICTMENTS			
20 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU		ı	1 210 70	20.00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line	*		1, 310. 79 23, 594	38. 00 39. 00
40. 00	Medically necessary private room cost applicable to the Progra	•		23, 594	40.00
	Total Program general inpatient routine service cost (line 39)	,		23, 594	

		itation Hospita				u of Form CMS-2	
COMPUTA	TION OF INPATIENT OPERATING COST		Provider C	CN: 15-3047	Peri od: From 05/01/2021 To 04/30/2022	Worksheet D-1 Date/Time Pre	
						9/15/2022 11:	
	0 1 0 1 0 1	Ŧ		e XIX	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total npatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4. 00	5. 00	
	NURSERY (title V & XIX only)						42. 00
	ntensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT						43. 00
	CORONARY CARE UNIT						44.00
	BURN INTENSIVE CARE UNIT						45. 00
	SURGICAL INTENSIVE CARE UNIT						46. 00
4	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description						
40.00			1: 000)			1.00	10.00
	Program inpatient ancillary service cost (Wk: Total Program inpatient costs (sum of lines 4			nc)		10, 194 33, 788	
49.00 F	PASS THROUGH COST ADJUSTMENTS	+1 till ough 46) (3	see mstructro	) (S)		33, 700	1 49.00
50. 00	Pass through costs applicable to Program inpa	atient routine s	services (from	n Wkst. D, sur	n of Parts I and	7, 320	50. 00
51. 00	Pass through costs applicable to Program inpa and IV)	atient ancillary	services (fr	om Wkst. D,	sum of Parts II	2, 522	51.00
	Total Program excludable cost (sum of lines!	50 and 51)				9, 842	52.00
	Total Program inpatient operating cost exclu		ated, non-phy	/sician anestl	netist, and	23, 946	53.00
	medical education costs (line 49 minus line ! FARGET AMOUNT AND LIMIT COMPUTATION	52)					
_	Program discharges					0	54.00
	Target amount per discharge					0.00	
56. 00	Target amount (line 54 x line 55)					0	56.00
	Difference between adjusted inpatient operati	ing cost and tar	get amount (I	ine 56 minus	line 53)	0	
	Bonus payment (see instructions)					0	
	Lesser of lines 53/54 or 55 from the cost rep market basket	porting period e	ending 1996, t	updated and co	ompounded by the	0. 00	59. 00
	Lesser of lines 53/54 or 55 from prior year (	cost report, upo	lated by the m	narket basket		0. 00	60.00
	If line 53/54 is less than the lower of lines				the amount by	0	61.00
	which operating costs (line 53) are less than		(lines 54 x	60), or 1% of	f the target		
	amount (line 56), otherwise enter zero (see i	nstructions)				0	/2.00
	Relief payment (see instructions) Allowable Inpatient cost plus incentive paymo	ent (see instruc	tions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST	cht (acc matruc				U	03.00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Decem	ber 31 of the	cost reporti	ng period (See	0	64. 00
	instructions)(title XVIII only)		0.4				/
	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decembe	er 31 of the d	cost reporting	g period (See	0	65. 00
	Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	4 plus line 6	55)(title XVII	Lonly) For	0	66.00
	CAH (see instructions)			, (		_	
	Title V or XIX swing-bed NF inpatient routing	e costs through	December 31 c	of the cost re	eporting period	0	67. 00
	(line 12 x line 19)	a acata after Da	oombor 21 of	the cost ross	anting paried	0	40.00
	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs after be	cember 31 01	the cost repo	orting period	0	68. 00
	Total title V or XIX swing-bed NF inpatient (	routine costs (I	ine 67 + line	e 68)		0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NU						
1	Skilled nursing facility/other nursing facili				)		70.00
	Adjusted general inpatient routine service co	,	ne 70 ÷ line	2)			71.00
1	Program routine service cost (line 9 x line 1	•	(line 14 v !!	no 3E)			72.00
	Medically necessary private room cost applica Total Program general inpatient routine servi						73.00
4	Capital-related cost allocated to inpatient	•	,		Part II, column		75.00
	26, line 45)		(		,		
76. 00		ne 2)					

Health Financial Systems Rehabi	litation Hospit	al of Northern	Indi	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 05/01/2021 To 04/30/2022	Date/Time Prep 9/15/2022 11:4	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	3, 155, 836	10, 171, 744	0. 31025	5 0	0	90. 00
91.00 Nursing Program cost	0	10, 171, 744	0.00000	0	0	91.00
92.00 Allied health cost	0	10, 171, 744	0.00000	0	0	92. 00
93.00 All other Medical Education	0	10, 171, 744	0. 00000	0 0	0	93. 00

Health Financial Systems Rehabilitation Hospita	l of Northern	Indi	In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od:	Worksheet D-3	
			From 05/01/2021 To 04/30/2022	Date/Time Prep 9/15/2022 11:4	
	Titl∈	XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	0.00	2)	
INDATIENT DOUTINE CEDVICE COCT CENTERS		1.00	2. 00	3. 00	
30.00 O3000 ADULTS & PEDIATRICS			3, 294, 000		30. 00
ANCI LLARY SERVI CE COST CENTERS			3, 294, 000		30.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 29949	99 33, 382	9, 998	54. 00
57. 00   05700   CT   SCAN		0. 29944		2, 495	
58. 00   05800   MAGNETIC RESONANCE I MAGING (MRI)		0. 29895		2, 473	1
60. 00   06000   LABORATORY		0. 16135		35. 707	60.00
65. 00   06500   RESPI RATORY THERAPY		0. 51430			
66. 00   06600   PHYSI CAL THERAPY		0. 92208			1
67. 00 06700 OCCUPATI ONAL THERAPY		0. 46187		·	
68. 00 06800 SPEECH PATHOLOGY		0. 51100		·	1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 73062		·	1
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 40046			1
74. 00 07400 RENAL DIALYSIS		1. 26582		·	
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS		1. 01655	20, 000	20, 331	76. 00
OUTPATIENT SERVICE COST CENTERS		•			
91. 00 09100 EMERGENCY		0.00000	00	0	91.00
91. 01   04951   OUTPATI ENT THERAPY		0.00000	0 0	0	91. 01
93.00 O4950 OUTPATIENT WOUND CENTER		0.00000	00	0	93. 00
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVICES					95. 00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			3, 494, 459	2, 034, 320	200. 00
201.00 Less PBP Clinic Laboratory Services-Program only charge	es (line 61)		0		201. 00
202.00 Net charges (line 200 minus line 201)		1	3, 494, 459		202. 00

Hool +h	Financial Systems Rehabilitation Hospital	of Northorn	Lndi	In Lie	u of Form CMS-2	DEE2 10
	Financial Systems Rehabilitation Hospital ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od:	Worksheet D-3	2332-10
1 101 7311	ENT ANOTEERIN'T SERVICE GOST ATTORTTONMENT	ITOVIACI C	011. 13 3047	From 05/01/2021		
				To 04/30/2022	Date/Time Pre 9/15/2022 11:	
		Titl	e XIX	Hospi tal	PPS	+5 diii
	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	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00	03000 ADULTS & PEDI ATRI CS			18, 000		30. 00
	ANCI LLARY SERVI CE COST CENTERS					
	05400 RADI OLOGY-DI AGNOSTI C		0. 29949		36	
57. 00	05700 CT SCAN		0. 29944		0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 29895		0	58. 00
60. 00	06000 LABORATORY		0. 16135		259	60.00
65. 00	06500 RESPI RATORY THERAPY		0. 51430		11	65. 00
66.00	06600 PHYSI CAL THERAPY		0. 92208		4, 159	66. 00
67. 00	06700 OCCUPATIONAL THERAPY		0. 46187		1, 672	67. 00
68. 00	06800 SPEECH PATHOLOGY		0. 51100	,	920	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 73062		663	
	07300 DRUGS CHARGED TO PATIENTS		0. 40046			73. 00
74.00	07400 RENAL DI ALYSI S		1. 26582		0	
76. 00	03950 OTHER ANCILLARY SERVICE COST CENTERS   OUTPATIENT SERVICE COST CENTERS		1. 01655	06 0	0	76. 00
01 00	09100 EMERGENCY		0.00000	00 0	0	91. 00
	04951 OUTPATIENT THERAPY		0.00000		0	91.00
	04950 OUTPATIENT WOUND CENTER		0.00000		0	
73.00	OTHER REIMBURSABLE COST CENTERS		0.00000	0	U	73.00
95 00	09500 AMBULANCE SERVICES					95. 00
200.00				18, 765	10, 194	
200.00		(line 61)		18, 703	•	200.00
202.00		(Time Oi)		18, 765		201.00
202.00	The sharges (Title 200 millios Title 201)		1	10,700	l	1202.00

Part I

From 05/01/2021 04/30/2022 Date/Time Prepared: 9/15/2022 11:43 am Title XVIII Hospi tal PPS Part B Inpatient Part A mm/dd/yyyy mm/dd/yyyy Amount Amount 1.00 2.00 3.00 4.00 1.00 Total interim payments paid to provider 5, 654, 969 1. 00 0 2.00 Interim payments payable on individual bills, either 2.00 submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment 3.00 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 ADJUSTMENTS TO PROVIDER 0 0 3.01 0 3.02 0 3.02 3.03 0 3.03 0 3.04 0 0 3.04 3.05 0 0 3.05 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 0 0 3.50 3.51 0 3.51 0 0 3.52 3.52 0 3.53 0 3.53 0 3.54 0 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 0 0 3.99 3.50-3.98) 5, 654, 969 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 0 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropri ate) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after 5.00 desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 5.01 TENTATIVE TO PROVIDER 0 0 5.02 0 0 5.02 0 5.03 0 5.03 Provider to Program 5.50 TENTATI VE TO PROGRAM 0 0 5.50 5.51 0 0 5. 51 0 5.52 0 5.52 5. 99 0 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 5. 99 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on 6.00 the cost report. (1) SETTLEMENT TO PROVIDER 6.01 205, 327 0 6.01 6 02 SETTLEMENT TO PROGRAM 0 6.02 7.00 Total Medicare program liability (see instructions) 5, 860, 296 7.00 Contractor NPR Date (Mo/Day/Yr) Number 0 1 00 2 00 8.00 Name of Contractor 8.00

Health Financial Systems	Rehabilitation Hospital	of Northern Indi	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-3047	Peri od: From 05/01/2021	Worksheet E-3

04/30/2022 Date/Time Prepared:

9/15/2022 11:43 am Title XVIII Hospi tal PPS 1.00 PART III - MEDICARE PART A SERVICES - IRF PPS Net Federal PPS Payment (see instructions) 5, 616, 032 1.00 Medicare SSI ratio (IRF PPS only) (see instructions) 0.0311 2.00 2.00 Inpatient Rehabilitation LIP Payments (see instructions) 218.464 3.00 3.00 4.00 Outlier Payments 108, 222 4.00 5.00 Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior 0.00 5.00 to November 15, 2004 (see instructions) 5.01 Cap increases for the unweighted intern and resident FTE count for residents that were displaced by 0.00 5. 01 program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR  $\S412.424(d)(1)(iii)(F)(1)$  or (2) (see instructions) New Teaching program adjustment. (see instructions) 6.00 0.00 6.00 7.00 Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new 0.00 7.00 teaching program" (see instructions) Current year's unweighted I&R FTE count for residents within the new program growth period of a "new 0 00 8 00 8 00 teaching program" (see instructions) 9.00 Intern and resident count for IRF PPS medical education adjustment (see instructions) 0.00 9 00 21. 260274 10.00 Average Daily Census (see instructions) 10.00 Teaching Adjustment Factor (see instructions) 0.000000 11.00 11.00 12.00 Teaching Adjustment (see instructions) 12.00 13.00 Total PPS Payment (see instructions) 5, 942, 718 13.00 14.00 Nursing and Allied Health Managed Care payments (see instruction) 14.00 Ω 15.00 Organ acquisition (DO NOT USE THIS LINE) 15.00 16.00 Cost of physicians' services in a teaching hospital (see instructions) 16.00 17.00 Subtotal (see instructions) 5, 942, 718 17.00 18.00 Primary payer payments 18.00 5. 942. 718 19.00 Subtotal (line 17 less line 18). 19 00 20.00 Deducti bl es 46,508 20.00 21.00 Subtotal (line 19 minus line 20) 5, 896, 210 21.00 22.00 Coi nsurance 58.373 22.00 23.00 Subtotal (line 21 minus line 22) 5, 837, 837 23.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 41, 771 24.00 24.00 25.00 Adjusted reimbursable bad debts (see instructions) 27, 151 25.00 38 879 26 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 26 00 27.00 Subtotal (sum of lines 23 and 25) 5, 864, 988 27.00 Direct graduate medical education payments (from Wkst. E-4, line 49) 28.00 0 28.00 29.00 Other pass through costs (see instructions) 29.00 30 00 Outlier payments reconciliation 30.00 0 31.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 31.00 31.50 Pioneer ACO demonstration payment adjustment (see instructions) 31.50 31.98 Recovery of accelerated depreciation. 31.98 Λ 31 99 Demonstration payment adjustment amount before sequestration 0 31 99 32.00 Total amount payable to the provider (see instructions) 5, 864, 988 32.00 32.01 Sequestration adjustment (see instructions) 4,692 32.01 32.02 Demonstration payment adjustment amount after sequestration 32.02 33.00 Interim payments 5, 654, 969 33 00 34.00 Tentative settlement (for contractor use only) 34.00 Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34) 35.00 205, 327 35.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 36.00 0 36.00 TO BE COMPLETED BY CONTRACTOR 50.00 Original outlier amount from Wkst. E-3, Pt. III, line 4 108, 222 50.00 Outlier reconciliation adjustment amount (see instructions) 51.00 0 51.00 52.00 The rate used to calculate the Time Value of Money 0.00 52.00 Time Value of Money (see instructions) 53.00 53.00 0 FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-19 PHE 99 00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 0.000000 99 00 99.01 Calculated Teaching Adjustment Factor for the current year. (see instructions) 0.000000 99.01

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

Provider CCN: 15-3047

Peri od: Worksheet G From 05/01/2021 To 04/30/2022 Date/Time Prepared:

onl y)			'	0 04/30/2022	9/15/2022 11:	
		General Fund	Speci fi c	Endowment Fund		
		1. 00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS			1		
1.00	Cash on hand in banks	100, 216		9	0	1.00
2. 00 3. 00	Temporary investments Notes receivable	0		_	0	2. 00 3. 00
4. 00	Accounts receivable	2, 463, 958	1	0	0	4. 00
5. 00	Other recei vable	0		Ö	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	-339, 220	) c	0	0	6. 00
7.00	Inventory	79, 133		0	0	7. 00
8.00	Prepai d expenses	287, 173	S	0	0	
9. 00 10. 00	Other current assets Due from other funds	0		0	0	9. 00 10. 00
11. 00	Total current assets (sum of lines 1-10)	2, 591, 260		_		11.00
11.00	FIXED ASSETS	2,071,200	1	<u> </u>		11.00
12.00	Land	0	) C	0	0	12. 00
13. 00	Land improvements	0	) c		_	13. 00
14. 00	Accumulated depreciation	0	0	0	0	14.00
15. 00 16. 00	Buildings Accumulated depreciation	22, 063, 736 -854, 590	1	0	0	15. 00 16. 00
17. 00	Leasehold improvements	104, 469		_	0	17. 00
18. 00	Accumulated depreciation	0		Ö	0	18. 00
19. 00	Fi xed equipment	-104, 469	) c	0	0	19. 00
20. 00	Accumulated depreciation	0	) c	0	0	20. 00
21. 00	Automobiles and trucks	0	) C	0	0	21.00
22. 00	Accumulated depreciation	7/0 200	) C	0	0	22. 00
23. 00 24. 00	Major movable equipment Accumulated depreciation	769, 308 -435, 862		0	0	23.00
25. 00	Mi nor equi pment depreci abl e	-433, 602		0	0	25. 00
26. 00	Accumulated depreciation	Ö			Ö	26. 00
27. 00	HIT designated Assets	0	) c	0	0	27. 00
28. 00	Accumulated depreciation	0	) C	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	04 540 500		_	0	29. 00
30. 00	Total fixed assets (sum of lines 12-29)  OTHER ASSETS	21, 542, 592	<u> </u>	0	0	30.00
31. 00	Investments	0	) (	0	0	31.00
32. 00	Deposits on Leases	0	o	0	0	32. 00
33. 00	Due from owners/officers	0	) c	0	0	33. 00
34. 00	Other assets	51, 100, 705		_	0	34. 00
35. 00	Total other assets (sum of lines 31-34)	51, 100, 705	1	_	0	35.00
36. 00	Total assets (sum of lines 11, 30, and 35)  CURRENT LIABILITIES	75, 234, 557		ı U	0	36.00
37. 00	Accounts payable	334, 730	) (	0	0	37. 00
38. 00	Salaries, wages, and fees payable	396, 837	•	0	0	38. 00
39. 00	Payroll taxes payable	49, 134	· c	0	0	39. 00
40. 00	Notes and Loans payable (short term)	0	0	0	0	40.00
41. 00	Deferred income	0		0	0	41.00
42. 00 43. 00	Accelerated payments Due to other funds	) 		0	0	42. 00 43. 00
44. 00	Other current liabilities	59, 479, 788		0	0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	60, 260, 489		0		
	LONG TERM LIABILITIES					
46. 00	Mortgage payable	0	0	_	0	
47. 00	Notes payable	0	C			
48. 00 49. 00	Unsecured Loans Other Long term Liabilities	20, 859, 025		_	0	48. 00 49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	20, 859, 025			0	50.00
51. 00	Total liabilities (sum of lines 45 and 50)	81, 119, 514				51.00
	CAPI TAL ACCOUNTS					
52.00	General fund balance	-5, 884, 957	1			52. 00
53. 00	Specific purpose fund		C			53.00
54. 00 55. 00	Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted			0		54. 00 55. 00
56. 00	Governing body created - endowment fund balance			0		56.00
57. 00	Plant fund balance - invested in plant				0	
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
	repl acement, and expansion		1			
59.00	Total fund balances (sum of lines 52 thru 58)	-5, 884, 957		0	0	
60. 00	Total liabilities and fund balances (sum of lines 51 and 59)	75, 234, 557	1		0	60.00
	l~·/	ı	I.	1	ı	ı

Health Financial Systems Rehabilitation Hospital of Northern Indi In Lieu of Form CMS-2552-10

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-3047
From 05/01/2021
To 04/30/2022
Pare/Time Prepared: 9/15/2022 11: 43 am

General Fund Special Purpose Fund Endowment Fund

					10 04/30/2022	9/15/2022 11:	
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2.00	3.00	4. 00	5. 00	
1. 00	Fund balances at beginning of period	1100	-4, 282, 644			0	1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-1, 603, 740				2. 00
3.00	Total (sum of line 1 and line 2)		-5, 886, 384		(	0	3. 00
4.00	INTERCOMPANY ADJ	1, 427			0	0	4. 00
5.00		0			0	0	5. 00
6.00		0			0	0	6. 00
7. 00		0			0	0	7. 00
8. 00		0			0	0	8. 00
9.00	T	0	4 40-		0	0	9. 00
10.00	Total additions (sum of line 4-9)		1, 427			0	10.00
11.00	Subtotal (line 3 plus line 10)		-5, 884, 957			0	11.00
12. 00 13. 00	Deductions (debit adjustments) (specify)	0			0	0	12.00
14. 00					0	0 0	13. 00 14. 00
15. 00					0	0	15. 00
16. 00					0	0	16. 00
17. 00					0	0	17. 00
18. 00	Total deductions (sum of lines 12-17)	1	0				18. 00
19. 00	Fund balance at end of period per balance		-5, 884, 957			o	19. 00
	sheet (line 11 minus line 18)						
		Endowment Fund	PI ant	Fund			
		6, 00	7. 00	8, 00			
1. 00	Fund balances at beginning of period	0.00	7.00	8.00	0		1. 00
2. 00	Net income (loss) (from Wkst. G-3, line 29)	1					2. 00
3. 00	Total (sum of line 1 and line 2)	O			0		3. 00
4.00	INTERCOMPANY ADJ		0				4. 00
5.00			0				5. 00
6.00			0				6. 00
7.00			0				7. 00
8.00			0				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			0				13.00
14. 00 15. 00			0				14. 00 15. 00
16. 00			0				16. 00
17. 00			0				17. 00
18. 00	Total deductions (sum of lines 12-17)		U		0		18.00
19. 00	Fund balance at end of period per balance				0		19. 00
50	sheet (line 11 minus line 18)				-		
		'	'	•	į.		•

40.00

41.00

42.00

43.00

0

14, 031, 330

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-3047 Peri od: Worksheet G-2 From 05/01/2021 Parts I & II Date/Time Prepared: 04/30/2022 9/15/2022 11:43 am Cost Center Description Outpati ent Inpati ent Total 1.00 2. 00 3.00 PART I - PATIENT REVENUES General Inpatient Routine Services 1.00 Hospi tal 7, 756, 000 7, 756, 000 1.00 2.00 SUBPROVIDER - IPF 2.00 3.00 SUBPROVIDER - IRF 3.00 4.00 SUBPROVI DER 4.00 Swing bed - SNF Swing bed - NF 5.00 0 0 5.00 6.00 0 0 6.00 SKILLED NURSING FACILITY 0 7.00 Λ 7.00 8.00 NURSING FACILITY 8.00 9.00 OTHER LONG TERM CARE 9.00 10.00 Total general inpatient care services (sum of lines 1-9) 7, 756, 000 7, 756, 000 10 00 Intensive Care Type Inpatient Hospital Services 11.00 INTENSIVE CARE UNIT 11.00 12.00 CORONARY CARE UNIT 12.00 BURN INTENSIVE CARE UNIT 13 00 13 00 SURGICAL INTENSIVE CARE UNIT 14.00 14.00 15.00 OTHER SPECIAL CARE (SPECIFY) 15.00 Total intensive care type inpatient hospital services (sum of lines 16, 00 0 0 16, 00 11 - 15) 17.00 7, 756, 000 17.00 Total inpatient routine care services (sum of lines 10 and 16) 7, 756, 000 18.00 Ancillary services 8, 362, 347 8, 362, 347 18.00 Outpatient services 19.00 0 0 0 19.00 RURAL HEALTH CLINIC 20.00 0 0 20.00 21.00 FEDERALLY QUALIFIED HEALTH CENTER 0 0 21.00 0 22. 00 HOME HEALTH AGENCY 0 22.00 AMBULANCE SERVICES 23.00 0 23.00 CMHC 24.00 24.00 25.00 AMBULATORY SURGICAL CENTER (D. P.) 25.00 26.00 HOSPI CE 26.00 27.00 OTHER (SPECIFY) 27.00 0 Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. 16, 118, 347 16, 118, 347 28.00 28.00 G-3, line 1) PART II - OPERATING EXPENSES Operating expenses (per Wkst. A, column 3, line 200) 29.00 14, 031, 330 29.00 0 30.00 ADD (SPECIFY) 30.00 0 31.00 31.00 32.00 32.00 0 33.00 33.00 0 34.00 34.00 35.00 35.00 36.00 Total additions (sum of lines 30-35) 0 36.00 0 37.00 DEDUCT (SPECIFY) 37.00 0 38.00 38.00 39.00 0 39.00 0

40.00

41.00

42.00

43.00

Total deductions (sum of lines 37-41)

to Wkst. G-3, line 4)

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

Health Financial Systems	Rehabilitation Hospital	of Northern Indi	In Lieu	u of Form CMS-2552-10
CTATEMENT OF DEVENUES AND EVDENCES		D	D!!	Waskahaat C 2

Health Financial Systems		Rehabilitation Hospital of Northern Indi		In Lieu of Form CMS-2552-10		
STATEMENT OF REVENUES AND EXPENSES			Provider CCN: 15-3047	Peri od:	Worksheet G-3	
				From 05/01/2021 To 04/30/2022	Date/Time Pre	nared:
				10 04/30/2022	9/15/2022 11:	
	-				1. 00	
1.00					16, 118, 347	1. 00
2.00	Less contractual allowances and discounts on patients' accounts				3, 731, 651	2. 00
3.00	Net patient revenues (line 1 minus line 2)				12, 386, 696	3. 00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)				14, 031, 330	
5.00	Net income from service to patients (line 3 minus line 4)				-1, 644, 634	5. 00
	OTHER I NCOME				_	
6.00	Contributions, donations, bequests	s, etc			0	6. 00
7.00	Income from investments				3, 660	7. 00
8. 00	Revenues from telephone and other		on services		0	8. 00
9. 00	Revenue from television and radio	servi ce			0	9. 00
	Purchase di scounts				0	10.00
	Rebates and refunds of expenses				0	11.00
	Parking lot receipts				0	12.00
	Revenue from laundry and linen ser				0	13.00
	Revenue from meals sold to employe				4, 982	
	Revenue from rental of living quar				0	15.00
	Revenue from sale of medical and s		than patients		0	16.00
	Revenue from sale of drugs to other				0	17.00
	Revenue from sale of medical recor				214	
	Tuition (fees, sale of textbooks,				0	19.00
	Revenue from gifts, flowers, coffe	ee snops, and canteen			0	20.00
	Rental of vending machines				445	
	Rental of hospital space				0	22. 00
	Governmental appropriations				0	23. 00
	MI SC I NC, TRANSPORT				31, 593	
	COVID-19 PHE Funding	24)			40.004	24. 50
	Total other income (sum of lines 6	1-24)			40, 894	
	Total (line 5 plus line 25)				-1, 603, 740	
	OTHER EXPENSES (SPECIFY)	27 and subseriets)			0	27. 00 28. 00
	Total other expenses (sum of line Net income (or loss) for the perio				-1, 603, 740	
∠9. 00	The File (of 1055) for the perio	ou (Time 20 IIII lius Time 28)			- 1, 603, 740	29.00